ATLANTIC CANADA
REGIONAL COUNCIL OF CARPENTERS
MILLWRIGHTS AND ALLIED WORKERS

# ATLANTIC CANADA REGIONAL COUNCIL HEALTH AND WELLNESS TRUST FUND

**September 2020**

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**All Plan Participants**
**Atlantic Canada Regional Council**
**Health and Wellness Trust Fund**

Insurance protection against the financial hardship that so often accompanies unforeseen events such as sickness, accident or death is important to all of us. In order to make this protection available to you, a Group Benefit Plan has been arranged to assist in protecting the Participants of the Atlantic Canada Regional Council from these hardships. The Major Medical and Dentalcare Benefits are designed to assist you with the payment of these expenses (it may not pay the total cost of services and supplies.) In effect, this Group Benefit Plan shares the payment of your medical and dental bills with you. The Accidental Death & Dismemberment benefit is underwritten by Chubb Life. Life Insurance, Dependent Life, Travel Medical Emergency, Medical Second Opinion, and Long Term Disability (if applicable) benefits are underwritten by Medavie Blue Cross. Weekly Income, Major Medical, and Dentalcare are self-insured by the Trust Fund.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependents.

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

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

We are pleased to make these arrangements on your behalf and we are certain that your participation in the Plan will bring greater security and peace of mind to you and your family.

Sincerely,

The Board of Trustees of the Atlantic Canada Regional Council
Health and Wellness Trust Fund

This booklet is for your general information only; however, it is not the insurance policy and does not grant or confer any contractual rights. In the following pages, you will find a brief description of the benefits that you and your dependent(s) are entitled to, the rules covering eligibility for these benefits and the procedures that should be followed in the event that it is necessary for you or your dependent(s) to make a claim. The final determination of any claim, questions or problem that may arise will be governed by the Group Policies issued by Medavie Blue Cross (10616), Self-Insured Policy (22717), Chubb Life (AB10406525), Express Scripts (22717), and by applicable law.

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

## Access to Documents

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

## Appeals

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

## Benefit Limitation for Overpayment

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

# Notice Regarding Personal Information

When you apply for coverage under the Group Benefit Plan, the Administrator, Coughlin & Associates Ltd., and the Insurers, Medavie Blue Cross, and Chubb Life will set up a file with personal information relevant to your benefit coverage under the Plan.

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

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

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

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

# Privacy

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

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

# Highlight of Benefits

**Group Policy Numbers**
Medavie Blue Cross – 10616
Chubb Life – AB10406525
Self-Insured Policy – 22717

## Life Insurance

Benefit.....$60,000
At retirement $10,000

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

**Premium is a taxable benefit.**

## Dependent Life Insurance

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

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

**Premium is a taxable benefit.**

## Optional Life Insurance
*(underwritten by Great-West Life)*

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. Contact the Administrator for more information or download application from Privileged Selection section at www.coughlin.ca.

## Accidental Death and Dismemberment (AD&D) Insurance

Principal Sum .....$75,000

*Members working towards initial eligibility*.....*$25,000*

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

## Weekly Disability Income (W.I.)

Benefit.....66 2/3% of weekly earnings to a maximum of $573 (E.I. maximum) per week

Commencement.....1st day due to injury/ 8th day due to illness

Maximum Duration.....26 weeks (subject to E.I. wrap around from weeks 2 - 16)

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

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

## Long Term Disability (LTD) Income
*(Marine Carpenters Officers only)*

Benefit Formula .....60% of 1st $2,250, 50% of next $2,250, 40% thereafter

- WCB/CPP direct offsets
- All-source limit is 85%
- Maximum benefit is $5,000/month

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

## Major Medical

Co-insurance:

For all eligible expenses.....100%

Maximum Benefits:

Prescription Drugs
(Pay Direct Card via Express Scripts – Policy #22717) Unlimited, however some types of drugs may be subject to limitations or special authorization as identified on page 46 in the Major Medical section

- subject to a $7.50 co-pay ($4.50 at Sobeys, Lawton Drugs, Walmart, Drugstore and Pocket Pills (home delivery) and $2.50 at Costco) per prescription
- mandatory generic substitution (unless brand name medically supported)
- any claims over $20,000 are subject to pre-approval

Vision Care ..... $350/person/24 months
..... $350/child under 18 years of age/12 months

Eye Exams (included in Vision Care maximum)
..... 1 exam/person/24 months
..... 1 exam/child under 18 years of age/12 months

Laser Eye Surgery ..... $800/person/lifetime

Prescription Safety Glasses (Members only) ..... $300/Member/24 months

Paramedical Services**....** $1,500 combined maximum/person/calendar year (massage therapist, physiotherapist, chiropractor, acupuncturist, chiropodist/podiatrist, dietician, naturopath, osteopath, psychologist, social worker, speech therapist)

Hearing Aids ..... $2,000/person/ear/60 months

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

Semi-Private Hospital ..... reasonable and customary

Orthotics ..... $400/person/12 months

Custom Made Orthopedic Shoes ..... $400/person/12 months

Off the shelf orthopedic shoes and Orthopedic Modifications *
..... $400/person/12 months

** it is strongly recommended to have approval prior to purchase*
Accidental Dental ..... $5,000/person/12 months

**Other benefits identified in Major Medical section.**

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

## Travel Medical Emergency
*(not available to Retired Members)*

For Emergency treatment coverage while traveling outside of Canada.

Deductible..... Nil

Maximum Duration.....60 days

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

Coverage ceases ..... please refer to Travel Medical Emergency section for complete details

## Member and Family Assistance Program (MFAP)

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

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

## People Connect – Mental Health Resource

Co-insurance:

Virtual Therapy Services.....100%

Maximum (per person) ..... included under Psychology benefit in Paramedical Services

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. The first $500 of eligible expenses per person can be direct billed to the Plan Administrator, if preferred.

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

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

## Dentalcare

Co-insurance:

Basic Services .....100%
Major Services .....75%
Orthodontic Services .....50%

Plan Maximums:

Basic and Major Services (combined) .....$2,000/person/calendar year

Orthodontics .....$2,000/person/lifetime
(for dependent children under age 18)

Fee Guide.....Current Provincial Fee Guide applicable
in the province where services are rendered

Recall Exams ..... once every 6 months

Coverage ceases .....please refer to Dental care
section for complete details

## Medical Second Opinion

Access to latest technologies, opinions of world class medical specialists and clinical guidance to confirm a diagnosis or suggest most effective treatment by drawing on a global database of peer ranked specialists.

Please refer to the Medical Second Opinion section for complete details.

# General Information

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

For each Participant, an account is kept by the Administrator that shows hours worked for a Contributing Employer for which contributions have been made for Group Benefits. This is called an Hour Bank Account.

## Eligibility

Each month 140 hours (monthly deduction) will be deducted from your Hour Bank Account. For Marine Carpenters, the hours worked should equate to the monthly deduction as there may not be an accumulation of hours worked. The number of hours in the Member's Hour Bank Account may not exceed 3,360 hours (enough to provide twenty four (24) months of coverage). Excess hours accumulated over 3,360 hours will be credited to the general reserves of the Trust Fund.

Should a Member transfer out of a participating Local under the Atlantic Canada Regional Council, that Member will be entitled to transfer his/her hours to another approved Health and Welfare Plan. From the date of the transfer, the Atlantic Canada Regional Council Health and Wellness Trust will be no further obligated or liable for any benefits to that member after that date.

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

## Eligible Participants

Under the Plan, the following Participants are eligible for coverage, provided they are considered a resident of Canada and are covered under a provincial health insurance program:

Union Members

Members in good standing with a Local Union under ACRC on whose behalf contributions are being made in accordance with the terms of a Collective Agreement to the Atlantic Canada Regional Council Health and Wellness Trust.

Permit Workers

Employees of Contributing Employers on whose behalf contributions are made to the Atlantic Canada Regional Council Health and Wellness Trust Fund, and are not Members of a Local Union under ACRC or any reciprocating Local will be eligible for benefit coverage while working for a Contributing Employer.

Retired Members

A Union Member is considered Retired when he/she has elected retirement under their Pension Plan.

## When You Become Insured Initially

For Life, Dependent Life, and Accidental Death & Dismemberment, **you will become eligible for coverage on the next day following 420 hours worked within six (6) consecutive months**. Furthermore, while members are initially working to become eligible, Members are insured for Accidental Death & Dismemberment for $25,000.

For Weekly Disability Income (WI), Major Medical Benefits, Travel Medical Emergency, Employee Family Assistance Program, People Connect, Second Opinion, and Dental Care Benefits, **you will become eligible for coverage on the first day of the following month after the Administrator is in receipt of 420 hours worked within six (6) consecutive months**.

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

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

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

## Eligible Dependents

Eligible dependents are eligible for coverage, provided they are considered a resident of Canada and are covered under a provincial health insurance program.

Eligible dependents under this Plan shall include:

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

- You or your spouse's unmarried children under age 21, who are not employed on a full-time basis. As well, dependents aged 21 to 25 provided they are in full-time attendance at a University or similar institution (evidence of attendance will be required).

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

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

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

## Survivor Benefit Provision

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

## Reinstatement of Insurance

If a Union Member's benefit coverage had previously terminated because of insufficient hours in his/her Hour Bank Account and the Member has not been out of benefit for a period exceeding twelve (12) consecutive months, the Union Member will again become insured for Life, Dependent Life, Accidental Death and Dismemberment and Long Term Disability benefits immediately upon accumulation of 140 hours worked within twelve (12) consecutive months in the Hour Bank Account.

The Union Member will be also eligible for Weekly Disability Income, Major Medical, Travel Medical Emergency, and Dentalcare benefits on the first day of the following month once the Administrator has received 140 hours in your Hour Bank Account within twelve (12) consecutive months. A statement will be mailed to you advising when your Hour Bank Account falls below 140 hours. Otherwise, you will have to meet the original eligibility requirements as though you were a new Participant of the Plan.

If a Retired Member returns to work and meets the minimum eligibility requirements of accumulating 140 hours in his/her Hour Bank Account, provided these hours are worked in twelve (12) consecutive months, the Retired Member would be eligible for all benefit coverage subject to the benefit age restrictions.

## Changes in Insurance Benefits

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

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

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

## Termination of Insurance

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

- For a Union Member, at the end of the month wherein you do not have at least 140 hours in your Hour Bank Account. However, you may arrange to have your benefit coverage continued on a self-pay basis as identified in the Self-Pay Provision section on the next page.

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

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

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

- If you enter military service.

- If the Group Policy terminates.

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

## Self-Pay Provision

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

If there are insufficient hours in a Union Member's Hour Bank Account (i.e. due to lay-off), he/she will be allowed to continue his/her coverage by making a direct contribution to the Fund. The Administrator will notify the Member if a self-payment is required. Such self-paid contributions must be continuous and consecutive for a period not to exceed 24 months. If a self-payment is not received by the required date, benefit coverage will be terminated without further notification as identified in the Termination of Insurance section of this booklet.

Self-paying Members are eligible for the Weekly Income benefit for the first six (6) months of self-payment only. Furthermore, Members may choose to not self-pay for Dental coverage. Once Members have chosen a self-pay class, they cannot switch classes while continuing to self-pay.

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

In order to reinstate the self-paying duration 24 months, a Union Member must return to employment and work a minimum of 140 hours within twelve (12) consecutive months.

**Retired Members** - Following depletion of the accumulated Hour Bank Account a Member who has been in good standing with the ACRC for a minimum of 10 years before the date of retirement and was insured as an active Member for 12 consecutive months immediately preceding retirement is eligible to extend their Life, Health (including Prescription Drugs) and Dental (optional) for their lifetime.

## Disability Claims

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

## Disability Provision

Disabled Union Member

If a Union Member is disabled and receiving disability payments for six (6) consecutive months and has maintained his/her eligibility status for benefits by either running down his/her Hour Bank Account or making self-payments during this six (6) month period, the Trust Fund will allow coverage for all benefits up to age 65, or until the Member is no longer deemed disabled, providing the appropriate self-payments are continued. Upon recovery, a Member may extend benefits through self-payment for up to a maximum of an additional 24 months. This provision is subject to review from time to time and it may change at the discretion of the Board of Trustees due to the financial stability of the Plan. If a Disabled Member refuses to make an application for the Waiver of Premium or is subsequently declined, all coverage (excluding WI) will only be extended for the remaining balance of the Member's self-pay provision to a maximum of 24 months. Benefits coverage will cease at the earlier of the date of recovery or when the Union Member reaches age 65.

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

Disabled Permit Worker

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

## Wage Loss Provision (Union Members only)

In the event that you incur a total disability while insured but on lay-off or leave of absence and "running down" your Hour Bank Account, or within the first six (6) months of self-payment the Plan will recognize your disability for wage loss benefits (W.I. and LTD) from the scheduled date of return to work, provided you are then totally disabled and submit attending physicians' statements certifying continued disability.

## Reciprocal Agreements

**Union Members** – Union Members working in a jurisdiction other than a Local included under the Atlantic Canada Regional Council, and on whose behalf contributions are being made to a Health and Welfare Trust Fund should complete a Transfer Authority Form and advise the Local Union or Administrator to reciprocate contributions to their "Home Fund". This will maintain coverage under the Atlantic Canada Regional Council Health and Wellness Trust Fund.

**Travel Card Members** – Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions or Funds and whose Funds have entered into a Reciprocal Agreement with the Atlantic Canada Regional Council Health and Wellness Trust Fund **will not** be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete the Transfer Authority Form available at one of the ACRC Union offices or from the Administrator.

## Third Party Liability

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

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

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

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

You or your dependent must notify the Administrator of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

# Life Insurance

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

## Amount of Benefit

You are entitled to the applicable Benefit amount outlined in the Highlight of Benefits section, with the benefit amount reducing at retirement.

## Coverage Ceases

Your Life Insurance coverage ceases at the earlier of the depletion of your Hour Bank Account and/or self-pay period; or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

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

## Waiver of Premium for Disability

If you become totally disabled for at least six (6) consecutive months before age 65, your Life Insurance will be continued without payment of premiums until you cease to be totally disabled or you reach the age of 65, whichever occurs first.

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

**Note**: In order to qualify for the Waiver of Premium, you must furnish proof of your disability satisfactory to the Insurer within twelve (12) months of the last active day of work.

## Conversion Privilege

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

# Dependent Life Insurance

## Amount of Benefit

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

## Coverage Ceases

Your Dependent Life Insurance coverage terminates at the earlier of the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

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

## Waiver of Premium for Disability

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

## Conversion Privilege

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

# Accidental Death and Dismemberment
## (Underwritten by Chubb Life)

### Coverage

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

### Amount of Benefit

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

### Coverage Ceases

Your Accidental Death & Dismemberment coverage terminates at the earlier of retirement, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

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

### Schedule of Losses

**Accidental Death & Dismemberment**

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

**Benefit Amount**

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

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

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

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

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

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

## Repatriation Benefit

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

## Rehabilitation Benefit

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

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

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

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

## Family Transportation Benefit

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

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

## Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

## Home Alteration and Vehicle Modification Benefit

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

- the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
- the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or drivable for an Insured Person.

Benefit payments herein will not be paid unless:

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

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

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

## Day Care Benefit

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

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

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

## Special Education Benefit

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

subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

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

## Bereavement Benefit

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

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

## In-Hospital Confinement Monthly Income Benefit

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

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

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

## Cosmetic Disfigurement Benefit

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

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

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

## Continuance of Coverage

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

## Seat Belt Benefit

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

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

## Identification Benefit

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

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

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

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

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

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

## Exposure and Disappearance

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

## Conversion Privilege

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

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

## Waiver of Premium for Disability

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

## Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of

the same disability and Chubb Life will waive the 6 months qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one 1 day.

## Coverage during Waiver of Premium

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

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

## Funeral Benefit

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

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

- intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
- declared or undeclared war or any act thereof;
- travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an
- Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection,

pipeline inspection, aerial photography or exploration;

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

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

# Weekly Disability Income

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

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

Benefits for any one disability are payable from the first (1st) day of disability for injury and the eighth (8th) day for disease or illness **but in no event prior to the first day of visit to your physician.** Your benefit will be payable for not more than 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 Administrator will advise you to apply for E.I. Disability benefits during the initial 1-week period.

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

**Note: Any benefits collected from this Plan are taxable.**

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

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

## Reductions

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

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

- any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial Automobile Insurance Act.

If you are receiving any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Plan shall not reduce the weekly benefit by that amount.

## Coverage Ceases

Eligibility for the Weekly Disability Income benefit terminates at the earlier of the depletion of the Hour Bank Account, the date of retirement, upon attainment of age 70, or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

For Permit Workers, coverage terminates immediately upon the earlier of the date of termination of employment, retirement, lay-off or age 70.

If you attain age 70 while receiving Weekly Disability Income benefits, the benefits will continue until you have received a total of 15 weeks of benefits or until you are no longer disabled or you retire, whichever comes first.

## Exceptions

**Benefits are not payable for:**

- disability resulting from an intentionally self-inflicted injury;

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

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

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

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

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

# Long Term Disability Income
## (Marine Carpenters Officers only)

### Qualifying Disability Period

The Qualifying Disability Period starts when you first become totally disabled and ends after 26 weeks provided the disability is continuous and you are under age 65. If the disability is not continuous, the days that you are disabled will be accumulated to satisfy the qualifying disability period provided:

- no interruption is longer than two (2) weeks; and
- the disabilities arise from the same or related disease or injury.

### Amount of Benefit

If you become totally disabled before age 65 because of a disease or accidental injury, the Insurer will pay a monthly benefit during the applicable benefit period. The amount of the monthly benefit is specified in the Highlight of Benefits section, **less any income and benefits payable under any Workers' Compensation Law or similar law**, and subject to the All Source Maximum (where applicable). Proof must be submitted to the Insurer that you became totally disabled while insured and have been continuously disabled during the qualifying disability period.

**This benefit is non-taxable to the receiving Participant.**

"**Totally Disabled**", for the first twenty-four (24) consecutive months of benefit payment, shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment. After such twenty-four (24) months, "Totally Disabled" shall mean you are incapacitated to the extent that you are not able to perform any and every duty of any occupation or employment for which you are reasonably qualified by education, training or experience.

The benefit for a period which is less than a full calendar month shall be 1/30$^{th}$ of the applicable Gross Monthly Benefit, less any Reductions of Coverage, multiplied by the number of days in said period.

Benefits will be payable for each month or partial month that such total disability continues beyond the applicable qualifying disability period. Benefits will not be payable for more than the applicable maximum benefit period specified in this section.

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

## Maximum Benefit Period

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

Benefits may be payable after your attainment of age 65 if you satisfy the qualifying disability period while age 64, in which case the maximum benefit period shall be twelve (12) consecutive months. In no event shall benefits be payable after your death, recovery, or attainment of age 66.

## All Source Maximum

Your total monthly income while disabled cannot exceed eighty-five percent (85%) of net monthly earnings as of the date disability commences. If the total income exceeds eighty-five percent (85%), the Long Term Disability Income benefit will be reduced by the amount of such excess.

With respect to your participation in a Program of Rehabilitation, total monthly income while disabled cannot exceed one-hundred percent (100%) of net monthly earnings as of the date disability commences. If total income exceeds one-hundred percent (100%), the Long Term Disability Income benefit will be reduced by the amount of such excess.

Total monthly income includes:

1) a) Long Term Disability benefits under this Plan;

   b) income or benefits specified under 2) and 3) below, including any income or benefit from a different or lesser paid occupation;

   c) with respect to your participation in a Program of Rehabilitation, income from the program of Rehabilitation;

2) Income payable to you under a Pension or Retirement Plan of the employer, or any plan or arrangement resulting in the payment of any salary, wage or other payment by the employer to you during the total disability;

3) Income or benefit payable under:

   a) any other plan or program provided to you by or through the Employer. Such plan or program includes any permanent and total disability benefit of Group Life Insurance for which you could have elected not to apply;

   b) any Workers' Compensation law or similar law;

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

   d) any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial Automobile Insurance Act. The Insurer shall not reduce the monthly benefit in respect of benefits payable by the Employment Insurance Commission.

You must apply for all benefits or income for which you may be or may become eligible for under any of the preceding sources.

If you are receiving any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the gross monthly benefit by that amount.

**Reduced Monthly Benefit**: If you are eligible for full benefits and you elect a different and lesser paid occupation not related to the Program of Rehabilitation described below, the gross benefit less reductions shall be further reduced by fifty percent (50%) of the earnings from the lesser paid occupation elected, subject to the **All Source Maximum** described in this section.

## Benefits during Program of Rehabilitation

The Insurer may recommend that a program of rehabilitation is appropriate for you. The Insurer will notify you in writing of its approval of the program and the extent, if any, of its support during such program.

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

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

Long Term Disability benefits will continue to be payable to you when participating in a rehabilitation program approved by the Insurer for up to twenty-four (24) consecutive months.

Expenses incurred by you in connection with the program and for which you have received prior approval from the Insurer will be reimbursed by the Insurer provided that, in the Insurer's opinion, they are reasonable and customary. Expenses which are payable through government programs or a third party insurer shall not be reimbursed by the Insurer.

**Reduced Monthly Benefit**: The Gross Benefit less reductions will be further reduced by fifty percent (50%) of any earnings received from employment under the rehabilitation program, subject to the **All Source Maximum** as defined in this section.

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

- the date that you cease to be Totally Disabled;
- the date that you complete the rehabilitation program; or

- the date it is determined by the Insurer that you are not participating in the rehabilitation program to the extent previously agreed upon by your Insurer.

## Continuous Period of Disability

If you were receiving Long Term Disability benefits and became disabled from the same or related causes within six (6) months after your return to active work, you would be considered disabled for one continuous period. If you return to active work for one (1) full day and become disabled from different and unrelated causes, you will begin a new period of disability.

## Coverage Ceases

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

## Waiver of Premium

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

## Extension of Benefits

If the policy or Long Term Disability Income benefit terminates and you are totally disabled at such termination, the Insurer continues to be liable as though the coverage remained in force.

If a disability recurs within six (6) continuous months after termination of this benefit, the Insurer will continue to pay benefits to you but only for the remainder of the original maximum benefit period. Such disability must have been caused by an accident or sickness that occurred before termination. The Insurer shall not be liable for benefits after termination of either the contract or Long Term Disability Income benefit once a replacing Insurer is bound contractually or as a matter of law.

## Subrogation

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

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share *pro rata* in that amount.

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

The term "**compensation"** shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

## Appeal Procedure

If you appeal the denial/termination of a Long Term Disability claim, you must submit a written notice of appeal to the Insurer. The notice must be submitted to the insurer within sixty (60) days of the date of the Insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the Insurer within six (6) months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

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

## Exclusions and Limitations

No benefits are payable to you for any total disability commencing within six (6) months of your effective date of insurance if the disability is caused or contributed to by, or is a consequence of, a sickness or injury for which you received medical treatment or services or have taken prescribed

medication at any time or times within ninety (90) days before the effective date of insurance.

No benefit shall be payable:

1) for any portion of a period of disability unless you are receiving ongoing supervision/ treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;

2) for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;

3) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;

4) for disability resulting from injury or disease which occurred while you are on active duty in the armed forces of any country, state, or international organization or for disability resulting from war or an act of war, whether declared or undeclared;

5) for disability resulting from participation in the commission of a criminal offence;

6) for the portion of a period of disability during which you are:

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

7) for a disability resulting from an accident which occurs while you are operating a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);

8) for a disability resulting from an intentionally self-inflicted injury or disease or attempted self-destruction, whether you are deemed sane or insane;

9) during any leave of absence (including maternity leave);

10) to you, if you refuse to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;

11) for a disability that commences on or after the date a strike commences, subject to any Provincial Employment or Labour Standards Act. However, you can fulfill your qualifying period during a strike.

# Major Medical Benefit

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

The Major Medical Benefit covers only those expenses which are considered reasonable and customary for the service provided, in the area where the expenses are incurred, provided you are resident in Canada, AND covered under a provincial health insurance program.

### Participant and Dependent Coverage

In the event that you incur in a calendar year any of the Eligible Expenses, the level of reimbursement is one-hundred percent (100%) subject to the maximums outlined in the Highlight of Benefits section in this booklet.

### Coverage Ceases

Your Major Medical coverage terminates at the earlier of the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

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

## Eligible Expenses

The following is a list of eligible expenses:

### Hospital Expenses in Canada

Charges, in excess of the hospital's public ward charge for accommodation and meals while in a hospital in Canada as an inpatient, up to the semi-private rate.

Benefits are only payable if:
1) the accommodation was specifically elected by the patient;
2) hospital was recommended by the attending physician;

3) the patient effectively receives curative treatment for illness, injury or for pregnancy.

Limitations:

- Charges for custodial or long-term care in a convalescent hospital, nursing home or similar institution will not be considered an eligible expense. Room charges for outpatient care, day surgery, private room, nursing home, chronic care facilities, home for the aged, and rest home will not be considered an eligible expense.
- Charges for the administrative fees charged by the hospital will not be considered an eligible expense.
- Private hospital will not be considered an eligible expense.

## Prescription Drug Expenses in Canada

Charges for any medically necessary drugs or medicine which by law requires a physician's prescription for purchase including oral contraceptives and preventative vaccines (excluding physician's fees), but shall not include any charge for off-the-shelf preparations which may be purchased without a physician's prescription, subject to a co-pay per prescription as identified in the Highlight of Benefits. Prescription Drugs are also subject to a mandatory generic substitution unless brand name is medically supported. Furthermore, any claims in excess of $20,000 in a calendar year are subject to pre-approval.

Coverage Limitations:

- Smoking Cessation - $500 lifetime
- Erectile Dysfunction Drugs - $250 annual maximum
- Fertility Drugs - $2,500 lifetime
- Anti-Obesity Drugs - $1,000 annual maximum
- Vaccines - $500 lifetime

Viscosupplementation Injections:

Orthovisc, Synvisc, Neovisc, Durolane, Euflexxa or any other viscosupplementation product is unlimited, but eligible only if dispensed by a physician. Does not include physician fees or any other fees.

## PRIOR AUTHORIZATION DRUG PROGRAM

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

**How it works:**

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

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

**Fax:**

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

**Mail:**

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

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

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

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

## Extended Health Expenses

1. Charges for licensed Convalescent Care Facility, up to $20 per day for up to 120 days.

2. Eligible Paramedical Services, subject to the maximum identified in the Highlight of Benefits include:

    - Massage Therapist (referral required for dependents)
    - Physiotherapist
    - Chiropractor
    - Acupuncturist
    - Chiropodist/Podiatrist
    - Dietitian
    - Naturopath
    - Osteopath
    - Clinical Psychologist
    - Social Worker
    - Speech Therapist

    * Most eligible practitioners subject to appropriate licensing

3. Charges for the services of a registered nurse (R.N.), licensed practical nurse (L.P.N.), or registered nursing assistant to the maximum identified in the Highlight of Benefits.

4. Charges for the purchase of external prostheses and standard artificial limbs (excluding myoelectric limbs). External breast prostheses at a maximum of one (1) per breast every twelve (12) consecutive months. Artificial eyes including repair and replacement, stump socks, shoulder harnesses and voice prostheses.

5. Reasonable and customary charges for professional ground ambulance service to the nearest hospital qualified to provide the necessary treatment. In addition, when the circumstances

dictate (as pre-approved by the Administrator), coverage may be considered for transportation by air, rail or water. Maximum of $1,000 per person per calendar year. Maximum of $500 per person per calendar year for Ambulance Attendant.

6. Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the Provincial Government Plan. Includes allergy testing and materials associated with the testing.

7. Foot Orthotics: Foot orthotics must be individually designed and constructed to medical specifications from an officially licensed laboratory specializing in foot orthotics to the maximum listed in the Highlight of Benefits. A written referral from a physician or chiropodist/podiatrist's will be required.

   In order to consider your claim, the following information is required:

   a) pre-dated physician/chiropodist or podiatrist referral including your diagnosis prior to purchase;
   b) eligible dispensers: registered podiatrist, chiropodist, pedorthist or orthotist;
   c) prescriber(exception is if prescribed by a Podiatrist) and dispenser must be two different providers unless the orthotic was sent to an offsite laboratory to be fabricated;
   d) if the orthotic was sent to an offsite laboratory, the laboratory information is required;
   e) gait analysis or biomechanical exam;
   f) description of how they were fabricated;
   g) name, license number and credentials of practitioners; and
   h) if the Member is to be paid, a paid in full receipt is required.

8. Orthopedic Shoes: Purchase, adjustment, replacement or repair of shoes custom designed and made to measure for the insured from a cast when such shoes are needed to correct a defect in

the foot and are obtained from a specialized orthopedic laboratory holding a license issued by legal authorities.

9. Stock/Off The Shelf Orthopedic shoe(s): must have permanent modification(s) which may include sole build-ups, lifts, wedges, steel plates, calliper plates, stirrups to accommodate braces and self-adhesive closures. Orthotics are not considered permanent modifications.

   Note: Orthotics / Orthopedic Shoes - A doctor's referral and medical diagnosis from doctor is required prior to purchase. A written referral from a Physician or Chiropodist/Podiatrist will be required. The cost of the footwear must be clearly separated from the cost of the permanent modification. **It is strongly recommended to have approval prior to purchase, or your claim may be denied.**

   The Orthopedic shoe benefit does not include shoes or work boots purchased only to accommodate orthotics or comfortable walking shoes such as Birkenstock, Nike, Brooks, Rockport, etc.

10. Charges for support stockings to a maximum of $250 per person per calendar year provided they are prescribed by a physician for a specific medical condition, and such condition requires a compression factor greater than 20 mm/Hg.

11. Charges for hearing aids, excluding batteries, when provided by a certified, clinical audiologist, up to the maximum identified in the Highlight of Benefits.

12. Molded ear plugs to a maximum of $75 every 24 months.

13. Speech aids to a maximum of $2,000 per lifetime.

14. CPAP machines up to $2,500 every 60 months, as well as an annual maximum of $300 for one (1) mask. CPAP supplies are excluded.

15. Intermittent positive pressure breathing machine. Maximum of one (1) per lifetime. Supplies are excluded.

16. Dental treatment as a result of an accident up to $5,000 every 12 consecutive months. Services must be completed within 180

days of the date of the accident. Any expenses over $500 are subject to pre-approval.

17. Purchase of a TENS (transcutaneous nerve stimulator) machine for the control of chronic pain to a maximum of $700 per lifetime.

18. Wigs as a result of chemotherapy treatment up to $200 per lifetime.

19. Medical Equipment, rental or purchase, when approved by the Administrator, limited to the cost of the device or item that adequately meets the patient's fundamental medical needs, as follows:

    - splints (excluding dental splints), casts, braces (containing rigid material), and cervical collars.
    - intra-uterine contraceptive devices (subject to insertion by a doctor) - $200 every 24 months
    - insulin pumps/supplies - $6,500 maximum every 60 months
    - insulin jet injector - $1,000 lifetime
    - glucometer – one (1) every 48 months
    - standard hospital bed (electric excluded)
    - extremity pump for lymphedema - $1,500 lifetime
    - speech aids - $2,000 lifetime
    - aerochambers
    - surgical brassieres – two (2) maximum annually
    - bed rails
    - colostomy and ileostomy Supplies
    - custom made burn garments and pressure supports for lymphedema
    - head halters/traction apparatus/trapeze bars
    - surgical shoes, boots, cast covers purchased after foot surgery for temporary use.
    - urethral catheters
    - mist tents and nebulizers
    - oxygen and the equipment needed for its administration
    - apnea monitors for respiratory dysrhythmias

20. Charges for rental (or, at the Plan's option, purchase) of mobility equipment, subject to a maximum benefit of $10,000 every 60 consecutive months, as follows:

    - crutches, canes, walkers
    - mechanical or hydraulic patient lifters - $2,000 every 60 months
    - outdoor wheelchair ramps - $2,000 lifetime
    - wheelchair, standard or where medically required electric – every 60 months, subject to pre-approval by Administrator

## Vision care Expenses

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

1) Eyeglasses or contact lenses and eye examinations to a maximum in any twenty-four (24) month period (twelve (12) month period for children under the age of 18 years).

2) Prescription safety glasses to a maximum in any twenty-four (24) month period.

3) Laser eye surgery subject to an $800 lifetime maximum.

4) Visual Training subject to a maximum of $150 per person per lifetime.

* Maximums identified in the Highlight of Benefits.

## Exclusions

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

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

2) Charges for general health examinations.

3) Charges for expenses resulting from any attempted suicide or self-inflicted injuries or illness while sane or insane.

4) Charges incurred for medical care resulting from voluntary participation in a war, riot, insurrection or criminal offence.

5) Charges for a surgical procedure or treatment performed primarily for beautification or charges for hospital confinement for such surgical procedure or treatment.

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

7) Charges for services or supplies associated with recreation or sports rather than with other daily living activities.

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

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

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

11) Charges for transport or travel including shipping and handling charges, other than as specifically provided under eligible expenses.

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

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

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

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

16) Charges for homeopathic services and homeopathic supplements and remedies.

# Travel Medical Emergency Benefit

## (Underwritten by RSA Travel Insurance)

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

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

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

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

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

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

## Coverage Ceases

Your Travel Medical Emergency coverage terminates at the earlier of age 70, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with a Local union the Atlantic Canada Regional Council. Your eligible dependents coverage will end the earlier of age 70 or when your coverage terminates.

# Member and Family Assistance Program

## Your Member and Family Assistance Program

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

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

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

## What Services Are Available To Me?

Your MFAP offers you and your eligible dependents short-term counselling in person, by phone or through the internet at www.aspiria.ca.

## What Does My Program Offer?

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

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

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

## How Does My Program Work?

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

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

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

## Who Provides My Counselling?

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

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

## Is the MFAP Confidential?

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

## Who Do I Contact?

To speak with someone confidentially, call Aspiria Corp 1-877-234-5EAP (327).

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

## Childcare and Eldercare Services

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

## Financial Counselling

Counselling can be provided for the following:

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

## Legal Counselling

The legal service provides two options:

- a telephone consultation through Lawline, an exclusive service provided by Aspiria Corp, or

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

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

Aspiria Corp sets the standard for services such as MFAP, health strategy and planning, disability management, employee selection and development, and workplace conflict resolution.

# People Connect - Mental Health Resource

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $75.00 per hour or $37.50 per 30 minutes and payable via credit card. The first $500 of eligible expenses per person can be direct billed to the Plan Administrator, if preferred.

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

For the purpose of this benefit, the Clinical Psychology benefit (within the combined paramedical practitioners) includes the following therapists as eligible expense:

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

# Dental Care Benefit

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

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

## Participant and Dependent Coverage

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

## Coverage Ceases

Your Dental Care coverage terminates at the earlier of the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with a Local under the Atlantic Canada Regional Council.

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

## Extension of Benefits

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

## Alternative Benefits and Submission of Treatment Plan

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

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

## Eligible Expenses

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

## Basic Preventative and Restorative Services

1) Recall oral examinations: 1 exam every six (6) consecutive months. Polishing and topical application of fluoride: 2 every twelve (12) consecutive months. Scaling and Root Planing combined: 10 units every twelve (12) consecutive months.

2) Complete oral examination: once every 36 months.

3) Specific oral examination & Emergency examination: 2 exams every twelve (12) consecutive months.

4) Dental x-rays: One complete series or panoramic x-ray during any thirty-six (36) month period. One Bitewing set during any twelve (12) month period.

5) Oral Hygiene instruction: 1 per lifetime.

6) Extractions & residual root removal; Frenectomy; Surgical excision, exposure & incision; Alveoplasty, in conjunction with extractions.

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

8) Anesthetics and injections of antibiotic drugs.

9) Treatment of periodontal and other diseases of the gums and tissues of the mouth. Periodontal appliances & maintenance: one (1) appliance per arch every thirty-six (36) consecutive months;

Occlusal equilibration: four (4) units every twelve (12) consecutive months.

10) Space maintainers & maintenance of space maintainers.

11) Endodontic treatment including root canal therapy.

12) Denture repairs; Denture rebase: 1 per arch every thirty-six (36) consecutive months; Denture reline: 1 per arch every thirty-six (36) consecutive months.

## Major Restorative Services

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

2) Replacement of crowns provided a period of at least sixty (60) months has elapsed since the last date on which the crowns were provided.

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

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

5) Initial placement of dentures. (Please see Exclusions and Limitations regarding pre-existing extractions.)

6) Replacement of dentures provided the existing dentures cannot be made serviceable and a period of at least five (5) years has elapsed since the last date on which dentures were provided or replaced.

7) Implant dental surgery and related oral services such as abutment insertion, ridge augmentation, bone preservation; implant periodontal surgery; and subsequent implant retained appliance.

## Dependent Orthodontic Services

Coverage is available for dependent children under age 18 as identified in the Highlight of Benefits section.

Coverage will be provided to the date of completion provided treatment commenced prior to attainment of age eighteen (18).

**A treatment plan prepared by the attending Orthodontist must be submitted to the Administrator for approval. Orthodontic services are payable over the course of the treatment plan, typically 18 to 24 months.**

## Exclusions and Limitations

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

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

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

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

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

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

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

8) Any charges for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay.

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

10) Any dental examinations required by a third party.

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

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

# Medical Second Opinion

Second Opinion® Services is an in-depth review of a participant's medical file by the Second Opinion institution or physician, including a review of the diagnosis and treatment plan. On completion of the review, a booklet containing the Second Opinion summary and recommendations (if applicable) is sent to the participant along with detailed information pertaining to the qualifying medical condition.

## Qualifying Medical Conditions

- AIDS
- ALS
- Alzheimer's disease
- Any amputation
- Any life threatening illness
- Benign brain tumor
- Cancer (all types)
- Cardiovascular conditions
- Chronic pelvic pain
- Coma
- Deafness
- Embolism/Thrombophlebitis
- Emphysema
- Hip and knee replacement
- Kidney failure
- Loss of speech
- Major or severe burns
- Major organ transplant
- Major trauma
- Multiple Sclerosis
- Neuro-degenerative disease
- Paralysis
- Parkinson's disease
- Rheumatoid Arthritis
- Stroke
- Sudden blindness due to illness

The list of Qualifying Medical Conditions may change without notice.

Second Opinion Services may not be available for population-wide exposure to poisonous gas or radioactive contamination.

## How to Access

The Second Opinion Services may be accessed toll-free Monday to Friday from 8am to 8pm EST 1-877-893-3122.

# Healthcare Spending Account

**Purpose**

For Union Members and their families to offset Healthcare, Visioncare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Atlantic Canada Regional Council Health and Wellness Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

**Eligibility**

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

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

As per Canada Revenue Agency (CRA) legislation, the Healthcare Spending Account is subject to forfeiture following no longer than 24 months and new allocations are at the direction of the Trustees given the Plan's continued positive financial stability.

The Healthcare Spending Account cannot be used for making self-payments or cash withdrawals. For a list of eligible medical expenses, please access the Canada Revenue Agency website via the link www.cra-arc.gc.ca and search *eligible medical expenses*. If you are unsure if a claim is eligible, please contact the Administrator for verification.

**Termination of Membership**

In the event of termination of Membership in Atlantic Canada Regional Council, the remaining Healthcare Spending Account balance will be immediately forfeited to the Trust Fund.

**Death**

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

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

**Reinstatement**

Reinstatement of a Union Member's Healthcare Spending Account is **not** applicable as it is a requirement that the Union Member remains a Member in good standing with a Local Union under the Atlantic Canada Regional Council.

**Marital Separation/Divorce**

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

# COORDINATION OF BENEFITS

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

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

## Order of Benefit Payment

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

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

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

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

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

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

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

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

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

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

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

**Submitting a Claim for Co-ordination of Benefits**

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

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

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

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

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

# How to Make a Claim

## Time Limitations

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

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

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

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

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

## Coughlin Plan Member Portal

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

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

- Auto-enroll in Pre-Authorized Deposit by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will

also receive an e-mail notification if any changes are made to their banking information.

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

- Download and print claim submission and administrative forms.

## Pre-Authorized Deposit (PAD)

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

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

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

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

## Drug Claims

You can pay for your prescription drugs at any retail pharmacy in Canada directly through your drug plan using the pay-direct drug card from Express Scripts 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 other than the Plan co-payment unless the claim exceeds any 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 Express Scripts and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

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

## Extended Health Care Claims

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

Claim forms may be obtained from the Administrator or Union Offices or from the Coughlin Plan Member Portal website at www.coughlin.ca, or the Atlantic Canada Regional Council website (Health and Welfare section).

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

## Submit Your Claims Electronically

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

Some important points to remember:

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

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

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

## Dental Claims

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

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin quickly, safely and confidentially right from your dentist's office.

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

- the Coughlin Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;

- your unique member identification number or social insurance number; and

- the policy number (**22717**) of your group benefit plan.

The Administrator 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 Administrator.*

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

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

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

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

# Questions and Answers

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

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

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

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

   This is an account kept by the Administrator for each Participant who works for a Contributing Employer. Contributions to the Plan are based on each hour worked. These contributions will be allocated to the Hour Bank Account. For Non-Union Participants, the hours worked should equate to the required monthly deduction as there may not be an accumulation of hours worked. Each month while insured, your account will be deducted the amount necessary to cover the monthly premium. The additional contribution, if any, will accumulate in your Hour Bank Account up to a maximum of 3,360 hours (or twenty-four (24) months of coverage).

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

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

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

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

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

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

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

The Local Union offices and the Administrator will have the latest Hour Bank Account balances for each eligible Participant. Furthermore, monthly statements are sent to Members to verify hours submitted to the Trust Fund and to identify if there are sufficient hours in your account to maintain benefit coverage. Note: Each eligible Participant is responsible for knowing his/her Hour Bank Account balance at any time.

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

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

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

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

## THIS PLAN IS UNDERWRITTEN BY:

**Medavie Blue Cross**

AND

**Chubb Life**

AND

**Atlantic Canada Regional Council Health and Wellness Trust Fund**

AND

**Express Scripts**
(Pay Direct Prescription Drug Card provider)

## THE PLAN IS ARRANGED AND ADMINISTERED BY:

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