Your Health and Welfare Plan

Effective date: June 1, 2017

United Association of Journeymen
and Apprentices of the Plumbing
and Pipe Fitting Industry
of the United States and Canada

Issued: June 1, 2017

To: Members of U.A. Local 71

Dear Brothers/Sisters:

Your trustees are pleased to provide you with an updated description of the benefits currently in effect under your health and welfare plan. Through the continued services of Coughlin & Associates Ltd., our appointed consultant and administrator, the trustees have made improvements to benefits while ensuring the best possible underwriting arrangements available to U.A. Local 71.

We encourage you to read the booklet carefully and familiarize yourself with the benefits. Any questions on the benefits, administration or claims should be directed to your plan administrator:

Coughlin & Associates Ltd.
466 Tremblay Road
Ottawa, ON K1G 3R1

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

General inquiries:
613-231-2266

Claims inquiries:
613-231-8540

Toll free:
1-888-613-1234

Fax:
613-231-2345

E-mail:
webmaster@coughlin.ca

Website:
www.coughlin.ca

Claim forms can be downloaded from the Coughlin & Associates Ltd. website at **www.coughlin.ca**.

This booklet is also available for viewing on the U.A. Local 71 website at **www.ualocal71.com** and the member portal at **www.coughlin.ca**.

We are pleased to make these arrangements on your behalf and trust you will agree that your improved health and welfare plan is proof of our continued interest in the security and well being of you and your family.

Fraternally yours,

The Trustees,

Michael Crosbie
Angus Maisonneuve
Michael Reid
Eric Turpin

Important

This document contains important information concerning your group benefits coverage and should be kept in a safe place. This booklet supersedes and replaces all previously communicated material and is the plan document in respect to the benefits described herein.

Manulife Financial underwrites the life, dependant life, survivor income and long-term disability insurance. Chubb Life Insurance underwrites the accidental death and dismemberment insurance. The weekly indemnity, extended health care and dental care benefits are underwritten on a self-insured basis by the U.A. Local 71 Health and Welfare Trust Fund. The Member Assistance Program (MAP) is provided by the Ottawa-Hull Building Trades Council. The Great-West Life Assurance Company underwrites the optional life insurance.

As sponsor of the plan, the U.A. Local 71 Health and Welfare Trust Fund or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The U.A. Local 71 Health and Welfare Trust Fund, or its trustees or designates, have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-insured extended health care, dental or vision coverage described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decisions of the U.A. Local 71 Health and Welfare Trust Fund, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

This information summarizes the benefits and provisions of your group benefits plan. It does not constitute the group contracts, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. However, if there is any question of interpretation, all rights with respect to a covered person will be governed by the group contracts issued or administered by the respective insurance companies or trust fund.

Change of Address

It is important to inform the plan administrator and the U.A. Local 71 union office of any address changes. All changes must be in writing and bear your signature.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should errors, omissions or disputes occur, the terms of the policies issued to the U.A. Local 71 Health and Welfare Trust Fund will prevail.

Respecting your personal information

The administrator of your group benefits plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Coughlin uses your Social Insurance Number for the purposes of government reporting, identification and administration of your benefits plan. Coughlin may exchange your personal information with the following persons, organizations or parties: financial institutions; government agencies; insurance companies; employers or former employers; your local union; plan trustees; actuaries; and, auditors. Coughlin may use the personal information on file to provide you with additional information regarding any benefits to which you are entitled.

You have the right to access or update any incorrect information by submitting a request in writing to:

The Privacy Officer
Coughlin & Associates Ltd.
P.O. Box 3517, Station C
OTTAWA, ON K1Y 4H5

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Contract Policy Numbers

The insurers and administrators of these benefits are as follows:

Benefit	Insurer / Administrator	Policy Number
Basic member life insurance, basic dependant life insurance, survivor income benefit and long-term disability benefit	Manulife Financial / Coughlin & Associates Ltd.	**0031319**
Basic accidental death and dismemberment (AD&D) insurance	Chubb Life Insurance / Coughlin & Associates Ltd.	**AB10406517**
Member and spouse optional life insurance	Great-West Life / Coughlin & Associates Ltd.	**135809 - Division 15**
Weekly indemnity, extended health care and dental care	Self-insured / Coughlin & Associates Ltd.	**L7194**
Member assistance program (MAP)	Ottawa-Hull Building Trades Council	

If you have questions about your group benefits that are not covered in this booklet, please contact Coughlin & Associates Ltd., your plan administrator, at 613-231-2266, or toll-free 1-888-613-1234, or fax 613-231-2345, or e-mail at webmaster@coughlin.ca.

If there are any discrepancies between the group contract and the member benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Benefit Summary (Effective June 1, 2017)

Life Insurance Benefit

Eligibility:	Active and retired members under age 65 and retired members age 65 and over who continue to work for a minimum of 40 hours per month for a contributing employer
Amount:	$100,000 Active or retired after May 31, 2012 $50,000 Members who did not work for a participating employer after May 31, 2012 $35,000 Members who did not work for a participating employer after December 31, 2000
Termination:	After 36 months of unemployment

Optional Life Insurance and Optional Spousal Insurance

Amount:	Units of $10,000. Maximum of 50 units or $500,000
Termination:	Attainment of age 70

Accidental Death and Dismemberment (AD&D)

Eligibility:	Active and retired members under age 65 and retired members age 65 and over who continue to work a minimum of 40 hours per month for a contributing employer
Amount:	$100,000 Active or retired after May 31, 2012 $70,000 Members who did not work for a participating employer after May 31, 2012
Termination:	After 36 months of unemployment

Survivor Income Benefit

Amount:	$300 per month
Maximum and minimum:	60 monthly payments
Termination:	Attainment of age 65 or after 36 months of unemployment, if earlier

Dependant Life Insurance

Eligibility:	Active and retired members under age 65 and retired members age 65 and over who continue to work for a minimum of 40 hours per month for a contributing employer

Active or retired after December 31, 2000:

Amount - spouse:	$10,000
Amount - each eligible child:	$10,000
Termination:	After 36 months of unemployment

Weekly Indemnity Benefit

Gross weekly benefit:	$543 and linked to changes in the level of Employment Insurance (EI) benefits
Elimination period:	Nil for accident or hospitalization; seven days for sickness
Maximum benefit period:	26 weeks from disability date

Termination:	After 24 months of unemployment, attainment of age 65, or retirement, if earlier
Note:	Benefits are not payable from the 2nd to the 16th week inclusive when the disabled member is eligible for Employment Insurance (EI) sickness benefits

Long-Term Disability

Gross monthly benefit:	$1,500 (may be reduced by other benefits)
Elimination period:	26 weeks including up to 15 weeks during which EI benefits are payable; otherwise, 26 weeks
Maximum benefit period:	To age 65
Termination:	After 24 months of unemployment, attainment of age 65, or retirement, if earlier

Extended Health Care Benefit (Member and Dependants)

Deductible:	Maximum of $25 per calendar year for individual or family coverage (extended health care and dental care benefits combined)
Co-insurance:	90% of eligible expenses in excess of the deductible amount. Prescriptions in excess of the deductible purchased through the Coughlin & Associates Ltd. Preferred Provider Network of pharmacies will be reimbursed at 100%
Lifetime maximum:	$60,000 per individual. If the lifetime maximum has been paid for any individual, it may be restored, provided evidence of good health is submitted to, and approved by, the plan administrator. If the evidence of good health is not approved, a continuing maximum of up to $1,000 per individual each policy year will apply
Prescription drugs and medication maximums:	Smoking cessation: $700 per calendar year Fertility drugs: $1,000 per calendar year Erectile dysfunction drugs: $1,000 per person per calendar year Viscosupplementation products: $1,500 per person per calendar year
Medical supplies:	Purchase or rental of any artificial limb or eye or spinal brace $750 per appliance once in a lifetime per person Purchase or rental of a brace for a limb, casts, splints, electronic heart pacemaker, truss or crutch Purchase or rental of a walker, wheelchair, hospital bed or iron lung Purchase or repair of custom-moulded arch supports two pairs per calendar year to a maximum of $225 per pair Purchase or repair of two pairs per calendar year of custom-made orthopedic shoes, lifts, wedges or Dennis Brown splints to an overall maximum of $300 per pair Support stockings six pairs per calendar year to a maximum of $60 per pair Supplies required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, Parkinson's syndrome, Crohn's disease and diabetes Glucometer once every five years and diabetic strips Purchase of external prostheses and bra(s) after mastectomy; mastectomy bra(s) up to six per calendar year Purchase or rental of cryocuff or continuous passive motion machines (CPM) to a combined maximum of $200 every three calendar years Purchase or rental of a transcutaneous nerve simulator (TNS) to a calendar year maximum of $200

	Purchase of wigs or hair piece to a lifetime maximum of $300 Circumcision to a lifetime maximum of $100 Plasma, blood or blood substitutes and their administration Hearing aids to a maximum $2,000 per five consecutive calendar years; Custom-molded ear plugs to a calendar year maximum of one pair and $200 per pair Purchase or rental of oxygen equipment IUDs to a limit of $500 every 60 months
Diagnostic procedures:	X-ray and diagnostic laboratory procedures and X-ray or radium therapy
Registered nurse:	To a lifetime maximum of $5,000
Paramedical services:	An aggregate calendar year maximum of $1,500 per person: Acupuncturist Audiologist Chiropractor Masseur Naturopath Osteopath Physiotherapist Podiatrist Psychologist Speech therapist
Termination:	No age limit

Vision Care Benefit (Member and Dependants)

Deductible:	Nil
Co-insurance:	100%
Eyeglasses:	Prescribed by an ophthalmologist or optometrist for the correction of defective vision including sunglasses and safety glasses; to a maximum of $100 each for frames plus the cost of lenses per individual, once in any 24 consecutive month period; or Replacement lenses for eyeglasses required within 24 consecutive months of the initial prescription due to a change in prescription; or
Contact lenses:	Prescribed by an ophthalmologist or optometrist; to a maximum of $150 per individual, once in any continuous period of 24 consecutive month period; or
Laser eye surgery:	Laser eye surgery, including the cost of the guarantee, to a lifetime maximum of $2,000 per individual
Eye examinations:	Eye examinations to a maximum of $125 every 24 consecutive months
Termination:	No age limit

Dental Care Benefit (Member and Dependants)

Deductible:	Maximum of $25 per calendar year for individual or family coverage (extended health care and dental care benefits combined)
Co-insurance:	Basic and major treatments: 95% of eligible dental expenses that are in excess of the deductible amount
Orthodontic services:	100% for a dependent child under age 19 to a lifetime maximum of $2,500
Calendar year maximum:	$1,500 per individual each year for basic and major treatments combined
Fee guide year:	The 2016 Dental Association fee schedule for general practitioners in the province where the dental procedure or service was rendered. The fee guide may be upgraded from time to time
Termination:	No age limit

Member Assistance Program (MAP)

MAP is a program designed to address personal concerns and matters of social well-being. You or your family may use the service for counselling, to get information about community services or get some help in solving personal problems.

The service is completely confidential. Contact the co-ordinator, Gabriel Chauvin, pager 613-787-8075 or at telephone number 613-742-7962.

Termination: No age limit

Note:

Please refer to the *General information* section for full details on the continuation and termination clauses applicable to this *Benefit Summary*.

General Information

Plan Effective Date

The plan described in this booklet is up-to-date as of June 1, 2017.

Your Plan Supplements Provincial Plans

Your group benefits plan is designed to provide valuable supplementary protection, but not to duplicate or take the place of the benefits available under the provincial hospital and medical care plans.

Therefore, the benefits plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

Hour Bank Account

The fund administrator maintains an Hour Bank account for each member. It shows the hours you worked for a contributing employer for whom contributions have been made to purchase of group insurance.

For each hour you work, a contribution, as defined in your collective agreement or participation agreement, will be made to your account.

Each month, a number of hours will be deducted from your Hour Bank account to cover the cost of your benefits. The number of required hours can fluctuate depending on the cost of the benefits. Any hours over and above those required to maintain your monthly coverage will accumulate in your Hour Bank.

Each month, you will receive a statement highlighting the hours you worked in the previous month.

It is important to understand how the cycle of reporting hours works. The hours you work in a month are reported to the plan administrator the following month. They are then used to provide coverage in the second month following the month worked. For example, the hours you work in February are reported to the administrator in March. They are then used to determine your eligibility for coverage for the month of April.

The following table illustrates this process:

Month Worked	Month Reported	Month Covered
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August

Who May Be Insured

This plan is for members in good standing of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, Local 71, who work for contributing employers or who are U.A. local representatives.

The staff of the U.A. Local 71 union hall and the U.A. Canadian office who have entered into a participation agreement with the U.A. Local 71 may also participate.

Independent contractors and non-members are not eligible.

Subject to the prior approval of the board of trustees, the office staff of plumbing contractors who have a participation agreement with the U.A. Local 71 may be allowed to participate upon the submission of evidence of insurability and the disclosure of pre-existing conditions.

Member Eligibility

You and your eligible dependants will become insured on the first day of the second month coincident with or next following the accumulation of 280 hours in your Hour Bank account. The 280 hours must be accumulated in a 24-month period.

If you are absent from work on the date your insurance would normally become effective or increase, then that insurance will not take effect until you return to work. An absence due solely to a paid vacation or general holiday will not delay your coverage.

Continuation of Coverage

The continuation of coverage provisions below are contingent on you satisfying the eligibility requirements of the plan and are subject to the termination of insurance clauses.

During Absence from Work (Members of the Union Excluding U.A. Representatives)

You may elect to make direct payments to the plan for continued coverage according to the conditions of the collective agreement. You may make direct payments up to a maximum of 24 consecutive calendar months for all benefits. If you qualify for the subsidy program for disabled members, you may participate for a longer period on a self-pay basis. However, if you become totally disabled while unemployed, your weekly indemnity coverage will only be payable in the event you are recalled to work and your disability prevents you from returning to work.

After 24 months of unemployment, you will not be eligible for weekly indemnity or long-term disability benefits and your monthly payment will reduce accordingly. After 36 months of unemployment, life insurance, accidental death and dismemberment, dependant group life and survivor income benefit will cease and your premiums will reduce again. At this point, your coverage will consist of extended health care, vision care, dental care and the member assistance program.

During Absence from Work (Eligible Staff/Contractors/Salaried Workers)

Your coverage will continue until your Hour Bank account balance is depleted. Direct payments are not permitted while you are unemployed.

While on Workplace Safety and Insurance Board (WSIB) Benefits

If due to a job-related sickness or injury, you are accepted to receive WSIB benefits, health & welfare and pension contributions will be made on your behalf for up to 12 months. The contributions are based on the number of hours required to cover the monthly premium. They will be made once the plan administrator is provided with a copy of the incident report (Form 7) from your employer and copies of the monthly WSIB cheque stubs from you. Please contact the plan administrator for further details.

If you remain on WSIB for more than 12 months, your coverage under this plan may be continued without payment of premiums for a maximum of seven years or to the end of the WSIB work re-integration program or the attainment of age 65, whichever is earlier.

The seven year period includes the first 12 months during which health & welfare and pension contributions are made on your behalf. It does not apply if you are approved for a lifetime WSIB pension.

While Disabled

If you become disabled as defined under the life insurance, the weekly indemnity or the LTD sections of this booklet, your coverage under this plan may be continued without payment of premiums, subject to the following conditions:

1. your Hour Bank account is completely depleted (for WI only); and
2. you have been accepted for waiver of premium by the insurer; or
3. you have been accepted for WI or LTD benefits by the insurer.

Following Retirement

When you retire and draw a pension from the U.A. Local 71 pension plan, your coverage will revert to one of the following options, providing the benefits are in force at the time you retire and you participated in the health and welfare plan for the two years immediately preceding your effective date of retirement.

1. If you retire before attaining age 64, you may maintain group life, dependant group life, accidental death and dismemberment, the survivor income benefit, extended health care and dental coverage until age 65. After that time, you may change your coverage to extended health care and dental coverage or extended health care coverage only.
2. If you retire at age 64, you may self-pay for all benefits (except weekly indemnity and long-term disability) for a maximum of 12 consecutive months. After that time, you may change your coverage to extended health care and dental coverage or extended health care coverage only.
3. If you retire at age 65 or later, you may select a benefits package that includes extended health care and dental coverage or extended health care coverage only.
4. If you retire at age 65 and continue to work a minimum of 40 hours per month, you may continue to have life, dependant group life, accidental death and dismemberment, extended health care and dental coverage. If you work less than 40 hours per month, you may choose between either of the options offered in Item 3 above.

The above options are also available to members in good standing who are insured at the time of their retirement and provide proof of retirement from another plan such as the Commission de construction du Québec (CCQ), the National Pipeline Plan or the U.A. International Plan administered in Washington. Staff of the U.A. Local 71 and U.A. Canadian office whose benefits are in force at the time of retirement are also eligible.

Completion of a member election form confirming your retirement status and choice of benefit package will be required at the time of your retirement.

A monthly payment is required from you to maintain your membership in the U.A. Local 71. A payment is also required for retiree coverage as described above. You may choose to have either or both of these monthly payments deducted automatically from your monthly pension payment by completing a payment deduction options form at retirement. As an alternative, you may subscribe to the Pre-Authorized Payment (PAP) program where the cost of your retiree coverage is taken directly from your bank account on the 15th day of every month. The PAP service cannot be used for the payment of membership dues.

Following Death

If you die while insured under this plan, your surviving spouse and dependent children are allowed to maintain extended health care and dental care benefits using the banked hours remaining in your account. If these banked hours are not sufficient to provide coverage for 24 months following your death, your surviving spouse may self-pay to the end of the 24 month period. If the banked hours are not sufficient to cover the first month's premium following the member's death, the plan will provide a one-month subsidy to the surviving spouse. If your surviving spouse is already insured as a plan member at the time of your death, your account balance will automatically be transferred to your surviving spouse's Hour Bank account.

Subsidy Programs

Subsidy Program for Unemployed Members

As a member in good standing of the union, you may qualify for a monthly subsidy of no more than 24 consecutive months in duration, if you meet the following criteria:

1. you are under the age of 65;
2. you are not collecting a pension from any source;
3. you are a member in good standing of the U.A. Local 71;
4. you are unemployed, or was not able to work more than 44 hours last month;
5. you have signed the book at the union hall confirming that you are available for work;
6. you have not refused a job from the U.A. Local 71 union hall dispatching;
7. your coverage is in force but your Hour Bank account has been depleted and contains less than one month's premium;
8. you must obtain the business manager's signature, submit a new application to the plan administrator, Coughlin & Associates Ltd., and pay the required $35 premium for every month you wish to be subsidized.

The subsidy programs may be terminated at any time without notice if the financial status of the plan no longer supports them. The $35 payment is also subject to change at the discretion of the Trustees.

Subsidy Program for Members in Receipt of Disability Pension

If you are approved for a disability pension from the U.A. Local 71 Pension Plan, your coverage will be subsidized until the age of 65 or until you recover from your disability, if earlier. To maintain your coverage, you will be required to pay $35 per month towards the cost of your benefits package.

Termination of Insurance

Your insurance coverage will terminate on the earliest of:

- the day you cease to be a member in good standing of the union;
- the first day of the second month following the month in which the number of bank hours in your account falls below the minimum required to continue your insurance;
- the first day of the month coincident with or immediately following the day you reach the applicable age limit, if any;
- for the WI and LTD benefits, the first day of the second month following the date on which you have been laid-off for more than 24 months;
- for life insurance, dependant life, AD&D and survivor income benefit, the first day of the second month following the date on which you have been laid-off for more than 36 months;
- the first day of the second month following the date you have made 24 consecutive monthly self-payments;
- the day on which you become a full-time member of the armed forces;
- the day you fail to make your premium contribution; or
- the day the group policy terminates.

For your benefits on termination, refer to the *Conversion privilege* and the *Benefits after termination* sections in each benefit description.

Termination of Insurance Following Transfer to Another Plan or Local

If you enter into a temporary reciprocal agreement and request that the hours you work in Ontario be transferred to your home plan with the Commission de Construction du Québec or another U.A. local in

Canada, all remaining funds in your Hour Bank account will be reciprocated to the home plan and your coverage under this plan will terminate. A letter of understanding will be required by the plan administrator as soon as you enter in the temporary reciprocal agreement.

Reinstatement of Benefits

If some or all of your coverage has terminated, you may again become eligible for that coverage on the date on which you have completed the waiting period as defined under *Member eligibility,* provided you remain within the eligible covered classes.

If coverage for extended health care, vision care and dental care is terminated and reinstated in the same calendar year, the applicable maximums established on January 1 are carried to the end of that calendar year.

Hour Bank Account Balance on Termination or Death of Member

If your coverage terminates because you have been expelled from the union or charged, you will forfeit any balance remaining in your account. If your coverage terminates because you are transferring to another local while a member in good standing, you will be entitled to a reciprocal transfer of your account balance.

If you die while insured under this plan, your surviving spouse and dependent children are allowed to maintain extended health care and dental care benefits using the banked hours remaining in your account. If these banked hours are not sufficient to provide coverage for 24 months following your death, your surviving spouse may self-pay to the end of the 24 month period. If the banked hours are not sufficient to cover the first month's premium following the member's death, the plan will provide a one-month subsidy to the surviving spouse. If your surviving spouse is already insured as a plan member at the time of your death, your account balance will automatically be transferred to your surviving spouse's Hour Bank account.

On retirement, you must use your account balance to extend coverage beyond your retirement date.

Hour Bank Account Balance Exceeding Two Years of Premiums

Health Care Spending Account (HCSA)

You may elect to transfer the eligible excess from your Hour Bank account, up to a maximum of $500, to a member Health Care Spending Account (HCSA). A declaration and election form will be sent to you in advance of the new year with a confirmation of the balance available for transfer to your HCSA.

Claims that have not been reimbursed at 100% by the core plan will automatically have the balance paid from the HCSA account's available balance. An eligible excess is any amount in excess of what is required to provide you with 24 months of coverage under the U.A. Local 71 Health and Welfare Plan, to a maximum of $500 per calendar year.

The HCSA option is permitted under applicable law if you elect the transfer within the deadline provided. You will be able to claim against your HCSA for eligible medical expenses not covered under the provincial health care system, for a period not to exceed 24 months, as prescribed by the Canada Revenue Agency (CRA), after which your remaining balance, if any, in the HCSA must be forfeited. A list of eligible medical expenses for an HCSA can be found on the CRA's website at the following address: **www.cra-arc.gc.ca/medical/**.

Refund of Annual Excess Funding

You may elect to withdraw the contributions made in the current calendar year that exceed the premiums required to provide the current year's benefits provided you keep a minimum of 24 months of coverage in your Hour Bank account. A declaration and election form will be sent to you in advance of the new year with a confirmation of the balance available for withdrawal. All withdrawals are subject to applicable withholding tax. The withdrawal is permitted under applicable law if you elect it within the deadline provided.

Dependant Eligibility

If you already have dependants, you are eligible for dependant insurance on the date you are eligible for insurance under this plan. If you are without dependants, you will be eligible as of the date you acquire a dependant.

If a dependant (other than a newborn child) is confined to a hospital on the date his insurance would otherwise become effective, then his insurance will not become effective until the first day immediately following his/her discharge from the hospital.

Once your dependant insurance commences, new dependants are insured automatically.

Definition of Dependant

*Qualified dependan*t means your spouse and dependent children as defined below.

Spouse means either:

1. an individual to whom you are legally married; or
2. your common-law partner who is an individual with whom you have been co-habiting for a period of at least 12 months and whom you publicly represent as your spouse.

For the purposes of the policy, you must state the name of the person to be considered your spouse. Only one spouse will be considered at any time as being covered under the policy. Divorced or legally separated spouses are not covered.

Dependent child means either:

1. an unmarried person who is your natural or adopted child; or
2. a child of a common-law spouse, who resides with you and is dependent on you for support and who is:

    A. younger than 21 years of age; or
    B. between the ages of 21 and 24 inclusively and in full-time attendance at an accredited institute of learning and dependent on you for support; or
    C. 21 years or older and incapable of self-sustaining employment due to a mental or physical disability. The child's coverage will be continued under the policy, provided the child's disability has existed continuously from a time when the child was otherwise insured as a dependant under this policy. Supporting documentation completed by a medical doctor will be required.

Termination of Dependant Insurance

Your dependant insurance will terminate on the earliest of:

- the day your insurance terminates;
- the day you no longer have any eligible dependants;

- the day you fail to make your premium contribution; or
- the day the dependant insurance terminates under the group policy.

The insurance of any one dependant will terminate the day that individual no longer meets the definition of dependant.

Beneficiary Rules

Beneficiary means the person you designate in writing to receive the benefits. Upon enrolment in the plan, a member must designate the beneficiary to whom the death benefits will be payable.

Benefits becoming payable under the policy on account of your death will be paid to your beneficiary. Any benefit amount for which there is no beneficiary at your death will be paid to your estate.

Subject to any statutory rights of any beneficiaries, you may change the beneficiary at any time by filing a new designation form with the plan administrator. The change will be effective on the date the form is signed, but it will not apply to any payment made by the insurer prior to the date the form is received by the plan administrator.

Where the Civil Code of Quebec applies, any designation of a spouse as beneficiary is **irrevocable** (cannot be changed without the written consent of the irrevocable beneficiary) unless you make the designation **revocable** (can be changed at any time without the consent of the revocable beneficiary). A spouse includes any person recognized by law in this context as equivalent to your spouse.

If there is more than one beneficiary and the form does not specify their shares, the beneficiaries will share equally in any payable benefit.

If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries or, in the absence of a designated beneficiary or beneficiaries, your estate, unless the designation form states otherwise.

Co-Ordination of Benefits

If you or your dependants are also covered under another pre-paid health insurance program or contract, the payment of your benefits will be co-ordinated so that the total benefit you will receive will not exceed 100% of allowable expenses determined based on the reasonable and customary amount.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

Order of Benefit Determination

If a person is eligible to receive a benefit under this plan and the same or a similar benefit under any other plan, payment of benefits shall be decided in the following manner:

1. if another plan does not contain a co-ordination of benefits provision, the benefits of such plan shall be deemed payable prior to the application of benefits under the plan;
2. if another plan contains a co-ordination of benefits provision, the benefits of such plan shall be co-ordinated with the benefits under the plan as follows:

    A. the benefits payable under a plan which insures the individual other than as a dependant will be determined before the benefits of a plan which insures the individual as a dependant;
    B. the benefits payable under a plan that insures the individual as a dependant of a covered person with the earlier month and day of birth in the calendar year; or

C. the benefits payable under a plan that insures the individual as a dependant of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday;

3. in cases of separation or divorce:

   A. the plan of the parent with custody of the child;
   B. the plan of the spouse-partner of the parent with custody of the child;
   C. the plan of the parent not having custody of the child; or
   D. the plan of the spouse-partner of the parent not having custody of the child;

4. if the person is covered under another plan, priority will go to:

   A. the plan where the member is an active, full-time member;
   B. the plan where the member is an active, part-time member; or
   C. the plan where the member is a retiree.

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

Preferred Provider Network (PPN)

Coughlin & Associates Ltd. has entered into an agreement with pharmacies throughout Ontario. Member pharmacies of the Coughlin & Associates Ltd. Preferred Provider Network limit their dispensing fee per prescription and their mark-up on certain drugs to reduce the cost of prescription drugs to you and your plan. Additional information is available from Coughlin & Associates Ltd. and on their website at **www.coughlin.ca**. The website allows you to search for the nearest PPN pharmacy using your postal code. It is suggested that you use the PPN whenever possible.

Change in Coverage

If your coverage changes due to a change in age, class, earnings, dependant status, etc. or as a result of a plan change, it will not be adjusted until the first day, on or after the date of the change on which you are actively at work and the appropriate contribution is being made.

If a dependant is confined to a hospital on the day increased benefits are scheduled to become effective, they will not go into effect until he/she is released. In any case, payment of services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

Change in Information

To ensure that you receive all correspondence and that the proper information is stored in your file, contact the plan administrator as soon as a change (i.e. change in marital status, new dependant, beneficiary or address) occurs. The administrator will tell you which forms you will need to complete to confirm the change.

Taxation

All employer-paid group term life insurance and accidental death and dismemberment insurance premiums are taxable to the member. At the end of February of each year, you will receive the appropriate tax form to be included in your tax calculation for the prior fiscal year.

Member Life Insurance Benefit

The member life insurance benefit pays a lump sum amount to your named beneficiary in the event of your death. The amount of life insurance payable is shown in the *Benefit Summary.*

You may change your beneficiary at any time (subject to any limits set by law) by completing and returning the form available from the plan administrator. If you survive your beneficiary and have not designated a new beneficiary, payment will be made to your estate. You should review your beneficiary designation to ensure it reflects your current intent.

Total Disability/Waiver of Premium

If you become totally disabled for at least six consecutive months before age 65, your life insurance will remain in force for as long as you remain disabled or to a maximum of age 65. No further premiums will be required.

To be considered totally disabled you must, as a result of sickness or injury, be unable to engage in any gainful occupation for which you are qualified or may reasonably become qualified by your training, education or experience. Proof of your total disability will be required from time to time.

To be accepted for the waiver of premium, an application must be submitted to the insurer within 12 months of the date of your total disability. Please contact the plan administrator for the application.

Conversion Privilege

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 did not apply for conversion.

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

Optional Life Insurance for You and Your Qualified Spouse

Coverage is available as outlined in the *Benefit Summary*.

Your group optional term life insurance coverage will become effective when your application for insurance is approved.

In the event of your death while insured, the amount of your optional life insurance is payable to your beneficiary.

No benefit will be paid for death resulting from self-destruction within two years of your insurance becoming effective.

Conversion Privilege

If your insurance terminates, you may convert your group optional term life coverage to an individual insurance plan from Great-West Life within 31 days of termination without evidence of insurability or medical examination.

Waiver of Premium

If you become totally and permanently disabled for a period of at least six months, your insurance premiums will be waived until you return to work on a full-time basis.

Accidental Death and Dismemberment (AD&D) Insurance Benefit

Beneficiary Designation

It is understood that indemnity for loss of life of the insured person will be payable to the beneficiary or beneficiaries as per the designation made under the policyholder's group life insurance policy unless a further designation has been made that specifically identifies this policy. Failing such designation, to the estate of the insured person.

All other indemnities of this policy will be payable to the insured person.

Hazards Insured Against

All Hazards Coverage

The company will pay the benefits described in the booklet for any accident which happens while an insured person is covered by the policy.

With respect to air travel, the insurance afforded shall apply to loss caused by or resulting from travel or flight in any aircraft or any other device for aerial navigation, including boarding or alighting there from, except:

a) while being used for any test or experimental purpose; or
b) while the insured person is operating, learning to operate or serving as a member of the crew thereof; or
c) while being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Canadian Armed Forces Air Transport Command or the similar air transport service of any other country; or
d) any such aircraft or device which is owned or leased by or on behalf of the policyholder or any subsidiary or affiliate of such policyholder, or by an insured person or any member of his/her household; or
e) while being used for firefighting, pipeline inspection, power line inspection, aerial photography or exploration.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above 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 one year of the disappearance, stranding, sinking or wrecking of the conveyance in which the insured person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that the insured person suffered loss of life resulting from bodily injuries sustained in the accident and covered under this policy.

Maximum Benefit

Coverage	Benefit Amount
Accidental death and dismemberment	see *Benefit Summary*
Repatriation benefit	$15,000
Rehabilitation benefit	$15,000
Family transportation benefit	$15,000

Coverage	Benefit Amount
Spousal occupational training benefit	$15,000
Home alteration and vehicle modification benefit	$50,000
Day care benefit	$5,000 per year/four years
Seat belt benefit	$25,000
Special education benefit	$5,000 per year/four years
Conversion benefit	$200,000
In-hospital confinement monthly income benefit	$2,500 per month/ 365 days overall maximum
Identification benefit	$15,000
Bereavement benefit	$5,000
Cosmetic disfigurement	$25,000
Funeral benefit	$5,000

Description of Coverage

If such injuries shall result in any one of the following specific losses within one year from the date of accident, the company will pay the benefit specified as applicable thereto, based upon the principal sum as outlined in the *Benefit Summary*; provided, however, that not more than one (the largest) of such benefits shall be paid with respect to all injuries resulting from one accident.

Schedule of Losses

Coverage	Benefit Amount
Loss of life	Principal sum
Loss of entire sight of both eyes	Principal sum
Loss of one hand and one foot	Principal sum
Loss of use of one hand and one foot	Principal sum
Loss of one hand and entire sight of one eye	Principal sum
Loss of one foot and entire sight of one eye	Principal sum
Loss of speech and hearing in both ears	Principal sum
Brain death	Principal sum
Loss of both arms, both hands, both legs or both feet	Two times the principal sum
Loss of use of both arms, both hands, both legs or both feet	Two times the principal sum
Quadriplegia	Two times the principal sum
Paraplegia	Two times the principal sum
Hemiplegia	Two times the principal sum
Loss of one arm or one leg	Three quarters of the principal sum
Loss of use of one arm or one leg	Three quarters of the principal sum
Loss of one hand or one foot	Three quarters of the principal sum
Loss of use of one hand or one foot	Three quarters of the principal sum
Loss of entire sight of one eye	Three quarters of the principal sum
Loss of speech or hearing in both ears	Three quarters of the principal sum
Loss of thumb and index finger of same hand	One third of the principal sum
Loss of use of thumb and index finger of same hand	One third of the principal sum
Loss of four fingers of same hand	One third of the principal sum
Loss of hearing in one ear	One third of the principal sum
Loss of all toes of same foot	One quarter of the principal sum

“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 loss of thumb and index finger of same hand or loss of four fingers of same hand, 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 the insured suffers complete severance of a hand, foot, arm or leg as described above, then the company will pay the amount specified above 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 the company to be permanent.

“Loss of use” shall mean the total and irrecoverable loss of function of an arm, hand, foot or leg, provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to the company 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

When injuries covered by this policy result in loss of life of an insured person outside 50 kilometres from their city of permanent residence or outside Canada and within 365 days from the date of the accident, the company 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 the maximum amount shown in the *Maximum benefit* section.

Rehabilitation

When injuries shall result in a payment being made by the company under any benefit excluding the loss of life benefit provided by the policy, the company will pay in addition the reasonable and necessary expenses actually incurred up to the maximum amount shown in the *Maximum benefit* section, provided:

a) such training is required because of such injuries and in order for the insured member to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;
b) expenses be incurred within two years from the date of the accident; and
c) no payment will be made for ordinary living, traveling or clothing expenses.

Family Transportation

When injuries covered by this policy result in an insured person being confined as an in-patient in a hospital outside 50 kilometres from the insured person's city of permanent residence or outside Canada and requires personal attendance of a member of the insured person's immediate family as recommended by the attending physician, in writing, the company 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 the confined insured person, but not to exceed the maximum amount shown in the *Maximum benefit* section.

“Member of the immediate family” means the spouse, legal or common-law, parent, grandparent, child over age 18, brother or sister of the insured person.

Spousal Occupational Training

When injuries to the insured member shall result in a payment being made by the company under the loss of life benefit, the company will pay in addition the expense actually incurred, within 365 days from the date of the accident, by the spouse of the insured member for a formal occupational 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 shall not exceed the maximum amount shown in the *Maximum benefit* section.

Home Alteration and Vehicle Modification

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 such injury subsequently requires the use of a wheelchair to be ambulatory, the company will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

a) the one-time cost of alterations to the insured person's principal residence to make it wheelchair accessible and habitable; and
b) the one-time cost of modifications necessary to a motor vehicle utilized by the insured person to make the vehicle accessible or operable for the insured person.

The maximum payable under items a) and b) above combined will not exceed 10% of the insured person’s amount of principal sum to the maximum amount shown in the *Maximum benefit* section.

Benefit payments herein will not be paid unless:

a) 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
b) 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.

Day Care

If an insured person suffers loss of life in a covered accident while the policy is in force, the company 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:

a) the lesser of 5% of the insured person's principal sum amount; or
b) a maximum of $5,000 per year;

for any dependent child who is 12 years of age and under. The dependent child must be enrolled in a legally licensed day care centre on the date of the accident or must be enrolled 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 four consecutive years, but only upon receipt of satisfactory proof that the child is enrolled in a legally licensed day care centre.

“Dependent child” or “dependent children” means the member’s eligible unmarried natural, legitimate, illegitimate, adopted, step child or common-law child who is principally dependent on the member or the member’s spouse for financial support.

Continuance of Coverage

Coverage shall be extended for a period of 12 months, subject to payment of premiums if the members of the policyholder are:

a) laid-off on temporary basis;
b) temporarily absent from work due to short-term disability;
c) on leave of absence; or
d) on maternity leave.

If an member of the policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt

This benefit is only payable in the event an insured person sustains an injury which results in one of the losses payable under the schedule of losses. The insured person's amount of principal sum will be increased by 10%, to the maximum amount shown in the *Maximum benefit* section, if, at the time of the accident, the 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.

Special Education Benefit

If an insured person suffers loss of life in a covered accident while the policy is in force, the company will pay, in addition to all other benefits payable under the policy, a special education benefit of 5% of the insured person's principal sum up 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 institution of higher learning within 365 days following the date of the accident.

The special education benefit is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Conversion

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

Waiver of Premium

If an insured member, under age 65, becomes totally disabled for six consecutive months, while this policy is in force and the insured member provides evidence of total disability satisfactory to the company, the company will then waive the payment of each premium which falls due with respect to the insured member and any insured dependants. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to the insured member until age 65 or earlier termination of the policy (applicable to accidental death and dismemberment insurance and critical illness

insurance only). If the insured member ceases to be disabled and the insured member returns to employment with the policyholder and is a member of an eligible class, insurance with respect to the insured member may be continued upon resumption of premium payments by the insured member or the policyholder.

If after 120 days, an insured member receives approval of any long-term disability claim provided under a policy of group insurance through the employer, the company will then waive the payment of each premium subject to the terms stated above.

Recurrent Disabilities

When an member becomes totally disabled again from the same or related causes within six months of cessation of the waiver of premiums, then all such recurrences will be considered a continuation of the same disability and the company will waive the six month qualification period.

If the same disability recurs more than six months after cessation of the waiver of premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

Termination of Waiver of Premium

Waiver of premiums will cease on the earliest of:

a) the date the member ceases to meet this policy's definition of totally disabled;
b) the date the member does not supply the company with appropriate medical evidence as deemed necessary by the company;
c) the date the member is no longer receiving regular, ongoing care and treatment of a physician appropriate for the disabling condition, as determined by the company;
d) the date the member does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by the company;
e) the date the member turns 65;
f) the date the policy terminates (applicable to accidental death and dismemberment insurance and critical illness insurance only); or
g) the date the member dies.

Coverage During Waiver of Premium

While premiums are being waived, insurance under this policy on the member and their dependants will continue to be in force. The principal sum will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

Totally Disabled or Total Disability

"Totally disabled" or "total disability" with respect to waiver of premium means disability resulting from injury or sickness which prevents engagement in the member's regular occupation for six consecutive months.

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 of this policy, excluding the loss of life benefit and the insured person is confined in a hospital as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself/herself, the company will pay for each full month 1% of the insured person's principal sum, subject to the maximum amount shown in the *Maximum benefit* section, or 1/30 of such monthly benefit for each day of partial month, retroactive to the first 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:

a) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
b) provides 24 hour a day nursing service by registered or graduate nurses;
c) has a staff of one or more licensed physicians available at all times;
d) provides organized facilities for diagnosis and surgical facilities; and
e) 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 who is provided at least one day's room and board by the hospital.

Identification

In the event accidental loss of life is sustained by the insured person not less than 150 kilometres from the 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, the company 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 three days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the insured person. The maximum amount payable will not exceed the amount shown in the *Maximum benefit* section.

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.

Bereavement

When injuries covered by this policy result in loss of life of an insured person within 365 days from the date of the accident, the company will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the insured person for up to six sessions of grief counseling, by a professional counsellor, subject to a maximum shown in the *Maximum benefit* section.

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

Cosmetic Disfigurement

If an insured person suffers a third degree burn due to an accident, the company 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	Percent of Principal Sum Payable
Face, neck, head	100%
Hand and 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 percent 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.

Funeral

When injuries covered by this policy result in loss of life of an insured person within 365 days from the date of the accident, the company will pay the actual expense incurred for preparing the deceased for burial or cremation, but shall not exceed the maximum amount shown in the *Maximum benefit* section.

Exclusions

This policy does not cover loss caused by or resulting from any one or more of the following:

a) intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
b) declared or undeclared war or any act thereof;
c) accident occurring while the 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 the company pro-rata for any such period of full-time active duty); and
d) 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.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of this policy. For residents of Alberta and British Columbia: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. For residents of Manitoba: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. For residents of Ontario: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person’s province of residence.

Survivor Income Benefit (SIB)

The survivor income benefit can guarantee continued security for your survivors by providing them with a regular monthly income in the event of your death. The amount of benefit payable is shown in the *Benefit Summary.*

If your spouse dies while receiving benefits during the guaranteed benefit period (five years from the date of the first payment), a lump sum value of the unpaid benefit that would have been paid during the guaranteed benefit period will be paid to your spouse's estate, unless designated otherwise.

The survivor income benefit is provided to all members, regardless of their marital status. If there is a surviving spouse at the time of your death, this benefit is payable to your surviving spouse. If there is no surviving spouse, this benefit is payable to your designated beneficiary or in the absence of a designated beneficiary, your estate. As it relates to the beneficiary, the term *surviving spouse* is, therefore, deemed to also be a surviving non-spouse with respect to the survivor income benefit only.

Total Disability/Waiver of Premium

If you become totally disabled for at least six consecutive months before age 65, your survivor income benefit will remain in force for as long as you remain disabled, subject to the age limit shown in the *Benefit Summary.* No further premiums will be required.

To be considered totally disabled, you must as a result of sickness or injury, be unable to engage in any gainful occupation for which you are qualified or may reasonably become qualified by your training, education or experience. Proof of your total disability will be required from time to time.

To be accepted for the waiver of premium, an application must be submitted to the insurer within 12 months of the date of your total disability. Contact the plan administrator for the necessary application forms.

Conversion Privilege

If your survivor income benefit terminates, because:

- your employment for insurance purposes terminates; or
- your employment classification changes to one that does not include the SIB; or
- you are disabled, eligible for the waiver of premium benefit, and do not return to active employment; and
- you are under age 65, or just attained age 65;

you may convert the commuted value of your terminated amount to an individual life insurance policy.

The convertible amount will be reduced by any previously converted life insurance still in force with Manulife Financial. Medical evidence is not required. However, you may not convert the survivor income benefit if you do not have eligible dependants, or you reach an age in which SIB coverage terminates.

To convert the benefit, you must submit a written application to Manulife Financial, together with the first premium, within 31 days of the date the benefit terminates. Should you die within this 31-day period, the amount you were eligible to convert would still be payable.

Conversion may be made to an individual policy of:

1. one-year term insurance, provided you have not attained age 65;
2. term insurance to age 65; or

3. any other regular plan then being issued by Manulife Financial.

The premium for such individual policy will be at the rate in use by Manulife Financial for the class of risk to which you then belong and for your attained age.

If you wish to exercise the conversion privilege, please contact the plan administrator.

Dependant Life Insurance Benefit

The dependant life insurance benefit pays you a lump sum amount in the event of the death of any of your insured dependants. The amount of life insurance payable is shown in the *Benefit Summary.*

Conversion Privilege

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 did not 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.

Weekly Indemnity (WI) Benefit

This benefit is designed to provide financial assistance if you become unable to work because of a non-occupational accident or sickness.

Total disability means you are unable, as a result of sickness or injury, to perform substantially the whole of the duties of your regular occupation and you do not engage in any other gainful occupation.

Non-occupational accident or sickness means an accident not related to employment or sickness not covered under any Workplace Safety and Insurance Board benefit or similar law.

Elimination period means the period of time shown in the *Benefit Summary* for weekly indemnity benefits that must elapse after the commencement of each period of total disability before any benefit is payable.

Weekly indemnity benefits pay you a regular weekly income while you are absent from work for brief periods of illness or disability. Benefits are available if you become totally disabled while insured under this benefit, provided you are under the regular and personal care of a physician. If you are on temporary lay-off at the time of your disability, the payment of benefits will not commence until you are called back to work, provided the elimination period has expired.

Payments start after the elimination period. They begin on the first day of disability due to an accident or hospitalization and on the eighth day of disability due to an illness. They continue as long as you remain totally disabled, up to the maximum benefit period shown in the *Benefit Summary.* Benefits are not payable from the 2nd week to the 16th week inclusive, if you are eligible to receive sickness benefits from employment insurance.

Amount of Benefit

The amount of weekly indemnity payable is the amount shown in the *Benefit Summary* in effect when you become disabled. Weekly indemnity benefits are reduced by any amount payable to you as a result of your disability under any Workplace Safety and Insurance Board Act, (or similar legislation) and by any indemnity for loss of time payable to you under the Quebec Automobile Insurance Act. Any payment for a period of less than one week will be at the daily rate of one-seventh of the relevant weekly payment.

There is no offset for partial disability pensions or Workplace Safety Insurance Board allowances for prior or unrelated disabilities.

Employment Insurance (EI) Benefits

Weekly indemnity benefits will not be payable from the 2nd to the 16th week inclusive if you are eligible for and receive EI sickness benefits. You must show proof of application to and response from EI. If you become disabled due to a non-occupational illness or sickness, application for EI benefits should be made immediately.

Subrogation

If you are entitled to recover damages from loss of income from another person as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the weekly indemnity benefit provision, the Health and Welfare Trust Fund will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

In connection with the Health and Welfare Trust Fund's right of subrogation, the plan administrator may require that you complete a reimbursement questionnaire and execute a reimbursement agreement. If within 30 days of the request, you do not complete and return the reimbursement questionnaire and agreement to the plan

administrator, the benefits which you would otherwise be entitled to receive under the weekly indemnity benefit provision will not be paid until you do so.

Exclusions

Disability benefits are not payable under the following circumstances:

- intentionally self-inflicted injuries while sane or insane;
- war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit, a criminal offence;
- medical or surgical care that is cosmetic, but does not include cosmetic care provided as a result of an accident;
- during a pregnancy leave of absence where you qualify for EI sickness benefits;
- during a period in which you are entitled to disability payments under any policy of group long-term disability insurance;
- for any period where you do not participate and co-operate in a reasonable and customary treatment program that is prescribed and performed by a legally licensed doctor of medicine and is of the nature and frequency for the condition involved;
- for any period where injury or disability results from substance abuse including alcoholism or drug addiction, unless you are participating in a recognized substance withdrawal program; or
- for a disability resulting from an accident that occurs while you are the operator of a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (0.08%).

Recurrent Disability

If your disability recurs within 14 days of returning to work and it is due to the same or related causes, payments for the balance of the benefit period will resume immediately.

Extension of Benefit After Termination

If you are totally disabled on the date your weekly indemnity benefit terminates, you will continue to be covered for that disability as if the benefit were still in force, provided the disability remains continuous and you qualify for long-term disability benefits. Please refer to the *Long-term disability* section of this booklet.

Taxation

Under tax regulations, losses of income benefits are subject to federal and provincial income tax. The federal and provincial taxes shall be withheld from your cheque and remitted to the proper government. At year end, a *T4A Supplementary* form and *Relevé 1,* if applicable, will be issued and should be included with your tax return.

Long-Term Disability (LTD) Benefit

The long-term disability benefit provides income security should you become totally disabled and remain so over a long period of time.

While you are insured under the benefit, it will provide monthly income payments if you become totally disabled and remain so during the elimination period, providing you remain under the regular care and personal attendance of a physician. If you satisfy the elimination period while age 64, the maximum benefit period shall be 12 consecutive months.

Alcoholism or drug addiction is considered a sickness under the benefit provision as long as you are receiving continuous care and treatment satisfactory to Manulife Financial.

Payments start after the elimination period and continue as long as you remain totally disabled and provide proof of continued total disability, as required by the insurer, to the maximum benefit period shown in the *Benefit Summary.*

The following definitions apply:

Physician means a person who is duly licensed to prescribe and administer any drugs or to perform surgical procedures.

Gross pre-disability earnings mean your monthly earnings on the date of commencement of total disability.

Total disability or totally disabled means that, during the elimination period and the following 24 months, you are incapacitated to the extent that you are unable to perform any and every duty of your own occupation or employment.

Thereafter, you shall be considered totally disabled if you are incapacitated to the extent that you are unable to perform any and every duty of any occupation or employment for which you are reasonably qualified by education, training or experience. Such incapacity must result from a medically determinable physical or mental impairment.

In no event shall total disability be deemed to exist for any period during which you are not under the regular care and treatment of a legally qualified physician.

Amount of Benefit

The amount of long-term disability benefit payable is the amount shown in the *Benefit Summary.* Any payments for a period of less than one month will be at the daily rate of 1/30 of the relevant monthly income.

Integration With Other Benefits

The long-term disability benefit determined from the *Benefit Summary* and payable to you will be reduced by any disability benefit which you are eligible to receive under any Workplace Safety and Insurance Act or similar law. In addition, it will be further reduced by the amount by which the sum of the long-term disability benefit plus all the amounts listed below, exceed 85% of your gross pre-disability earnings:

- any disability benefit which you are eligible to receive under the Canada or Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan, excluding dependant benefits payable to you under those plans, and excluding cost of living increases made under those plans after the commencement of benefits under this benefit provision;

- any disability benefit or retirement benefit payable under any group insurance or retirement plan available through employment or a professional association;
- where permitted by law, any disability or loss-of-time benefits payable under any no-fault provision in any government plan of automobile insurance;
- any payments provided under any other government plan or law or by any other government agency, but excluding benefits payable by the Employment Insurance Commission;
- any amounts paid by any employer as salary continuation or as severance allowance and vacation pay which commence on or after the date of the commencement of the total disability for which benefits are payable under this benefit provision, unless proof is submitted to Manulife Financial that your application for any such benefit has been denied;
- any income received while participating in a rehabilitation program;
- self-employment income.

If you participate in a rehabilitation program, your total monthly income while disabled cannot exceed 100% of your gross monthly earnings as of the date the disability commenced. If your income exceeds 100%, the long-term disability income benefit will be reduced by the amount of the excess.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the long-term disability benefit provision, Manulife Financial will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

The company may require you to complete a reimbursement questionnaire and execute a reimbursement agreement. If within 30 days of the request you do not complete and return the reimbursement questionnaire and agreement to Manulife Financial, the benefits which you would otherwise be entitled to receive under the long-term disability benefit will not be paid until you do so.

Waiver of Premium

Effective with the first full policy month for which benefits become payable, Manulife Financial will waive any premium due under this benefit. Benefits will continue for each full policy month for which benefits are payable.

Rehabilitation

Manulife Financial may recommend an appropriate rehabilitation program for a member receiving LTD benefits. They will notify you in writing of their approval of the program and the extent of their support for it.

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

- your regular occupation on a part-time basis;
- a formal vocational training program; or
- any other training program deemed suitable by Manulife Financial.

LTD benefits will continue to be payable to a member participating in a Manulife Financial-approved rehabilitation program for up to 24 consecutive months.

All reasonable and customary expenses incurred by you in connection with the program and for which you have received prior approval from Manulife Financial, will be reimbursed by that company. Expenses payable through government programs or a third party insurer will not be reimbursed by the insurer.

The gross benefit, less reductions, will be further reduced by 50% of any earnings received from employment under the rehabilitation program, subject to the all-source maximum outlined in the *Integration with other benefits* section.

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

- the date you cease to be totally disabled;
- the date you complete the rehabilitation program; or
- the date Manulife Financial determines that you are not participating in the rehabilitation program to the extent previously agreed upon by you and the insurer.

If you are eligible for full benefits and elect a different and lesser paid occupation not related to the program of rehabilitation described above, the gross benefit less reductions shall be further reduced by 50% of the earnings from the lesser paid occupation elected, subject to the *Integration with other benefits* section.

Exclusions

Long-term disability benefits are not payable under the following circumstances:

- for disability resulting from intentional self-inflicted injury or disease or attempted self-destruction while sane or insane;
- from injury or disease that occurred while you are on active duty in the armed forces of any country, state or international organization or which results from war, or act of war, whether declared or not;
- disability resulting from participation in the commission of a criminal offence;
- injury or disability resulting from substance abuse including alcoholism or drug addiction, unless you are participating in a recognized substance withdrawal program;
- during a period of imprisonment in a penal institution or confinement in a hospital or similar institution as a result of criminal proceedings;
- for any portion of a period of disability during which you receive treatment by a therapist, unless the treatment is recommended by a physician deemed appropriate by Manulife Financial;
- for disability resulting from an accident that occurs while you operate a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (0.08%);
- during any leave of absence, including maternity leave;
- if you refuse to participate in a rehabilitation program deemed appropriate by Manulife Financial, the attending physician or independent medical opinion; or
- during any portion of a period of disability during which you do not participate in the treatment program recommended by your physician.

Termination of Payments

Payments under this benefit will cease on the earliest of the following dates:

- the date on which you cease to be totally disabled;
- the date on which you engage in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- the date on which payments have been paid up to the maximum benefit period shown in the *Benefit Summary* for any one period of total disability;
- the premium due date coincident with or immediately following your 65th birthday;
- the date on which you die; or
- the date on which, as determined by Manulife Financial, you have failed to furnish satisfactory evidence of continued total disability or failed to submit to a medical examination as requested by that company.

Recurrent Disability

If your disability recurs within six months of returning to work and is due to the same or related causes, this subsequent period of total disability will be considered to be a continuation of the previous period of total disability. If you return to active work for one full day and become disabled for different and unrelated causes, you will begin a new period of disability.

Extension of Benefit After Termination

If you are totally disabled on the date your long-term disability insurance terminates, Manulife Financial will continue your coverage as if the benefits were still in force, provided the disability remains continuous.

Appeal Procedure

If you appeal the denial/termination of a long-term disability claim, you must submit to the insurer a written notice of appeal. The notice must be submitted to Manulife Financial within 60 days of the date of the insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the insurer within six months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

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

Taxation

Under tax regulations, losses of income benefits are subject to federal and provincial income tax. This tax shall be withheld from your cheque, and remitted to the proper governments. At year end, a *T4A Supplementary* form and *Relevé 1,* if applicable, will be issued and should be included with your tax return.

Extended Health Care Benefit

The extended health care benefit helps pay the cost of eligible medical expenses incurred by you and your insured family members. You will be reimbursed for eligible expenses, not covered by your provincial medicare plan, subject to the deductible, co-insurance, and maximums, if any, shown in the *Benefit Summary.*

Payment will be made for those eligible expenses which are reasonable and necessary and which are incurred on the prior recommendation of a legally qualified physician.

Deductible

The deductible amounts shown in the *Benefit Summary* is the total amount of eligible expenses you must absorb in any calendar year before reimbursement can be made.

Preferred Provider Network (PPN)

Coughlin & Associates Ltd. has entered into an agreement with pharmacies throughout Ontario. Member pharmacies of the Coughlin & Associates Ltd. Preferred Provider Network limit their dispensing fee per prescription and their mark-up on certain drugs to reduce the cost of prescription drugs to you and your plan. Additional information is available from Coughlin & Associates Ltd. and on their website at **www.coughlin.ca**. The website allows you to search for the nearest PPN pharmacy using your postal code. It is suggested that you use the PPN whenever possible. You must identify yourself as a member of the PPN when you present your prescription.

Pay-Direct Drug Card

Members and their dependants can have their drug claims processed immediately at any pharmacy in Canada, using the pay-direct drug card, provided by Express Scripts Canada.

With the pay-direct drug card, your drug claims will be processed in seconds while you wait at the retail pharmacy of your choice. Simply present the card to your pharmacist when you purchase a prescription medication. There are no forms to complete.

The generic equivalent of a brand name drug will automatically be dispensed and the plan will reimburse based on the generic price unless the physician has indicated that the patient has an adverse reaction to the generic drug.

If you have single coverage, you will receive one pay-direct drug card. If you have family coverage, you will receive two cards; one for you and one for your spouse. Note: Only the name of the covered member appears on the card.

An additional card will be issued in the name of each eligible dependant between the ages of 21 and 24 inclusively and in full-time attendance at college or university.

If you need an additional card, or if your card is lost or stolen, contact Coughlin & Associates Ltd. at 613-231-2266.

Eligible Expenses (In Canada)

Prescription Drugs and Medication

- Drugs, sera, vaccines and injectables available only by prescription when prescribed by a physician or dentist and dispensed by a pharmacist, physician or dentist to a maximum of three months' supply at one time. Birth control drugs are subject to a maximum of a one-year supply. Certain eligible medications may require prior authorization of the administrator. The generic equivalent of a brand name drug will automatically be dispensed and the plan will reimburse based on the generic price unless the physician has indicated that the patient has an adverse reaction to the generic drug. A special form will need to be completed by the physician for the plan administrator;
- Compound mixture: when at least one ingredient is a prescription-requiring medication and is eligible under the plan.
- Charges for nicotine replacement products will be reimbursed as outlined in the *Benefit Summary*. A doctor's referral is required for the nicotine patch and gum.
- Fertility drugs are reimbursed as outlined in the *Benefit Summary*. The limit does not apply to drugs related to artificial insemination and in vitro-fertilization when listed on the Régie d'Assurance-Maladie du Québec (RAMQ) formulary.
- Erectile dysfunction drugs are reimbursed as outlined in the *Benefit Summary*.
- Xenical® is covered, if prescribed for non-cosmetic reasons.
- Allergy serum.
- Drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and Parkinson's or heart disease are covered.
- Viscosupplementation products (such as Synvisc®, Neovisc®, or Replasyn®) are covered as outlined in the *Benefit Summary*.
- Hospital administered drugs are not covered.
- Only prescription drugs that are for non-cosmetic use will be considered.
- All medications listed under the RAMQ formulary.

Reimbursement for prescription drugs will not be permitted where the member and/or spouse qualifies for reimbursement under their provincial health plan. Members age 65 and over must subscribe to a provincial plan, when available. Provincial deductible and co-payment charges are included as eligible expenses.

While the plan pays 90% of all drug costs, members who are residents of Quebec may apply to have the balance of the remaining 10% of charges to be covered by the RAMQ. Members residing in the province of Quebec must provide proof of payment of the maximum out-of-pocket expense under RAMQ before reimbursement can occur under this plan.

Medical Supplies

The plan will pay for the following medical supplies and expenses on the recommendation of a qualified, licensed physician:

- purchase or rental (not repair or replacement) of any artificial limb or eye or spinal brace where the loss of the limb or eye occurs while the individual is insured under this benefit. Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental (not repair or replacement) of a brace for a limb, casts, splints, electronic heart pacemaker, truss, or crutch (braces must be constructed in rigid or semi-rigid material required for normal activities of daily living not solely for sports related activities);
- purchase or rental of a walker, wheelchair, hospital bed or iron lung. The physician's referral must indicate the medical diagnosis;
- purchase or repair of custom-moulded arch supports. Coverage is limited as outlined in the *Benefit Summary*. The physician's referral must indicate the medical diagnosis;

- purchase or repair of custom-made orthopedic shoes, lifts, wedges or Dennis Brown splints. Coverage is limited as outlined in the *Benefit Summary*. The physician's referral must indicate the medical diagnosis;
- support stockings, purchased from a medical supply store. Coverage is limited as outlined in the *Benefit Summary*. A prescription showing the brand name and compression ratio is required as well as the medical diagnosis;
- supplies required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, Parkinson's syndrome, Crohn's disease and diabetes;
- glucometer and diabetic strips necessary to take readings. Coverage is limited as outlined in the *Benefit Summary*;
- purchase of external prostheses and bra(s) after mastectomy; mastectomy bra(s) are eligible as outlined in the *Benefit Summary*;
- purchase or rental of cryocuff or continuous passive motion machines (CPM). Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental of a transcutaneous nerve simulator (TNS). Coverage is limited as outlined in the *Benefit Summary.* The physician's referral must indicate the medical diagnosis and expected duration of treatment;
- purchase of wigs or hair piece in the event of loss of hair due to a medical condition. Coverage is limited as outlined in the *Benefit Summary*;
- circumcision. Coverage is limited as outlined in the *Benefit Summary*;
- plasma, blood or blood substitutes and their administration;
- hearing aids when prescribed by the attending certified ear, nose and throat specialist. Coverage is limited as outlined in the *Benefit Summary*. It does not include payment for repairs and maintenance, batteries or recharging devices or other such accessories. If hearing loss is work-related, you should seek reimbursement from WSIB (Ontario) or the CSST (Quebec);
- custom-molded ear plugs. Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental of oxygen equipment; and
- IUDs as outlined in the *Benefit Summary*.

It is strongly recommended that an estimate be submitted, along with all supporting medical documentation, prior to incurring any costs. Any approved equipment will be reimbursed based on the date for which the item is paid in full.

Diagnostic Procedures

X-ray and diagnostic laboratory procedures and X-ray or radium therapy (not while confined to a hospital).

Registered Nurse

The plan will pay the service of an out-of-hospital registered nurse who is not related to you by blood or marriage or normally lives with you or any of your dependants. However, if you are a retired member, eligible expenses will be as outlined in the *Benefit Summary*. Prior approval by the plan administrator is required.

Paramedical Services

Professional services of the following licensed, certified or registered practitioners (when operating within their recognized fields in the province in which they are registered and not treating members of their immediate family). Coverage is limited as outlined in the *Benefit Summary*. Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment plan for services, reimbursement will be made at the end of the contract period by submitting all receipts and a copy of the contract. All receipts must clearly indicate the names of those attending the sessions/services.

Note that fees for forms or reports for use by a third party are not eligible for reimbursement.

Practitioners

Acupuncturist	Osteopath
Audiologist	Physiotherapist
Chiropractor	Podiatrist
Masseur	Psychologist
Naturopath	Speech therapist

* Psychology services are not subject to co-insurance factor.
** Payable on first dollar basis (provincial maximum does not have to be satisfied first).

Detox Facilities

Hospital expenses to cover the treatment of alcoholism or drug addiction in a residential treatment centre approved by the province, to a maximum period of 28 days per confinement for the treatment of alcoholism and to a maximum of 92 days for the treatment of drug addiction, for usual and customary charges. Doctor's recommendation is required.

Dental Treatment (Accidental Injury)

The repair or replacement of natural teeth as a direct result of an accidental injury sustained while the individual is insured under this benefit. Treatment must start within 90 days of the injury. Reimbursement will be made up to the suggested fees in the current provincial dental association fee guide for general practitioners (of the province where the dental treatment was provided) for the least expensive treatment that will provide a professionally adequate result. No reimbursement is made for treatment performed more than two years after the date of injury.

Transportation

A licensed local ground or air ambulance to transport an individual because of either emergency or in-patient treatment:

- from the place where the individual suffers the accident or sickness to the nearest hospital where adequate treatment is available;
- from one hospital to another hospital; and
- from a hospital to the individual's residence.

Vision Care Benefit

Reimbursement of eligible eyewear is based on the date the items are paid for in full.

This benefit does not contain any deductible or co-insurance factor. The plan will pay for vision care charges incurred as outlined in the *Benefit Summary*.

You may claim either for eye glasses or contact lenses, not both, in addition to prescription safety glasses, every 24 consecutive months.

Outside Canada

Expenses incurred outside Canada will not be reimbursable under this plan. However, if you are a member in good standing and are working for a U.A. contractor in the United States, your prescription drugs may be covered while out-of-country to a limit of $10,000 per lifetime and subject to approval by the board of trustees.

Out-of-Province but Within Canada

Expenses incurred out-of-province, but within Canada are covered as if benefits would have been payable had they been incurred in your home province providing:

- treatment is for an emergency or unexpected illness, if the insured person is temporarily out-of-province for business, vacation or furthering education; or
- the required medical treatment is not readily available in the province of residence and the person is forced to seek such treatment elsewhere.

Benefit is limited to $10,000 per lifetime for retired members.

Expenses Not Covered

- Expenses incurred as a result of intentionally self-inflicted injuries (while sane or insane) or as a result of committing, or attempting to commit, a criminal offence.
- Dental treatment except those listed under the *Dental care* benefit or the *Dental treatment (accidental injury)* section.
- Cosmetic treatment unless due to an accidental bodily injury sustained while the individual was insured under this benefit.
- Any injury or illness for which the covered person is entitled to indemnity or compensation under any Workplace Safety and Insurance Board Act.
- Expenses for treatment required as a result of war (declared or not), service in the armed forces of any country or participation in a riot, insurrection or civil commotion.
- Services, treatments or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Examinations or services required for the use of a third party.
- Travel for health reasons.
- Any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage.
- The replacement of an existing appliance that has been lost, mislaid or stolen.
- Drugs, sera, injectables and supplies that are not approved by Health Canada (Drugs and Health Products) or are experimental or limited in use whether or not so approved.
- Proprietary or patent medicines, dietary or health foods and nutritional products.
- Hospital room charges.
- Charges for the administration of drugs.
- Expenses that are required for recreation or sports.
- Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society.
- Diaphragms and breast pumps.

Note:

Faxed medical claims are not accepted.

Restoration of Lifetime Maximum

If the lifetime maximum has been paid for any individual, it may be restored, provided evidence of good health is submitted to and approved by the plan administrator. If the evidence of good health is not approved, a continuing maximum of up to $1,000 per individual each calendar year will apply.

Extension of Benefit After Termination

This benefit normally ceases the date your coverage terminates. However, if on that date you are totally disabled or any of your insured dependants is confined to a hospital, this health benefit will continue for the duration of the disability or hospitalization up to the end of the next calendar year following the year you terminated employment. Benefits will cease on termination of the group policy.

To be considered totally disabled you must, as a result of sickness or injury, be unable to engage in any gainful occupation for which you are qualified or may reasonably become qualified by your training, education or experience.

Dental Care Benefit

The dental care benefit helps with the cost of certain eligible dental expenses incurred by you or your insured family members. To qualify as an eligible expense, the dental treatment must be recommended and performed by a dentist or an independent dental hygienist. Reimbursement will not exceed the suggested fees in the appropriate dental fee guide for the least expensive treatment that will provide a professionally adequate result.

Fee Guide

Fee guide means the Dental Association Fee Guide for General Practitioners of the province where the dental procedure or service was rendered published for the calendar year identified in the *Benefit Summary.* If there is no applicable fee guide in that province or territory, the appropriate fee guide in Ontario will be used.

Alternate Benefit Clause

Situations may arise where alternate methods of treatment may be available. It is solely up to you and your dentist to decide which method will be employed. As the basis for determining its liability, the plan administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result. The Alternate Benefit Clause cannot be applied to excluded provisions, services or devices.

Only those treatments listed are eligible.

Pre-Existing Condition

Eligible expenses incurred by an individual during the first four months of his/her coverage, will not be reimbursed if those expenses result from dental treatment begun or arranged for in the four months before his/her coverage began.

Treatment Plan or Estimate

In order for you and your dentist to learn in advance how much the plan will pay and how much must be paid by you, it is recommended that a treatment plan be filed with the plan administrator whenever the total cost of the proposed dental work is expected to exceed $500. The plan identifies coverage and limitations for specific services, specific limits and dental fee guide allowance before dental treatment commences. It is not intended to limit your choice of dentist, tell you or your dentist what treatment should be performed, establish fees or to guarantee reimbursement after coverage ceases.

A treatment plan is a plan of dental treatment (including X-rays, if required) showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the dentist, and the cost of the proposed treatment.

Deductible

The deductible amount shown in the *Benefit Summary* is the total amount of eligible expenses you must absorb in any calendar year before reimbursement can be made. If the deductible for the extended health care has already been paid, the deductible under the dental care does not need to be paid and vice-versa.

Eligible Expenses

Basic and Preventive Treatment

- The following services will be eligible for payment once every calendar year:

    - recall oral examinations (once every calendar year);
    - bite-wing X-rays (once every calendar year);
    - prophylaxis/polishing (maximum one unit of 15 minutes duration per calendar year);
    - topical application of an anti-carcinogenic substance.

- Complete oral examinations (once every 24 consecutive months).
- Dental X-rays, except that panoramic film and full mouth X-rays are each limited to one set in any period of 24 consecutive months.
- Dental consultations.
- Mouthguards and the initial provision and installation of space maintainers for missing primary teeth.
- Occlusal equilibration.
- Pit and fissure sealants, on permanent molars only, for dependent children up to age 18, once per tooth per lifetime.
- Amalgam, silicate, acrylic or composite restorations excluding prefabricated veneer application.
- Retentive pins, pre-formed stainless steel and polycarbonate crowns.
- Injection of antibiotic drugs when prescribed by a dentist.

Note:

Eligible expenses for services that are performed by a dental hygienist under the supervision of a dentist or an independent dental hygienist will be covered.

Endodontics, Periodontics, Oral Surgery

- Endodontic services covering the treatment of disease of the pulp chamber and pulp canals (root canal therapy), including endodontic bleaching.
- Periodontic services covering the treatment of disease of the soft tissues (gums) and bone supporting the teeth.
- Uncomplicated removal of erupted teeth and the surgical removal of impacted teeth and residual roots.
- General anesthesia required in relation to dental surgery or extractions.
- Oral surgery not specifically provided under *Basic and preventive treatment.*
- Therapeutic scaling is limited to a maximum of eight units of time (15 minutes per unit) every calendar year.

Major Restorative Treatment

- Full or partial dentures or fixed bridgework or other appliances:

    - if necessitated by the extraction of at least one natural tooth while the individual is insured under this benefit;
    - if the existing appliance is temporary and is replaced by a permanent denture or bridgework within 12 months of the date the temporary appliance was installed; or
    - if the existing appliance is at least five years old and cannot be made serviceable (does not apply to dentures).

- Metal inlays, onlays and crowns, once every five years.
- Repairs to an existing crown, bridge, inlay or onlay, once every five years.
- Veneer application for non-cosmetic reasons.
- Repair, re-basing and re-lining of dentures.

- Denture adjustments, except that minor adjustments are limited to once in any period of six consecutive months.
- Replacement dentures once every five years.
- Dental implants (payable under Alternate Benefit Clause).

Note:

Eligible expenses for services that are performed by a licensed denturist within the scope of his/her license will be covered.

Orthodontic Treatment

Orthodontic treatment reimbursed as outlined in the *Benefit Summary* for dependent children aged 18 or under. Coverage is limited as outlined in the *Benefit Summary*.

- Orthodontic examination.
- Diagnostic photographs and casts.
- Orthodontic observations, adjustments or appliances.
- Payment for on-going treatment in progress.
- Related laboratory fees.

An orthodontic treatment plan must be submitted prior to initial claim. Reimbursement for the initial orthodontic fee must not exceed 35% of the total cost of the treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan. Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

Expenses Not Covered

- Expenses incurred as a result of intentionally self-inflicted injuries (while sane or insane) or as a result of committing or attempting to commit a criminal offence.
- Dental treatment received outside Canada.
- Any injury or illness for which the covered person is entitled to indemnity or compensation under any Workplace Safety and Insurance Board Act.
- Expenses for treatment required as a result of war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.
- Charges levied by a dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Cosmetic surgery or treatment (when so classified by the plan administrator) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Expenses for permanent splinting of teeth.
- Services, treatments or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
- The replacement of an existing appliance that has been lost, mislaid or stolen.
- Examinations required for the use of a third party.
- Porcelain appliances on molar teeth.

Benefit After Termination

No benefits are payable for dental care expenses incurred after the date your coverage under this benefit terminates. This would apply even if you had submitted a detailed treatment plan and the plan administrator had advised you of the amount of eligible reimbursement.

Member Assistance Program (MAP)

Purpose of the Program

MAP is a confidential service to assist members and their dependants who are experiencing personal problems.

U.A. Local 71, in co-operation with the Ottawa-Hull Building Trades Council, is pleased to be able to offer help in many areas such as:

- stress induced by personal, work or family issues;
- burn-out;
- financial and legal concerns;
- alcohol or drug abuse, including referrals to treatment, after-care and help for the family;
- communication;
- family violence;
- abuse (verbal, sexual, physical); or
- divorce or separation.

Please call Co-ordinator Gabriel Chauvin, at pager number 613-787-8075 or at telephone number 613-742-7962. He will return your call as soon as possible.

Confidentiality means that any information you share with Mr. Chauvin will not be given to anyone, unless you give written permission to share something with a specific person, unless demanded by law.

How to Claim Benefits

When you have a claim, ask the plan administrator for the appropriate claim form. Complete it promptly and return it to the plan administrator. Make sure your claims are submitted within the time period required. You can be assured of faster payment of claims, where required information is complete and accurate.

Sometimes, physicians or dentists send in the claim forms directly. This frequently delays claim settlement as they may not realize that the member and/or employer sections must also be completed.

Life, Dependant Life, Survivor Income Benefit

Written proof of the occurrence, cause and circumstances of the loss will be required by the earliest of the following:

- 15 months following the date the loss was incurred;
- 90 days following the date of termination of an individual's insurance; or
- 90 days following the date of termination of a coverage or the policy.

Accidental Death and Dismemberment

In the event of a claim, immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Notice of claim must be given to Chubb Life Insurance within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life Insurance within 90 days from the date of the accident or after survival period.

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 reasonable 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 Chubb Life Insurance accept notice of claim beyond one year.

Long-Term Disability

Initial written notice of a claim must be submitted to the plan administrator within 30 days of the expiry of the elimination period and initial written proof, within six months after termination of the first month following the qualifying disability period. Proof of a continuing total disability will be required from time to time.

Access to Plan Documents With Respect to Benefits Covered by Manulife Financial

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

- the sections of the group policy and/or plan document that apply to you and your dependants;
- your application for group benefits; and
- any evidence of insurability you submitted as part of your application for benefits.

Manulife Financial reserves the right to charge you for such documentation after your first request.

Time Limit for Legal Action With Respect to Benefits Covered by Manulife Financial

You may not commence legal action against Manulife Financial (with respect to benefits underwritten by Manulife Financial) less than 30 days after proof has been filed as outlined under *How to claim benefits*. Every action or proceeding against Manulife Financial for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

Weekly Indemnity

Written notice of a claim must be submitted to the plan administrator within 90 days and written proof within 120 days of the date your total disability commenced. Proof of continuing total disability will be required from time to time.

Extended Health Care and Vision Care

Keep a record of all out-of-pocket expenses incurred by you and your covered dependants. It is important that all original receipts for eligible expenses clearly indicate the name of the person for whom the expense was incurred.

If expenses are incurred, obtain a claim form from Coughlin & Associates Ltd. or from their website, **www.coughlin.ca**. Complete the form in its entirety and return it, along with any original receipts, to Coughlin & Associates Ltd.

To be eligible for payment, health claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

Note:

Original receipts in support of claims will not be returned. They will be retained by Coughlin & Associates Ltd.

Dental Care

Standard Dental Claim forms are available from all dentists and are acceptable provided the member, employer information and/or policy number is clearly indicated.

If dental expenses are incurred, obtain a claim form from Coughlin & Associates Ltd. or your dentist, have the dentist complete his/her portion of the form, complete your portion of the form, and return it to Coughlin & Associates Ltd. for validation. Written proof of claim must be given by the end of the calendar year following the year in which the expense was incurred.

Electronic Dental Claims Processing

Coughlin & Associates Ltd. 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 & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To take advantage of Coughlin's EDI service, please inform your dentist that Coughlin & Associates Ltd. is your plan administrator and present them with the following security codes:

- the Coughlin & Associates Ltd. 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 of your group benefit plan.

The plan administrator can provide you with your member identification number.

When your dental care claim is submitted electronically, it will be processed within two to four business days. The Coughlin & Associates Ltd. walk-in claim processing service is not linked to Telus.

Walk-In Claims Service

For immediate processing and reimbursement, just submit your claim form in person Monday to Friday during regular business hours to the Coughlin & Associates Ltd. head office located at 466 Tremblay Road, Ottawa, Ontario K1G 3R1.

Note:

When your health, vision or dental care benefits terminate for any reason, written proof of claim must be given to Coughlin & Associates Ltd. within 90 days of the date of termination of coverage.

Pre-Authorized Deposit

You can have your health and dental claim reimbursements deposited directly to your bank account.

With Coughlin's Pre-Authorized Deposit (PAD) reimbursement program, you can receive your reimbursements within two to five days following the approval of your health and dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in Coughlin's PAD service, just click on the *"Pre-authorized deposit forms"* on the homepage of the Coughlin & Associates Ltd. website at **www.coughlin.ca**.

Check Your Claims Electronically

You can check the status of your claims and access your claims history and accumulated medical, drug, dental and paramedical claim totals electronically. But first, you have to register with Coughlin & Associates Ltd.'s claims administration system. Just follow these steps:

- Go to **www.coughlin.ca**.
- At the top of the page is the "Portal log in area".
- Select the "Member portal" option from the drop-down menu and click on the "GO" button.
- First-time users must click on the "Click here" link under the "New user? Register now…" section and complete the registration form. Note: your temporary password, which is needed to register, should have been provided on previous claim assessments.
- On the Plan Member Registration page, enter your information (Personal ID, Plan Number and Temporary Password) and click on the "Submit" button.
- You should now be successfully registered and logged-in on the *Member portal*.
- After that, just click on "Claims History" to review the status of your recent claims.

Co-Ordination of Benefits

If you or any of your dependants are insured under another plan with similar benefits, the benefits payable under this plan will be adjusted so that the total amount reimbursed from all plans does not exceed the actual expense incurred.

This provision permits you to claim any unpaid portion of a claim under your spouse's plan. To determine which spouse should submit a claim for a dependent child, check the birth dates of the two adults. The spouse whose month and day of birth falls first in the year must submit the child's claim under his/her plan. The remainder can be submitted to the other spouse's plan.

Administration of the Health and Welfare Plan

Subject to the limitation of the health and welfare plan, the trustees may establish rules or regulations for its administration and the transaction of its business. The trustees have the right to interpret the plan and to decide any and all matters, including the right to remedy possible ambiguities, inequities, inconsistencies or omissions. All interpretations, determinations and decisions of the trustees with respect to any matter within their competence shall be final and binding on all parties. In carrying out the provisions of the plan, the trustees may:

- establish committees with powers as they shall determine;
- authorize one or more committee members or an agent to execute or deliver any instrument or make any payment on their behalf;
- retain actuaries, legal counsel and other professional advisors; and
- employ agents and provide for clerical, accounting and actuarial services, as they may require.

Insurance

The trustees shall have the right to enter into an agreement with any properly licensed body to underwrite any or all portion(s) of the benefits.

Payment of Plan Expenses

All reasonable and customary expenses incurred in the operation of the health and welfare plan shall be paid out of the trust fund.

Transactions of the U.A. Local 71 Health and Welfare Trust Fund

The plan administrator shall maintain accounts showing the fiscal transactions of the plan and shall keep this data as necessary for periodic review.

Register

The plan administrator shall keep a register of the names of all members insured under the plan, the amount of benefit coverage in force with respect to each of these members, together with the date coverage became effective and the effective date of any coverage increase or decrease.

Clerical Errors

Clerical errors made by the trustees and the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated. Upon discovery of an error or delay, an appropriate adjustment of premiums will be made.

Claims Appeals Process

In the event a claim is denied and the member is not in agreement, an appeal may be submitted in writing by the member to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the member.

Your Plan is Designed and Fully Administered by:

Coughlin & Associates Ltd.
466 Tremblay Road
Ottawa, ON K1G 3R1

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

General inquiries:
613-231-2266

Claims inquiries:
613-231-8540

Toll free:
1-888-613-1234

Fax:
613-231-2345

E-mail:
webmaster@coughlin.ca

Website:
www.coughlin.ca