HEALTH AND WELFARE TRUST FUND

June 2022

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To: All Plan Participants
SMART Local Union 296
Health and Welfare Trust Fund

We are pleased to present this updated booklet which highlights the current benefits and provisions of the Health and Welfare Plan. We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependents.

These benefits may change at any time given legislative revisions and/or the financial stability of the Plan. Members will be advised of such changes accordingly on a timely basis. The Healthcare, Visioncare, and Dentalcare Expense Benefits are designed to assist you with the payment of these expenses. It may not pay the total cost of services and supplies. In effect, this Group Insurance Plan shares the payment of your Medical and Dental bills with you. The Benefits are underwritten by The Canada Life Assurance Company (formerly referred to as Great-West Life), AIG Insurance Company, and Chubb Life Insurance Company of Canada (Chubb Life). The Prescription Drug Card is coordinated with Express Scripts Canada.

The Plan continues to be administered by L.U. 296 with all claims paid by Coughlin & Associates Ltd.

Your continued participation in the Plan will maintain greater peace of mind and an increased feeling of security for you and your family .

Sincerely,

The Board of Trustees of the
SMART Local Union 296
Health and Welfare Trust Fund

This booklet is for your general information only and is not the insurance policy. In the pages which follow, you will find a brief description of the benefits to which you and your family are entitled, the rules covering eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim, question or problem, which may arise, will be governed by the Trust Agreement and the Insurance Policy issued by The Canada Life Assurance Company, AIG Insurance Company, and Chubb Life.

In the event of any variation between information in this booklet and the provisions of the policies, the later will prevail.

Important Notice

This booklet highlights the principal features of the Plan and is presented as a matter of general information only. Please note that this information is in reference to the governing documents of the Plan:

- AIG Insurance Company. – Travel Medical Emergency benefits – Policy # CMG 9428902
- Chubb Life – Critical Illness – Policy #CI20001801 and Accidental Death & Dismemberment – Policy #AB10406507
- People Corporation – People Connect Mental Health Tool and Preferred Provider Network
- The Canada Life Assurance Company – All remaining benefits – Policy #44791
- Express Scripts Canada – Pay Direct Prescription Drug Card provider

In the event of any variation between the information in this booklet and the provisions of the policy, the latter will prevail.

Notice Regarding Personal Information

When applying for coverage under the Group Benefit Plan, the applicable insurance companies, Express Scripts Canada (Drug Card Provider), the Plan Administrator, and the Claims Adjudicator, Coughlin & Associates Ltd., set up a file with personal information relevant to your benefit coverage under the Plan.

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

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

The files are kept in their offices to allow access to these files when required for insurance purposes.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be placed in writing and may be sent to the office of the Plan Administrator.

Privacy

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

In conjunction with the Insurers, Express Scripts Canada, SMART Local Union 296, and Coughlin & Associates Ltd. are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the Insurers' privacy policies or Coughlin's Privacy Policy, please contact Coughlin & Associates Ltd. directly or via the website www.coughlin.ca for Coughlin's Privacy Policy.

Medical Information Bureau (MIB)

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

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

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

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

Highlight of Benefits

Administration Contact: 296admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca

Member Life Insurance

Benefit..$50,000

Coverage.................................reduces by 50% at age 65 and ceases at age 71
Please refer to Life Insurance section for complete details

Dependent Life Insurance

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

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

Optional Life Insurance

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

Critical Illness (Deluxe Plan)

Participants are eligible to a $10,000 flat benefit for any of 23 insured conditions. The Critical Illness benefit ceases at age 65. Please refer to the Critical Illness booklet prepared by Chubb Life for more information

Optional Critical Illness

Coverage in units of $5,000 to a maximum of $150,000 for Participant and Participant's spouse subject to Medical Questionnaire and approval by Insurer. Please refer to www.coughlin.ca (privileged section) for more information.

Accidental Death and Dismemberment (AD&D) Insurance

Principal Sum $100,000

Coverage..................................reduces by 50% at age 65 and ceases at age 71
Please refer to AD&D Insurance section for complete details

Weekly Disability Income (W.I.)

Benefit...................................... 67% of weekly earnings to the E.I. Maximum

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

Maximum Duration..26 weeks
(subject to E.I. wrap around)

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

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

Long Term Disability (LTD) Income

Benefit $2,000/month

- Subject to direct offsets (WCB and CPP Disability or Retirement benefits)
- All-source limit is 80%

Qualifying Disability Period... following 26 weeks

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

This benefit is non-taxable.

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

Will Preparation (Self-Insured)

Benefit ....$125 plus taxes/lifetime
for Members in good standing with L.U. 296

Custom Molded Earplugs (Self-Insured)

Benefit ....for Insured Members
up to $100/5 years subject to proof of purchase

Visioncare

Laser Eye Surgery, Frames, Lenses ....$400/individual/24 months
$400/12 months if under 18 years of age

Eye Examinations..$100/individual/24 months
$100 /12 months if under 18 years of age

Healthcare

Deductible...Nil

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

Maximum Benefits:

Nursing..$10,000/lifetime

Hospital ....Semi-private room and board

Convalescent Hospital .... $10 per day for each of the first
120 days of confinement

Massage/Chiropractor .... $500/individual/specialist/calendar year
(no medical referral; only covered if provided by a licensed masseur)

Paramedical Services
(Speech Therapy, Naturopath, Osteopath,
Acupuncture, Podiatrist .... $500/individual/specialist/calendar year
(no medical referral)

Psychologist ....$1,000/individual/calendar year
(no medical referral)

Physiotherapy ....$600/individual/calendar year
(no medical referral)

Nicotine Patches/Gum (when prescribed)..................$500/person/lifetime

Orthotic/Orthopedic Shoes .... $500/person/24 months

Hearing Aids ....$500/person/5 years

Prescription Drugs
(Pay Direct Drug Card via Express Scripts Canada)

Maximum .... $3,500/family/calendar year

Dispensing Fee Maximum $12/prescription

Reimbursement based on Generic equivalent (unless Doctor indicates medical necessity) and limits pharmacy markup to 20% of wholesale cost.

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

Fertility Treatments .... $10,000/lifetime max.

Viagra & Family of Drugs .... $200/individual/calendar year

Coverage ceases .... Please refer to the Extended Healthcare Benefit section of this booklet for complete details

People Connect – Mental Health Resource

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

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

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

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

Travel Medical Emergency

Policy Number .... CMG 9428902

Deductible .... Nil

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

Maximum Duration .... 90 days

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

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

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

Dentalcare

Deductible.. Nil

Reimbursement Level .... 90% for Basic Services and Dentures
.... 75% for Major Services
.... 50% for Orthodontic Services (children under 18)

Maximum Benefit .... $1,500 /individual/calendar year
for combined Basic and Major

Orthodontics .... $2,000/dependent /lifetime under age 18

Fee Guide.. SDA for Current year
(for the province where the service is rendered)

Healthcare Spending Account (HSA)

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

Eligibility ...... Local Union 296 Insured Members and Eligible Dependents only

General Information

The Plan is administered by the Board of Trustees who retain the services of SMART Local Union 296 (hereinafter referred to as the Administrator) to perform this function.

An account is kept by the Administrator of the Fund for Members which show hours worked for a contributing employer for which contributions have been made for the purchase of group insurance. This account is called an Hour Bank Account.

Each month, 115 hours will be deducted from your Hour Bank Account. The number of hours in your Hour Bank Account may not exceed 1,380 hours (enough to provide twelve months of coverage even though you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

Note: Each eligible Member is responsible for knowing what his Hour Bank Account balance is at any time.

Eligibility

You are eligible to participate (provided you are insured under the applicable Provincial Medicare Plan) in this Plan for Life Insurance, Accidental Death and Dismemberment and Long Term Disability on the first day following the date on which you have accumulated at least 400 hours of work credit in your Hour Bank Account. For **all other benefits**, you are eligible the first day of the month following the month in which the Plan Administrator has received 400 hours of work credited in your Hour Bank Account. If you are unable to work when coverage is to become effective, the effective date of coverage will be postponed until you are back to work.

You and your dependents will be covered as soon as you become eligible. **An Application for Group Coverage form must be completed to be eligible to receive benefits.**

A Member who has been disabled and has received Workers Compensation benefits for at least two weeks in any calendar month will be covered by the plan for that month but no deduction will be made from his Hour Bank. In other words, the hours of your Hour Bank will be "frozen". Coverage on the basis is available for a maximum period of three consecutive months.

Reinstatement

If your insurance terminated because your Hour Bank Account has less than 115 hours of work credit, you shall again become eligible for insurance on the first day of the month coinciding with or the next following the date on which you have accumulated at least 115 hours of work credit in your Hour Bank Account. In this event, all hours forfeited within the previous 6 month period will be reinstated, providing the accumulation of 115 hours occurs within 6 months of the termination of your insurance.

Termination of Insurance

The insurance for yourself and your dependents will terminate:

- when you are no longer a Member in good standing with Local 296;

- for Union Members of Local 296, at the end of any month where you do not have at least 115 Bank Hours in your Hour Bank Account. However, you may arrange to have your insurance continued for as long as 18 months on a self-paying basis. See Self-Pay Provisions for further details;

- for Office Staff (Support Workers) on cessation of employment, unless disabled or retired. If on a disability, coverage can be extended up to 24 months provided a contribution remittance received with an approved Life Waiver premium in place. On retirement, if an Office Staff has 10 consecutive years of service with Local 296, all coverage (excluding disability) extended for 18 months with a further extension of Visioncare, Healthcare, Dentalcare and Travel Medical Emergency benefits to age 75 provided a contribution remittance received.

- if you cease to be a member in an eligible class;

- if you enter military service;

- if the Group policy terminates;

- the Survivor Benefits coverage will also terminate if you no longer have any qualified survivors because of legal separation, divorce, death or attainment of the age limit;

- a dependents Visioncare, Healthcare, Travel Medical Emergency, and Dentalcare Insurance will terminate when they are no longer an eligible dependent;

- a retired Union Member will continue to be covered (disability coverage excluded) until his accumulated Hour Bank Account is depleted and, if chosen, once his 18 month self-pay period has ceased. In addition, a retired Union Member with 10 consecutive years with Local 296 may self-pay for Dentalcare, Travel Medical Emergency, Visioncare, and Healthcare benefits to age 75.

- when your coverage terminates, you may be entitled to an extension of benefits under the plan. Your Administrator will provide you with details.

Changes in Insurance Benefits

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

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

Extension of Coverage by Self-Payments

A Union Member whose coverage is terminating due to insufficient hours may continue his coverage for himself and his family from month to month (up to a maximum of 18 consecutive self-payments) by making a self-payment to the Fund Office. **Weekly Disability Income is excluded for self-paying Members.**

A disabled Union Member may continue to self-pay for Dentalcare, Visioncare, Travel Medical Emergency, and Healthcare only for up to 24 consecutive months following depletion of his Hour Bank Account.

A Retired Member may continue to self-pay for all benefits (excluding disability benefits) for an initial 18 months following his hour bank depletion. Following that, a Member with 10 consecutive years with Local 296 may self-pay for Dentalcare, Visioncare, Travel Medical Emergency, and Healthcare only up to the attainment of 75 years of age.

Note:

1) Eligibility to self-pay is contingent on the Member being in good standing with Local Union 296.

2) The first payment must be made prior to termination of eligibility (i.e. end of month in which Hour Bank drops below 115 hours). The amount is subject to the discretion of the Trustees.

3) Self-payments must be continuous, and must be made in advance of the month for which coverage is desired (i.e. a self-payment made prior to the end of August provides coverage for the month of September).

4) For all-non-working members, who maintain their membership in good standing, who are not disabled (unless the disabled member has been declined for a life waiver), Life Insurance coverage will be extended following our 18-month self-pay period, up to age 71 (subject to a 50% reduction in coverage at 65), and premiums will be paid by the fund.

5) Self-payments cannot be made by Permit Workers

If you have any questions on self-payment procedures, eligibility or the status of your own Hour Bank Account, call the Administrator at (306) 522-4566.

Survivor Benefit Provision

Healthcare, Visioncare, Travel Medical Emergency, and Dentalcare coverage for eligible dependents shall continue without payment, following the death of the Member or Office Staff up to a maximum of 24 months from the date of death.

Reciprocal Agreements

SMART Local Union 296 Health and Welfare Trust Fund Members working in a jurisdiction other than Local Union 296 on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with SMART Local Union 296 Health and Welfare Trust Fund should complete a Transfer Authority form and advise the Administrator to reciprocate contributions to their Home Fund. This will maintain coverage under the SMART Local Union 296 Health and Welfare Trust Fund.

Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions or Funds whose Funds have entered into a reciprocal agreement with the SMART Local Union 296 Health and Welfare Trust Fund will not be eligible for benefits but will have all contributions made on behalf reciprocated to their Home Fund after they complete the Transfer Authority form available at the SMART Local Union 296 office.

Permit Workers – Employees of Employers on whose behalf contributions are made but who are not members of Local Union 296 or any reciprocating Local will be extended benefit coverage under the SMART Local Union 296 to the end of the following month after the date of lay-off or termination with the exception of disability benefits (WI and LTD) which cease on the date of lay-off or termination. Permit Workers are not eligible to make self-payments.

Dependent Coverage:

Dependent means:

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

- Your spouse, legal or common-law.

- Your unmarried children under age 21, or 21 years of age or over if they are full-time students.

- Children under 24 hours are not insured for Dependent Life Insurance.

- Children under age 21 are not covered if they are working for more than 30 hours a week, unless they are full-time students.

- Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

Important: Report all changes of beneficiary dependent status as soon as possible.

Disability Claims

All disability claims should be recorded with Coughlin & Associates Ltd. and Canada Life within 12 months of the last active day of work regardless of whether or not you are eligible to receive Workers Compensation. This record will assist you should Workers Compensation decline your claim either immediately or at at a future date. In addition, proper application will be made relative to a waiver of Life Insurance premium which is required within 12 months of the date of initial disability.

Wage Loss Provision

In the event that you incur a total disability while insured but on layoff or leave of absence, the plan will recognize your disability for wage loss benefits (WI and LTD) from the scheduled date of return to work, provided you are then totally disabled and furnish attending physicians statements certifying continued disability. It is assumed that you were not making self-payments as Weekly Disability Indemnity coverage would then be excluded.

Third Party Liability

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

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

If a Member or dependent receives a lump sum payment under judgement or settlement for benefits which would otherwise be payable by the Insurer, no further benefits will be paid by the Insurer until the benefits that would otherwise be payable equal the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse the Insurer the amount that reasonably reflects the loss of benefits that would otherwise be payable by the Insurer.

A Member or dependent must notify the Administrator of any action commenced against a third party and of any judgement or settlement in the circumstances described above.

Member Life Insurance

Amount of Benefit

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

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

Coverage Ceases

For Union Members, Life Insurance coverage ceases at the earlier of age 71, and reduces by 50% at age 65.

For Permit Workers, coverage ceases at the earlier of the date of termination of employment, lay-off, or retirement, and is subject to 50% reduction at age 65 with termination at age 71.

For Office Staff (support staff), coverage ceases at the earlier of the date of termination of employment, layoff, or retirement and is subject to 50% reduction at age 65 with termination at age 71. For Office Staff with 10 consecutive years of service with Local 296, coverage can be extended 12 months.

For Probationary Members, coverage terminates immediately upon the earlier of the date of termination of probationary membership, date of retirement, or depletion of Hour Bank Account, and is subject to 50% reduction at age 65 with termination at age 71.

Waiver of Premium For Disability

If you become totally disabled for six (6) consecutive months before age 65, your Life Insurance premiums will be continued without payment of premiums until you cease to be totally disabled or until you reach age 65, whichever occurs first. To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation, and you must submit proof of your continuing disability as may be required by the Insurer.

All disability claims should be recorded with Canada Life and Coughlin & Associates Ltd. regardless of whether or not you are eligible for Workers Compensation, Auto Insurance or Employment

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

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

Conversion Privilege

If any or all of your insurance terminates, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See the Administrator for details.

Dependent Life Insurance

Amount of Benefit

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

Conversion Privilege

If your spouse's insurance terminates, he or she may be eligible to apply for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after your group insurance terminates. See the Administrator for details.

Accidental Death and Dismemberment Insurance

(underwritten by Chubb Life)

Accidental Death

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

Accidental Dismemberment

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

Amount of Benefit

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

Coverage Ceases

For Union Members, Accidental Death & Dismemberment Insurance coverage ceases at the earlier of age 71 and reduces by 50% at age 65.

For Permit Workers, coverage ceases at the earlier of the date of termination of employment, lay-off, or retirement, and is subject to 50% reduction at age 65 with termination at age 71.

For Office Staff (support staff), coverage ceases at the earlier of the date of termination of employment, layoff, or retirement and is subject to 50% reduction at age 65 with termination at age 71. For Office Staff with 10 consecutive years of service with Local 296, coverage can be extended 12 months.

For Probationary Members, coverage terminates immediately upon the earlier of the date of termination of probationary membership, date of retirement, or depletion of Hour Bank Account, and is subject to 50% reduction at age 65 with termination at age 71.

Waiver of Premium For Disability

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

SPECIFIC LOSS SCHEDULE

Accidental Death & Dismemberment

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

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

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

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

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

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

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

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 50 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident,

Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

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

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

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

Family Transportation Benefit

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

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

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the

purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

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

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

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

Benefit payments herein will not be paid unless:

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

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

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

Day Care Benefit

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

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

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

Special Education Benefit

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

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

Bereavement Benefit

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

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

In-Hospital Confinement Monthly Income Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full

month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

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

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

Cosmetic Disfigurement Benefit

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

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

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum

payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

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

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

Identification Benefit

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

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

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

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

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

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

Exposure and Disappearance

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

Conversion Privilege

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

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

Recurrent Disabilities

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

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

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

Funeral Benefit

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

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

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

2) declared or undeclared war or any act thereof;

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

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

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

How to Claim

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

Weekly Disability Income

In the event a Participant becomes totally disabled due to an injury or illness the Participant will receive a disability benefit provided the Participant is under the continual treatment of a qualified and licensed physician.

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (Canada Life) regardless of whether or not the Participant is eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance Disability Benefits. This recording will assist the Participant should a claim with these agencies be declined either immediately or at a future date. The Insurer will not be liable for a Long Term Disability claim for which initial notice is submitted twelve (12) months after the date the disabled Participant was last actively at work. In addition, proper application must be made relative to a waiver of Life Insurance Premiums which is required within twelve (12) months of the date of initial disability.

Benefits for any one disability are payable from the first (1st) day of disability for injury, hospitalization or surgeryand the eighth (8th) continuous day of disability for illness, **but in no event prior to the first day of visit to the Participant's doctor.** The Participant's benefits will be payable for not more than twenty-six (26) weeks during any one period of disability.

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

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

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

- Weeks 17 to 26 will be covered by the Plan.

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

"Totally Disabled" shall mean the Participant is incapacitated to the extent that the Participant is not able to perform all of the usual and customary

duties of his/her occupation. A Participant is not considered totally disabled unless he/she is under the active and continuous care of a physician and is following the treatment prescribed by the physician for that disability.

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

Amount of Benefit

A Participant of the plan is eligible for an amount of weekly disability income as outlined in the **Highlight of Benefits** section**,** but in no event higher than 67% of the Participant's basic weekly earnings.

If the Participant is receiving other forms of retirement income or disability income, the weekly benefit under this plan will be reduced so that the disability income which the Participant receives from all sources does not exceed 100% of his/her regular weekly earnings at the time the Participant became disabled. Benefits payable under any individual disability income policy or rider attached to an individual life insurance policy will not be included as disability income.

Coverage Ceases

For Union Members, coverage terminates at the earlier of the end of any month when one does not have the required monthly hour deduction in their Hour Bank Account, upon his/her retirement, or age 71. For Office Staff and Permit Workers, coverage terminates on the date of cessation of employment or lay-off.

Benefits are not payable for:

- injury sustained while working for pay or profit other than with an Employer who is signatory to the Collective Agreement or alternatively a Project Agreement;
- disability resulting from an intentionally self-inflicted injury;
- disability resulting from voluntary participation in a war, riot, insurrection or criminal offense;

- the portion of a period of disability during which a Participant is receiving Workers' Compensation or Auto Insurance benefits, unless proof is submitted to the Insurer that the Participant has been disqualified for such benefits;

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

  a) imprisonment in a penal institution; or

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

- the scheduled duration of any lay-off or leave of absence including maternity leave.

  Maternity leave is considered to begin on the earlier of:
  i) the date agreed upon by the Employee and Employer, and
  ii) the date of delivery.

Successive Periods of Disability

Successive periods of disability shall be considered as a one period of disability, unless the employee returns to work and completes at least 2 complete consecutive weeks of active and full-time employment before commencement of the later disability or unless the later disability is due to cause wholly different from those of the prior disability and commence after the employee has returned to work.

Extended Benefits after Termination of a Member's Insurance

If a Member is wholly and continuously disabled by bodily injury or sickness and prevented from performing his regular work on the date his insurance terminates, he shall be entitled during the continuance of the disability to any Weekly Disability Income Insurance Benefits that would have been payable had the insurance not terminated.

Long Term Disability

If the Participant becomes totally disabled before reaching age 65 and is unable to work, the Participant is eligible for a monthly disability benefit. Although it is not necessary for the Participant to be confined to his/her house during the entire period of his/her disability, the Participant must be under the care of a physician.

Description of Benefit

A Participant will begin receiving disability payments after he or she has been continuously and totally disabled for a qualifying period of 26 weeks and the Participant's salary continuance plan (i.e. Weekly Income) has expired. Payments are made at the end of each month and continue as long as the Participant is totally disabled, even if the Group Policy terminates, but not beyond the date that the Participant reaches 65 years of age or returns to work. During any period of disability payments, premiums will not be required.

Disability is considered "Total" when it prevents the Participant from performing 60% of his or her regular duties during the qualifying period and the first two (2) years that the Participant is entitled to disability payments. If the Participant is still disabled at the end of this time, disability is considered "Total" when it prevents the Participant from performing any work wherein the requirements are within the range of his/her education, training or experience.

If the Participant recovers and returns to work, but the same disability reoccurs, it will be considered a continuation of the previous disability if the period between disabilities is less than one (1) month during the qualifying period or less than six (6) months during the period when disability payments are being made. A recurrence of disability due to an unrelated cause will be considered a new disability if the Participant has worked at least one (1) day between disabilities.

Other Income

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

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

- benefits under any Workers' Compensation Act or similar law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 80% of your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount. All sources of total monthly income includes:

- your income under this plan

- Canada or Quebec Pension Plan disability benefits to which another family member may be entitled to as a result of the member's disability. (Benefits payable directly to the family member are not included.)

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

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

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

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

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return a gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Coverage Ceases

For Union Members, Long Term Disability coverage terminates upon attainment of age 65 or retirement, whichever occurs first. For Office Staff and Permit Workers, coverage terminates on the earlier of age 65 or the date of cessation of employment or lay-off.

Subrogation

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

In the event that the insured Participant provides proof to the Insurer that the said Participant has not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should the Participant choose to settle the matter prior to judicial determination, the Participant understands that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term "Compensation" shall include any lump sum or periodic payments which the Participant receives or is entitled to receive on account of past, present or future loss of income.

Waiver of Premium

The Insurer will waive the payment of premiums for the Long Term Disability insurance for each Participant who is receiving benefits under this coverage. Premiums will be waived beginning with the premium for the first full policy month for which benefits became payable and continuing for each full policy month for which benefits are payable.

Rehabilitation

As the Participant's condition improves, he or she will want to get back to work. If the Participant's condition does not allow for a return to his/her job on a full-time basis, the Participant might be able to work on a part-time basis or take a less demanding job. The Participant should inform their Canada Life Case Manager this and it may qualify as a rehabilitation program.

If Your Long-Term Disability Terminates

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

Exclusions and Limitations

No benefits are paid for:

- Disability that begins before the Participant's insurance starts or after it ends.

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

- The scheduled duration of a temporary lay-off or leave of absence (as defined in the Weekly Income section).

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

- Any period of prison confinement.

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

- Any 12-month period during which the Participant does not live in Canada for at least six (6) months.

Visioncare

Benefits are subject to plan maximums and frequency limits. Check the Highlight of Benefits for this information.

The Plan covers reasonable and customary charges for the following services and supplies, provided they are not covered under your provincial government plan and the provincial law allows Canada Life to cover them.

Covered Expenses

- Laser Eye Surgery, eyeglasses, prescribed safety glasses or contact lenses when required for an initial or changed lens Prescription.

- Contact lenses when the corna is impaired so that the visual acuity cannot be improved to at least 20/40 level in the better eye with glasses.

Limitations

- No benefits are paid for artificial eyes or sunglasses.

Healthcare

All expenses will be reimbursed at the level shown in the Highlight of Benefits. Benefits may be subject to plan maximums and frequency limits. Check the Highlight of Benefits for this information.

The Plan covers reasonable and customary charges for the following services and supplies, if they are not covered under your government plan and provincial law permits Canada Life to cover them. Reasonable and customary is a term used to refer to the commonly charged or prevailing fees for healthcare services with a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for that particular service with that specific community.

Covered Expenses

- Doctor's services outside your province of residence.
- Psychologist and similar qualified Specialists (up to $1,000 per individual per calendar year) and are subject to reasonable and customary limits per visit/duration of visit. No medical referral.
- Physiotherapy (up to $600 per individual per calendar year) if provided by licensed Physiotherapist and are subject to reasonable and customary limits per visit/duration of visit. No medical referral.
- Massage Therapy (up to $500 per individual per specialist per calendar year) if provided by licensed masseur and are subject to reasonable and customary limits per visit/duration of visit. No medical referral.
- Services of a Chiropractor, Speech Therapist, Naturopath, Acupuncturist, Osteopath, Podiatrist (up to $500 per specialist per individual per calendar year) and are subject to reasonable and customary limits per visit/duration of visit. No medical referral.
- Ambulance transportation to the nearest centre where adequate treatment is available.

- Out-of-hospital treatment of injury to natural teeth when completed within 6 months after an accident.

- Diagnostic x-rays and lab tests.

- Rental, or at Canada Life's discretion purchase of certain medical supplies, appliances, and prosthetic devices prescribed by a doctor.

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

- Insulin, insulin syringe and testing supplies for diabetics.

- Out-of-hospital services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse.

- Confinement in an Intensive Care Unit.

- Custom made orthotics/orthopedic shoes prescribed by a physician, podiatrist or chiropractor (up to $500 every 24 months). Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

- Hearing Aids prescribed by a physician (up to $500 every 5 years).

- Services and supplies received during hospital confinement.

- Out-patient treatment.

- Convalescent hospital care provided the confinement is:

  a) recommended by your physician
  b) is not for custodial care, and
  c) follows a 3-day confinement in a hospital as a registered bed-patient and is for the same condition

- Drugs, vaccines, and medicines which are prescribed by your doctor for the treatment of injury or illness and dispensed by a licensed pharmacist with a family maximum of $3,500 per calendar year. Reimbursement based on generic equivalent, unless a Doctor indicates a medical necessity, and subject to dispensing fee maximum and pharmacy markup in the Highlight

of Benefits. (Note: Viagra and other erectile dysfunction drugs limited to $200 maximum per individual per calendar year; smoking cessation drugs and products are limited to $500/lifetime)

- Fertility Drugs and other fertility related procedures paid to a medical practitioner or public or licensed private hospital to conceive a child. Coverage is inclusive of expenses for in vitro fertility program, laboratory tests, x-rays including ultrasound, and subject to a lifetime maximum as specified in the Highlight of Benefits.

Limitations

No benefits are paid for:

- Delivery, transportation and administration charges.
- Services and supplies required for recreation or sports but which are not medically necessary for regular activities.
- Chronic or custodial care.
- Vitamins, food, food products, salt and sugar substitutes, contraceptive preparations and devices.
- Any single purchase of drugs which would not reasonably be used within 90 days.
- Any drug item which does not have a drug identification number as defined by Canadian legislation, and drugs that are registered under Division 10 of the Regulations of the Food and Drugs Act Canada.
- Expenses incurred for anyone who is not insured under the Provincial Medicare Plan.

Travel Medical Emergency
(Underwritten by AIG/ Global Excel)

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

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

How to Claim

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

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

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

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

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

Give the operator your name and your Policy Number: CMG 9428902

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

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

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

Dentalcare

All expenses will be reimbursed at the level shown in the Highlight of Benefits. Benefits are subject to plan maximums and frequency limits. Check the Highlight of Benefits for this information.

The plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level shown in the Schedule of Benefits.

Treatment Plan

Before you begin any course of dental treatment expected to cost more than $500, ask your dentist to complete a treatment plan and submit it to Coughlin & Associates Ltd. Coughlin & Associates will calculate the benefits payable for the proposed treatment, so you know in advance the portion of the cost you will have to pay. The calculation is valid for 90 days.

Routine Treatment

The following preventative services not more than once in any calendar year:

- Oral examinations.
- Polishing of teeth.
- Bite-wing x-rays.
- Fluoride application.
- Oral hygiene instruction.
- Scaling of teeth.
- Full mouth series of x-rays once every 24 months.
- Extractions.
- Fillings.

- Dental surgery, including related diagnostic x-rays, lab procedures and anesthesia.

- Endodontics.

- Pedodontics.

- Space maintainers.

- Habit-breaking appliances.

- Stainless steel crowns.

- Denture relines and rebases to existing dentures.

- Initial prosthodontic appliance (i.e. removable partial or complete dentures) are covered only when they are required because at least one additional natural tooth was necessarily extracted after the date the person's coverage became effective.

- Replacement of an existing prosthodontic appliance (i.e. removable partial or complete dentures) are covered only when:

    - they are required because of the extraction of one or more natural teeth after the person's coverage became effective and the existing appliance cannot be made serviceable.

- If the existing appliance could have been made serviceable, only the expense for that portion replacement appliance which replaces the teeth extracted after the person's coverage became effective shall be covered.

    - the existing appliance is at least 5 years old and cannot be made serviceable.

    - a permanent appliance is required to replace a temporary appliance made after the person's coverage became effective and was installed providing installation was within 12 months after the installation of the temporary appliance.

- the replacement is required as a result of an initial placement of an opposing denture while covered,
- the replacement is required as a result of an accidental injury while covered.

- Sealants.

- Adjustments to an initial or replacement prosthodontic appliance (i.e. removable partial or complete dentures) after the 3 month post-insertion care period.

- Repairs and adjustments to dentures.

Major Treatment

- Crowns and inlays.

- Initial prosthodontic appliance (i.e. fixed bridge restoration) are covered only when required because at least one additional natural tooth was necessarily extracted after the date the person's coverage became effective.

- Replacement of an existing prosthodontic appliance (i.e. fixed bridge restoration) are covered only when:

  - they are required because of the extraction of one or more natural teeth after the person's coverage became effective and the existing appliance cannot be made serviceable.

- If the existing appliance could have been made serviceable, only the expense for that portion of replacement appliance which replaces the teeth extracted after that person's coverage became effective shall be covered.

  - the existing appliance is at least 5 years old and cannot be made serviceable a permanent appliance is required to replace a temporary appliance made after the person's coverage became effective and was installed providing installation was within 12 months after the installation of the temporary appliance.

    - the replacement is required as a result of an accidental injury while covered.

- Repairs and recementing of crowns, inlays or existing bridgework.

- Treatment involving gold if there is no substitute available.

- Implants and Implantology

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

Orthodontics

- Treatment for the correction of malposed teeth for your dependent children who are at least 6 years of age but not more than 18 years of age at the time the treatment commences.

Limitation

No benefits are paid for:

- Cosmetic treatment, experimental treatment, dietary planning, plaque control, congenital or development malformation.

- Dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature.

- Services and supplies rendered for facings on crowns or pontics posterior to the second bicuspid.

- Lost or stolen dentures.

- Charges for treatment involving gold in excess of the charges for a reasonable substitute.

- Charges for broken appointments or completion of claim forms.

- Full mouth reconstruction, vertical dimension correction, or correction of temporomandibular joint dysfunction.

- Treatment of accidental injury to natural teeth completed more than 12 months after the accidents.

Continuation of Health Benefits for Dependents

If you die, the Health benefits (Healthcare, Visioncare, Dentalcare, and Travel Medical Emergency) for your dependents will be continued for a period of up to 2 years.

- If your surviving children cease to qualify as eligible dependents (as defined earlier in this booklet), the benefits being continued after your death will terminate on the date they no longer qualify.

- If a dependent is disabled on the date insurance under this continuation terminates, his/her insurance payments will be continued until the earliest of the following:

    - the date disability ends

    - the date your dependent that received maximum benefits.

    - 90 days from the date the insurance terminated.

Note: If your dependent is in the hospital on the last day of his 90-day period, insurance payments for the depending will be continued until the hospital confinement ends or until maximum benefits have been paid out.

General Limitations

No benefits are payable for expenses incurred for the following services or supplies or in the following substitutions:

- Injury sustained while working for pay or profit other than for this employer.
- Injury or illness covered under Workers Compensation.
- Services required as a result of or associated with cosmetic treatment, intentionally self-inflicted injury, war, insurrection, participation in a riot, or service in the armed forces of any country.
- Services received in a government hospital unless they are required to pay.
- Services to which you are entitled without charge, or for which there would be no charges if there was no coverage.
- Services provided under any government plan.
- Services paid for by any government or for which a government prohibits payment of benefits.
- Services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, or similar type of group.

Healthcare Spending Account
(H.S.A.)

Purpose

To assist Union Members and their families in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the SMART Local 296 Health and Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums). Allocations are intended to be made subject to the discretion of the Trustees considering the financial stability of the Plan. As per Canada Income Tax Technical interpretation (9431185) regulations, the Healthcare Spending Account is subject to forfeiture every 12 months.

Claims Procedures

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

Eligibility

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your H.S.A. balance following your last day of coverage under the Group Insurance Plan provided you maintain your good standing as a Member of the Local Union 296.

Termination

In the event of termination of Membership from Local Union 296, the remaining H.S.A. balance will be immediately forfeited to the Trust Fund.

Death

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

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

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

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with Local Union 296 at all times.

Marital Separation / Divorce

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

List of Eligible Medical Expenditures

A list of eligible medical expenses is available via CRA's website at http://www.cra-arc.gc.ca/medical/#mdcl_xpns.

To determine the outstanding balance in a Member's individual H.S.A., the Member should refer to his/her latest claims cheque record, monthly Member statement, or alternatively contact the Claims Adjudicator, Coughlin & Associates Ltd..

Co-Ordination of Benefits

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

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

Order of Benefit Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

2) The Plan of the spouse of the parent with custody of the child pays (i.e. if the parent with custody of the child is remarried or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child) , then

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

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

5) A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

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

Submitting a Claim for Co-ordination of Benefits

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

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

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

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

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

How to Make a Claim

Time Limitations

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

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

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

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

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

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

Coughlin Plan Member Portal

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

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference and viewing your dependant information.

- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).

- Download and print claim submission and administrative forms.

Pre-Authorized Deposit (PAD)

Eligible reimbursements for extended health and dental care claims can be deposited directly into your bank account within two to five days following their approval. In order to enrol in Coughlin & Associates Ltd.'s PAD program:

- Print the PAD form from the Coughlin Plan Member Portal or at www.coughlin.ca.

- Complete and return the form with a void cheque to Coughlin.

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

Submit Your Claims Electronically

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

Some important points to remember:

- The maximum amount that can be claimed is $1,000 for vision care and $500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.

- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.

- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Drug Claims

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

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

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

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

The card can be used at any pharmacy in Canada.

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

Visioncare and Healthcare Claims

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

Claim forms may be obtained from the Administrator, Claims Adjudicator, or from Coughlin's website at www.coughlin.ca.

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

Dental Claims

Coughlin will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim can be sent directly from your dental office to our claims department for adjudication.

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

- the Coughlin Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique member identification number; and
- the policy number (44791) of your group benefit plan.

The Claims Adjudicator can provide you with your member identification number.

Pre-Authorization

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

Have your dentist/denturist complete the appropriate form or section. Mail the form to the Claims Adjudicator.

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

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

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

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

Claims Inquiries

If you have any claim questions kindly direct to winnclaims@coughlin.ca

TRUSTEES:

Employer Trustees	Union Trustees
D. Christie	A. Willette
D. Thorpe	M. Skrypnyk
J. Grohs	T. Marshall
R. Steinhauer	TJ King

INSURANCE UNDERWRITERS:

The Canada Life Assurance Company
(www.canadalife.com)
and
AIG Insurance Company
and
Chubb Life Insurance Company of Canada
and
Express Scripts Canada
(Pay Direct Prescription Drug Card provider)

CONSULTANTS AND CLAIMS ADJUDICATOR:

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