LOCAL UNION 739

HEALTH & WELFARE TRUST FUND

GROUP INSURANCE BENEFIT PLAN BOOKLET

January 2019

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INSURANCE UNDERWRITER

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ACE INA – Policy No. AB10406516

PAY DIRECT DRUG CARD PROVIDER

Express Scripts Canada (ESC)

TABLE OF CONTENTS

April 2018

To All Plan Participants
Local Union 739
Health & Welfare Trust Fund

Insurance protection against the financial hardship that so often accompanies 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 Local Union 739 from these hardships. The Healthcare 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 AD&D benefit is underwritten by ACE INA, while the prescription Drug Card benefit is self-insured and co-ordinated with Express Scripts Canada, and the remaining benefits are underwritten by Great-West Life Assurance Company.

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

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 Plan Administrator is Coughlin & Associates Ltd. and their office is located at Suite 100 – 175 Hargrave Street, Winnipeg, Manitoba, R3C 3R8. If you have any questions concerning your benefits or claim procedures, please contact the Plan Administrator for this information at (204) 942-4438 or Toll Free 1-888-204-1234.

We are pleased to make these arrangements on your behalf and 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 Local Union 739
Health and Welfare Trust Fund

IMPORTANT NOTICE

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 dependant(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 dependant(s) to make a claim. The final determination of any claim, questions or problem that may arise will be governed by the Group Policy issued by Great-West Life (165013), ACE INA (AB10406516), and by the Trustees via the Self-Insured Contract for any self-insured benefits.

In the event of any variation or discrepancy between the information in this booklet and the provision of the Master Policy or Self-Insured Policy , the latter will prevail.

Notice Regarding Personal Information

When you apply for coverage under the Group Benefit Plan, the Plan Administrator, Coughlin & Associates Ltd., the Insurers, Great-West Life, ACE INA, and the Pay Direct Drug Card Provider, Express Scripts Canada (ESC) will set up a file with personal information relevant to your benefit coverage under the Plan.

The purpose of this file is to permit Great-West Life, ACE INA, Express Scripts Canada (ESC), and Coughlin & Associates Ltd. to administer all financial services provided to you, and to keep information specific to the Insurer 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 office of the Plan Administrator. The Employees of Great-West Life, ACE INA, Express Scripts Canada (ESC), and Coughlin & Associates Ltd. have access to the file when required for insurance purposes.

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

Privacy

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

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

HIGHLIGHT OF BENEFITS

Group Policy No. 165013

Life Insurance

Benefit ..... Under age 65 - $75,000
..... Age 65 to 70 - $37,500
Coverage Ceases ..... Please refer to Life Insurance section as provisions vary

Optional Life Insurance

Coverage in units of $10,000 to a maximum of $500,000 each (Participant and Spouse) subject to medical questionnaire and approval by insurer. Call the Plan Administrator for more details.

Dependant Life Insurance

Benefit ..... Spouse - $10,000
..... Child - $5,000
Coverage Ceases ..... Please refer to Dependant Life Insurance section

Accidental Death and Dismemberment (via ACE INA)

Benefit (Principal Sum)
..... Under age 65 - $75,000
..... Age 65 to 70 - $37,500
Coverage Ceases ..... Please refer to Accidental Death & Dismemberment section as provisions vary

Short Term Disability

Benefit ..... 66 2/3% of weekly earnings to a maximum of $562/week (EI equivalent)

Commencement ..... 1st day accident/
4th day sickness
Maximum Duration ..... 37 weeks
(subject to E.I. wraparound)

Note: You must apply for E.I. This benefit is taxable if Employer contributions are remitted to cover the premiums.

Will Preparation

To encourage Members to prepare a last Will and Testament, the Trust Fund will reimburse Members up to $125 per lifetime who are in good standing over one year.

Extended Health Benefit

Deductible ..... Nil
Reimbursement ..... 100% of all eligible expenses
Maximums Benefits:
Paramedical Services $300/person/
calendar year/specialist
Physiotherapy ..... $600/person/calendar year
Hearing Aids ..... $300 /person/5 years
Hospital ..... Private (in Canada)
Prescription Drugs (Self Insured)
(via Express Scripts Canada (ESC) Drug Card
in Canada) ..... $2,500 per family per
benefit year (April 1 – March 31)
Nicotine Patches/Gum/Champix/Zyban
..... $500/person/lifetime
Overall Extended Health
Benefit Maximum ..... $1,000,000 lifetime
Out of Country / Province
Emergency Travel
Coverage ..... No overall maximum
(certain treatment limits apply,
refer to Extended Health

Benefits section)
(for medical emergency expenses while traveling outside of your Province of Residence)
(Note: Global Medical Assistance & Out of Country coverage ceases the earlier of age 70 or retirement)
Coverage Ceases..... Please refer to Extended Health Benefits section

Note: the Out of Country/Province coverage pays for your medical expenses incurred as a result of an emergency while traveling outside of your Province of residence, while the Global Medical Assistance Program Benefit pays for assistance to locate medical services and obtains Great-West Life's approval of covered services incurred as a result of an emergency while traveling outside of Canada.

Bereavement Benefit

Benefit ..... Up to $500
Maximum Duration ..... 3 days
Eligibility ..... Minimum 1 year union membership subject to direction via Local Union

Note: Benefit received is taxable. Tax slip issued.

Best Doctor's

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 Best Doctor's section for complete details.

Visioncare

Deductible ..... Nil

Eyeglass frames/ lenses or contacts..... $300/person/ 24 months

Routine Eye Examinations ..... $75/person/ 24 months (eye exams every 12 months if medically necessary due to a medical condition)

Coverage Ceases..... Please refer to Visioncare Benefit section

Dental Benefit

Deductible ..... Nil

Co-Insurance

Basic Treatment 80%

Major Treatment 70%

Orthodontic Treatment.....50%

Accidental Coverage 100%

Fee Schedule ..... Current Provincial Fee Guide where services are rendered

Plan Maximums

Basic and Major Treatment (combined)..... .....$1,500/person/calendar year

Orthodontic Treatment .....$2,500/person/lifetime (for dependant children ages 6 - 18)

Accidental Coverage .....Unlimited

Coverage Ceases..... Please refer to Dental Benefit section

THE BENEFITS LISTED ABOVE ARE SUBJECT TO TRUSTEE REVIEW FROM TIME TO TIME AND MAY CHANGE AT THE DISCRETION OF THE BOARD OF TRUSTEES.

GENERAL INFORMATION

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

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

Eligibility

Each month 130 hours will be deducted from the Union Hour Bank Account. For Office Staff, the hours worked should equate to the monthly deduction (see above) as there may not be an accumulation of hours worked. The number of hours in your Hour Bank Account may never exceed 780 hours. Excess hours accumulated over 780 hours will be forfeited to the general reserves of the Trust Fund.

Eligible Participants

Union Members

Members in good standing with Local Union 739 on whose behalf contributions are being made in accordance with the terms of a Collective Agreement with Local Union 739.

Office Staff

Office Staff of Local Union 739 and Contributing Employers (support staff) on whose behalf contributions are being made to the Local Union 739 Health & Welfare Trust Fund, and are not Members of Local Union 739 or any other reciprocating Local, will be eligible for benefit coverage while working for Local Union 739 or a Contributing Employer.

Retired Members

A Union Member is considered retired when he/she has attained age 55 or older and has indicated in writing to Local Union 739 of his/her retirement from the trade.

When You Become Insured Initially

For Life, Dependant Life, and Accidental Death & Dismemberment Insurance, you will become eligible for coverage on the first day following the day that you have accumulated 390 hours of work within six (6) consecutive months.

For Short Term Disability, Extended Healthcare, Visioncare, Dentalcare, and Travel Medical Emergency you will become eligible for coverage **on the first day following the month on which the Plan Administration has received 390 hours of hours worked (hours may vary slightly depending on the hourly rate of contribution) within six (6) consecutive months.**

Office Staff 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 receive benefits.**

Eligible Dependants

Eligible dependants under this Plan shall include:

- Your spouse as the result of a valid civil or religious ceremony, or a person 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 or 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 the age of 21. As well, dependants aged 21 to 24 inclusive 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 physically or mentally incapable of self-support beyond the limiting age may be continued under the Extended Health and Dental 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 Insurer within thirty-one (31) days after dependant coverage would otherwise terminate. Additional proof will be required from time to time.

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

Survivor Benefit Provision

Extended Health, Visioncare, and Dental coverage for eligible dependants shall continue, without premium payment, following your death up to a maximum of twenty four (24) months from the date of death. Refer to Continuation of Health Benefits for Dependants section for greater detail.

Changes in Insurance Policy

Any changes 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 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, dependant 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 dependant confined in hospital on the date the new benefits would otherwise become effective, do not become effective until he or she is released from hospital. In any case, payment for services and supplies received before the date of an increase in benefits will always be based on Plan benefits in effect before the change.

Termination of Insurance

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

- For a ***Union Member***, at the end of the month where you do not have at least 130 hours in your Hour Bank Account. However, you may arrange to have your benefit continued for up to sixty (60) consecutive

months on a self-paying basis. The Plan Administrator will contact you with the required self-pay amounts.

- For ***Office Staff***, at the end of the month following the date of termination of employment or layoff (except Short Term Disability which ceases immediately). Office Staff are not eligible to make self-payments.

- For a ***Retired Member***, upon depletion of your accumulated Hour Bank Account ***(except Short Term Disability and Emergency Travel Accident coverage which cease immediately).*** However, you may arrange to have your benefit continued for up to sixty (60) consecutive months on a self-paying basis (subject to Plan age limitations (i.e. Life/AD&D ceases at age 70)). The Plan Administrator will contact you with the required self-pay amounts.

- For specific benefits, if you reach the benefit age restriction (please refer to the Highlight of Benefits section).

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

- If you enter military service.

- If the Group Policy terminates.

- For a dependant, once they no longer qualify as an eligible dependant (please refer to Eligible Dependants section).

Self-Pay Provision

Only Union Members and Retired Members are eligible to self-pay to continue benefit coverage. If there are insufficient hours in a Union or Retired Member's Hour Bank Account (i.e. due to lay-off or depletion of the Hour Bank Account), he/she will be allowed to continue his/her coverage by making a direct contribution to the Fund. The Plan 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 sixty (60) months. The payment must be made prior to the fifteenth (15^{th}) of the month following the month in which the Hour Bank Account falls below 130 hours. 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.

If a Union Member has only been self-paying for a single month, full coverage may be reinstated if a minimum of 130 hours is worked in the following month.

Eligibility to self-pay is contingent with the Union or Retired Member being in good standing with Local Union 739.

Note:

- **Short Term Disability, Global Medical Assistance, and Emergency Travel Accident coverage is excluded for Retired Members.**
- **Short Term Disability coverage is excluded for self-paying Union Members.**
- **Office Staff cannot make self-payments.**

Disability Claims

All disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (Great-West Life) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance, or Disability benefits. This recording will assist you should your claim with these agencies be declined at a future date. In addition, proper application will be made relative to a Waiver of Life Insurance which is required six (6) months of the date of initial disability.

Extension of Coverage for Disabled Members

Disabled Union Member

If a Union Member is disabled and receiving disability payments for two (2) consecutive weeks in any month, the Union Member will be covered by the Plan for that month but no deduction will be made from the Member's Hour Bank Account. In other words, the hours in the Member's Hour Bank Account will be "frozen". Coverage on this basis is available for a maximum of thirty-seven (37) consecutive weeks (9 months), however, no longer than twelve (12)

consecutive weeks (3 months) if the Member is receiving Workers' Compensation or Auto Insurance Benefits. Benefit coverage will cease at the earlier of age 70, the date of recovery or attainment of the maximum period of coverage.

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.

Disabled Office Staff

If an Office Staff is receiving disability payments, coverage will be extended for a maximum period of thirty-seven (37) consecutive weeks (9 months), however, no longer than twelve (12) consecutive weeks (3 months) if the participant is receiving Workers' Compensation or Auto Insurance Benefits. **For coverage to be maintained during this period, the required premium will be required to be remitted to the Plan by the Participant.** Benefit coverage will cease at the earlier of the date of recovery or attainment of the maximum period of coverage. 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.

Reciprocal Agreements

Local Union 739 Union Members working in a jurisdiction other than Local Union 739 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 Plan

Administrator to reciprocate contributions to their "Home Fund". This will maintain coverage under the Local Union 739 Health and Welfare Trust Fund.

Travel Card Members - Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions or Funds and whose Funds have entered into Reciprocal Agreement with the Local Union 739 Health and Welfare Trust Fund **will not** be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete a Transfer Authority Form available at the Local Union 739 office or from the Plan Administrator.

IMPORTANT:

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

Third Party Liability

If you or your dependant 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:

- past, present or future loss if income, and

- any other benefits, otherwise payable by the Insurer.

If you or your dependant 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 received.

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

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

Coordination of Benefits (Extended Health Care and Dental Care Expenses)

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

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

Order of Benefit Payment

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

- If your Spouse's Plan does not provide 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 dependant.

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

- 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 Dependant 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 beings 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 benefits for the dependant 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 with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the dependant child).

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

Submitting a Claim for Co-ordination of Benefits

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

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

- Submit all necessary 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 to the Secondary Carrier for further consideration of payment, if applicable.

HOW TO MAKE A CLAIM

In the event of a claim, you or a member of your family should obtain the proper claim form from the Union Office or the Plan Administrator or alternatively from the Plan Administrator's website www.coughlin.ca. The Plan Administrator's Office is open Monday to Friday at the following address:

Coughlin & Associates Ltd.
100 – 175 Hargrave Street
Winnipeg, Manitoba, R3C 3R8
Telephone: (204) 942-4438
Outside Winnipeg Toll Free: 1-888-204-1234
E-mail: winnclaim@coughlin.ca

Please note that the original receipts submitted with your claim will not be returned to you as a detailed claims summary provided by the Plan Administrator on finalization of your claim is sufficient for the purposes of tax reporting and co-ordination of benefits.

The completed claim form can be dropped off at the Plan Administrator's office or mailed to:

Coughlin & Associates Ltd.
P.O. Box 764
Winnipeg, Manitoba, R3C 2L4

All claim forms must be signed by the Insured Participant.

Dentalcare

There are two options available to submit your Dental Claims:

1. Electronic Data Interchange (EDI)

With EDI, your dental claim is sent directly from your dental office to the Plan Administrator for claims adjudication. The Plan Administrator's EDI service uses the secure data networks of CDAnet, the dedicated claims processing network sponsored by the Canadian Dental Association.

To take advantage of Coughlin's EDI service, just tell your dentist/denturist that Coughlin & Associates Ltd. is your claims administrator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. CDAnet carrier identification number (also known as the BIN number), which is **610105 on the TELUS network** and;
- your unique Personal Identification Number (which is your Social Insurance Number);
- the policy number of your Group Benefit Plan, which is **165013.**

Not all dental offices are members of CDAnet. So, be sure to first ask your dentist/denturist or his/her office administrator about CDAnet access.

2. In case your dentist/denturist is not set up for EDI:

- Obtain a claim form from Local Union 739 or the Plan Administrator (directly or via the website at www.coughlin.ca).
- Have the dentist/denturist complete his/her portion of the form. You must sign at the appropriate place in Part 1 if you want the dentist/denturist to be paid directly by the Dental Plan.
- Complete and sign Part 2 of the form.
- Indicate in Part 3, if you want to apply any available funds in your Healthcare Spending Account, if applicable, toward eligible expenses not covered under your Group Benefit Plan.
- Date and sign the form in Member Authorization and Declaration section.
- Return the completed form promptly to the Plan Administrator.

Pre-Authorization

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

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

For major dental services, ask your dentist/denturist to send the x-rays with the form.

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

Please note that the portion of your Dental claim not covered by the Plan is payable immediately to your Dentist/Denturist.

Extended Health Claims

- Obtain a claim form from Local Union 739 or the Plan Administrator (directly or via the website at www.coughlin.ca).
- Obtain a receipt from your doctor, specialist, paramedical specialist, pharmacist, ophthalmologist, optometrist or optician.
- Complete the form and sign at the bottom of the form.
- Return the completed form with **original** receipts promptly to the Plan Administrator.

Note: For Prescription Drug claims, we will provide you with an Express Scrips Canada (ESC) Prescription Drug Identification Card. Present card when purchasing drugs to cover the cost up to the Plan maximum and percentage of coverage.

Pre-Authorized Deposit

Members and Employees of benefit plans adjudicated by Coughlin & Associates Ltd. can now have their health and dental claim reimbursements deposited directly to their bank accounts.

With Coughlin's new Pre-Authorized Deposit (PAD) reimbursement program, members can receive their reimbursements within two to five days following the approval of their health and dental claims. They will

not have to wait for the arrival of a cheque and a trip to the bank before depositing their reimbursement.

This new claims reimbursement program is designed to speed-up the claims reimbursement process by reducing cumbersome paper-based systems that rely on standard postal services.

Enrol in PAD Today

Step 1 – Begin Enrolment

Enroling in Coughlin's PAD service is both fast and easy. First, just click on the notice under *"Claims reimbursement direct to your bank account"* on the main page of the Coughlin & Associates Ltd. website at www.coughlin.ca

Step 2 – Complete and Return the PAD Form

Then, complete and sign the Pre-Authorized Deposit form on the website and return it, along with a sample cheque marked "*void*" to:

Pre-Authorized Deposits
Coughlin & Associates Ltd.
Box 764
Winnipeg, MB R3C 2L4

Step 3 – Logging On

Once enrolled, the member will receive a confirmation notice by e-mail. If email is not available, he or she will be notified by regular mail. The confirmation will contain his/her bank account number. To protect privacy, the *branch transit number* and the bank

institution number will ***not*** be included in the confirmation notice.

Once confirmation is received, the member may use the *Member and Trustee Log On* feature of the Coughlin website. It will direct him or her to the plan member portal where the most up-to-date information on his or her health and dental claims, plan booklets, claim forms or other information is available.

Step 4 – Use the Plan Member Portal

Using the portal is easy. Simply key-in your user identification number and password. Note: first-time users will also be required to provide their plan number 165013 and social insurance number.

A temporary password will also be provided. However, the first-time user will be required to create his/her own permanent password.

Step 5 – Inside the Plan Member Portal

Once inside the portal, members will find a menu of choices.

Step 6 – Check the Status of Claims

Just click on *"Claims history"* to review the status of recent claims. The listing of claims activity will appear. The deposit will also be confirmed by email.

A Giant Step Forward

For most members, Coughlin's Pre-Authorized Deposit program will offer a speed and convenience that will be hard to beat.

However, members can still receive reimbursements via cheque, if they prefer.

Please Note:

Employer's name:	Local Union 739 Health and Welfare Trust Fund
Group Policy Number:	165013
Certificate Number:	is your Social Insurance Number

Time Limitations

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

A.D.&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.

Extended Healthcare, Visioncare and Dentalcare
Claims for these benefits must be submitted within twelve (12) months of the date incurred.

Short Term Disability
A claim for Short Term Disability income benefits must be submitted within six (6) months following the date of disability.

PAY DIRECT DRUG CARD

Local Union 739 insured Members can pay for their prescription drugs at any retail pharmacy in Canada directly through their drug plan using the pay direct card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete, no payment required outside of the co-insurance and no waiting for a reimbursement cheque to arrive. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately. It's that simple.

The card can by used by you as well as your spouse and eligible dependants. Remember, the Local Union 739 **pay direct drug card is designed to cover only prescription drug costs. It cannot be used for dental, vision, or other healthcare claims.** (Submit claims for those services to Coughlin & Associates Ltd., in the normal fashion.)

You must present the Express Scripts Canada (ESC) card to your pharmacist in order to take advantage of this fast and convenient service.

How it Works

When you purchase prescription drugs, simply present the Local Union 739 pay direct card to your pharmacist. The prescription data will be submitted electronically to Express Scripts Canada (ESC) and

your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

There are no deductibles.

Number of Cards to be Issued

If you are single, you will receive one pay direct card. If you have family coverage, you will receive two cards; one for you and one for your spouse. Note: Only the name of the covered Local Union 739 Member appears on the card.

An additional card will be issued in your name for eligible dependants over age 21 and in full-time attendance at college or university.

If you need an additional card, or if your card is lost or stolen, please contact Coughlin & Associates Ltd., at **204-942-4438** or Toll Free **1-888-204-1234.**
Only in Canada

The pay direct card cannot be used outside of Canada.

If you Forget your Card

You can fill your drug prescription without the Local Union 739 pay direct drug card. However, your drug claim will have to be submitted to Coughlin & Associates Ltd. and processed manually.

If it Doesn't Work

Occasionally, there are cases when the drug card is not accepted by a pharmacist's system. This is usually a result of either input error or incorrect data being on file. If you encounter difficulties, ask your pharmacist to confirm or correct key data such as the spelling of your name, birth date, address, etc. Most errors can be corrected on-the-spot.

Otherwise, ask your pharmacist to contact Express Scripts Canada (ESC) Pharmacy Call Centre at **1-800-563-3274.** If you continue to run in difficulties, please contact Coughlin & Associates Ltd., at **204-942-4438** or Toll Free **1-888-204-1234.**

You can submit your claim manually to Coughlin & Associates Ltd. at the following address:

The Claims Department
Coughlin & Associates Ltd.
Box 764
Winnipeg, MB R3C 2L4

Most claims are processed within 2 – 3 business days of receipt by mail.

If your Personal Information Changes

If you have any changes to your personal information, such as the adding or removal of a dependant, new address, etc., please contact Coughlin & Associates Ltd.

LIFE INSURANCE

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

Amount of Benefit

For Members of Local Union 739, you are entitled to the applicable benefit amount outlined in the Highlight of Benefits section. At age 65, the benefit amount reduces by 50%.

Coverage Ceases

Your Life Insurance coverage ceases at the earlier of age 70 following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 739. For Office Staff, coverage terminates at the earlier of the date of termination, lay-off, retirement, or age 70.

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 Great-West Life and Coughlin & Associates Ltd. regardless of whether or not you are eligible for Workers'

Compensation, Auto Insurance, or EI 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 notify the Plan Administrator of your disability within six (6) months of your last active day of work and furnish proof of your disability satisfactory to the Insurer.

Conversion Privilege

You Life Insurance continues for thirty-one (31) days following the termination of your coverage. During this thirty-one (31) day period if under the age of 65, you may convert the amount of your Life Insurance to an individual whole life or a convertible one-year term 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. Please contact the Plan Administrator for more details.

DEPENDANT LIFE INSURANCE

Amount of Benefit

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

Coverage Ceases

Your Dependant Life Insurance coverage terminates at the earlier of age 70, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 739.

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

Waiver of Premium for Disability

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

Conversion Privilege

The Dependant Life continues for thirty-one (31) days following your death or your termination of coverage. During this thirty-one (31) day period if under the age of 65, your spouse's amount of Dependant 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. Please contact the Plan Administrator for more details.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Coverage

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

Eligibility

All active eligible members under age 70.

Benefit Amount

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

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, ACE INA Life Insurance 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.

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 ACE INA Life Insurance 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 ACE INA Life Insurance 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 ACE INA Life Insurance 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, ACE INA Life Insurance 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 ACE INA Life Insurance under any benefit excluding the Loss of Life Benefit, ACE INA Life Insurance 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, ACE INA Life Insurance 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 ACE INA Life Insurance under the Loss of Life Benefit, ACE INA Life Insurance 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, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

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

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

Benefit payments herein will not be paid unless:

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

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

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

Day Care Benefit

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

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

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

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance 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 dependant child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependant 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, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred by the spouse and dependant 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, ACE INA Life Insurance 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, ACE INA Life Insurance 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% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

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

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by a "Member of the Immediate Family" has been requested by the police or a similar governmental authority, ACE INA Life

Insurance will reimburse the reasonable expenses actually incurred by such member for:

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

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

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

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

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

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person. If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at

the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

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 ACE INA Life Insurance. The individual policy will be effective either as of the date that the application is received by ACE INA Life Insurance 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 ACE INA Life Insurance. 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 ACE INA Life Insurance (not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).

Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for 6 consecutive months and an Insured Employee provides evidence of total disability satisfactory to ACE INA Life Insurance, ACE INA Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependants. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, ACE INA Life Insurance will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

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 ACE INA Life Insurance 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.

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

a) the date an Insured Employee ceases to meet the policy's definition of totally disabled;

b) the date an Insured Employee does not supply ACE INA Life Insurance with appropriate medical evidence as deemed necessary by ACE INA Life Insurance;

c) the date an Insured Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by ACE INA Life Insurance;

d) the date an Insured Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by ACE INA Life Insurance;

e) the date the policy terminates;

f) the date an Insured Employee turns 65; or

g) the date an Insured Employee dies.

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, ACE INA Life Insurance will pay the actual expense incurred for preparing the deceased for burial or cremation but shall not exceed $5,000.

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

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

2. declared or undeclared war or any act thereof;

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

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

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

SHORT TERM DISABILITY

In the event you become totally disabled due to an injury or illness and are unable to perform the essential duties of your occupation, 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 Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Great-West Life Assurance Company and ACE INA) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance, or EI 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 the Waiver of Life Insurance, required within six (6) months of the date of initial disability.

Benefits for any one disability are payable from the first (1st) day of disability due to injury or the fourth (4th) day for sickness or hospitalization **but in no event prior to the first day of visit to your physician**. Your benefit will be payable for not more than thirty-seven (37) weeks during any one period of disability.

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

- The first one (1) week of disability will be covered by the Plan. The Plan Administrator

will advise you to apply for E.I. Disability benefits before the end of 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.

- Weeks 17 to 37 will then again be covered by the Plan.

Note: This benefit is taxable if only Employer contributions are remitted.

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 are 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 sub division or agency of the governments 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 Insurer shall not reduce the weekly benefit by that amount.

Coverage Ceases

Eligibility for Short Term Disability coverage terminates at the earlier of age 75, depletion of the Hour Bank Account, the date of retirement, or if you are no longer a Member in good standing with Local Union 739.

For Office Staff, coverage terminates immediately upon the date of termination of employment, retirement, lay-off or age 75.

Exceptions

Benefits are not payable for:

- disability due to injury or illness while working for pay or profit for which you are covered under Workers' Compensation or similar program, or
- disability due to cosmetic surgery except where the surgery is required to correct a deformity resulting from illness or injury or a congenital defect that interferes with function, or
- disability during a period you are serving a prison sentence, or

- disability resulting from self-inflicted injury, war, or engaging in a riot or insurrection.

EXTENDED HEALTH BENEFIT

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

The Extended Health 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 a resident in Canada.

Coverage Ceases

Your Extended Health coverage terminates at the earlier of age 70, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 739. Actively Working Members are eligible to have their health coverage extended past age 70 up to the extent of the Member's Hour Bank account with no ability to self-pay. For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off or retirement.

Please note that emergency Out of Province/Country coverage and the Global Medical Assistance Program offered by Great-West Life terminate at the earlier of age 70 or retirement.

Eligible Expenses

The following is a list of eligible expenses:

- For hospital room and board, the Insurer pays up to the usual daily charge of the hospital concerned for:

  a) Private care in your province of residence, and
  b) private care, for expenses incurred outside your province of residence, and
  c) semi-private accommodation on a reasonable and customary basis for the area in which they are incurred for confinement outside of Canada.

  Hospital charges shall **not** include any in-patient admission charge, hospital users fee or out-patient visit charge made by your home province.

  Other medically necessary hospital services and supplies.

  Charges for confinement in an Intensive Care Unit.

- Charges for the services of a registered nurse who is not normally resident in the patient's home, nor a relative of the patient, rendered in the patient's home, to a maximum of $5,000 in any three consecutive years prior to age 65. Over age 65, the maximum is $5,000 lifetime less any nursing expenses claimed in the three years prior to age 65;

- Charges for an ambulance or via any form of emergency transportation when an ambulance is unavailable, up to a maximum of $1,200 per calendar year;

- Medical report costs incurred as required in conjunction with a Short Term Disability claim;

- Medical supplies, on the written recommendation of a physician based on the cost to rent, or at Great-West Life's discretion, the cost to purchase:

    a) Charges for drugs, medicines, serums and vaccines obtainable only upon a written prescription and dispensed by a pharmacist or physician, up to a maximum of $2,500 per family per benefit year (April 1 – March 31),;
    b) Breathing equipment such as oxygen and equipment needed for its administration, continuous positive airway pressure machines ($2,500 every 5 years up to $5,000 lifetime), mist tents, etc.;
    c) Orthopedic equipment including braces, cervical collars, casts, splints, custom made foot orthotics and custom made orthopedic shoes, etc.;
    d) Prosthetic equipment including artificial eyes, standard artificial limbs, myoelectric arms (up to $10,000 per prosthesis), external breast prosthesis (once per year), and surgical brassieres (twice a year), etc.;

e) Mobility aids such as canes, walkers, crutches, mechanical/hydraulic patient lifters (once every 5 years), and wheelchairs, etc.;
f) Diabetic supplies such as insulin and insulin syringes, insulin pumps (once every 5 years), blood glucose monitoring machines, test strips, etc.;
g) Other medical supplies inclusive of the following: nicotine patches and gum ($200 per lifetime), hospital beds, colostomy and ileostomy supplies, burn garmets, etc.

- Charges for hospital services and supplies while the insured is not confined in a hospital;

- Charges for the services of a dental surgeon for treatment of a fractured jaw or accidental injuries to whole or sound teeth (capped or crowned teeth shall be deemed as whole or sound), including replacement of such damaged teeth, providing the accident causing such injuries occurred while insured. Treatment must be started within 60 days of the accident unless a medical condition delays treatment beyond the 60 days. Payments made under this benefit shall be in accordance with the schedule of fees published by the dental association in your province of residence. Where no schedule of fees is available, the Ontario Dental Association schedule of fees will apply;

- Charges for the services of a qualified physiotherapist, up to a maximum of $600 per calendar year;

- Charges for the services of a qualified speech therapist subject to a maximum of $300 in any calendar year;

- Charges for the services of a registered psychologist subject to a maximum of $300 in any calendar year;

- Charges for prescribed hearing aids (excluding batteries and repairs) when initially required or if required to a change in prescription, restricted to three instruments during the lifetime of each insured and subject to a maximum of $300 per instrument and one expense in any five (5) consecutive years.

- Charges for paramedical services, inclusive of x-rays and lab services if within the scope of the legally licensed practitioner subject to a maximum of $300 for each practitioner per calendar year:

    a) acupuncture;
    b) chiropractors;
    c) osteopaths;
    d) chiropodists or podiatrists;
    e) naturopaths;
    f) massage therapist;
    g) charges for diagnostic x-rays and laboratory tests by the above mentioned practitioner.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependant is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometers from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet.

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality

lodgings up to $1,500 and for a round trip economy class ticket.

- If you or a dependant is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependant's medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependant and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependant is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.

- In case of death, preparation and transportation of the deceased home.

- Return transportation home for minor children travelling with you or a dependant who are left unaccompanied because of your or your dependant's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary.

- Costs of returning your or your dependant's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependant from driving, to a maximum of

$1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependant is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

  - treatment by a physician
  - diagnostic x-ray and laboratory services
  - hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependant is covered
  - medical supplies provided during a covered hospital confinement
  - paramedical services provided during a covered hospital confinement
  - hospital out-patient services and supplies

- medical supplies provided out-of-hospital if they would have been covered in Canada
- drugs
- out-of-hospital services of a professional nurse
- ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

Limitations

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private insurers are not permitted to cover by law

- Services or supplies for which a charge is made only because you have insurance coverage

- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan

- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to

a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:

  - treatment performed only for cosmetic purposes

  - recreation or sports rather than with other daily living activities

  - the diagnosis or treatment of infertility

  - contraception, other than oral contraceptives

- Services or supplies not listed as covered expenses

- Extra medical supplies that are spares or alternates

- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance

- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance

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

- Chronic care

- Visioncare services and supplies required by an employer as a condition of employment

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTOR'S SERVICE)

This service is designed to allow you, your dependants and your attending physician or specialists access to the expertise of world-class specialists, resources, information and clinical guidance.

If you or your dependants are diagnosed with a serious medical condition for which there is objective evidence, or if your physician or you or your dependant suspect you have this condition, you can access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a medical condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How It Works

- You or your dependant can access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- You will be connected with a member advocate who will be dedicated to your case and will provide support through the process. The member advocate will take the necessary medical history and answer your questions. Any information provided is not

shared with either your employer or the administrator of your health plan.

- Based on the information and questions, the member advocate determines the optimal level of service for you or your dependant.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet your health needs. They can also help identify individual community supports and resources available.

If it is appropriate, the member advocate may arrange for an in-depth review of your medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing

- Test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to you and your physician. On average, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and the amount of medical records to collect.

- If you decide to seek treatment by a different physician, the member advocate can help identify the specialist best qualified to meet your specific medical needs. Expenses incurred for travel and treatment are not covered by this service.

- If you decide to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also access hospital and physician discounts, arrange for forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.

Note: These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

VISIONCARE

Charges are covered for necessary visual supplies recommended by an ophthalmologist or optometrist subject to the maximum listed below, provided such expenses are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Coverage Ceases

Your Visioncare coverage terminates at the earlier of age 70, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 739. Actively Working Members are eligible to have this Vision coverage extended past age 70 up to the extent of the Member's Hour Bank with no ability to self-pay. For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off or retirement.

Eligible Expenses

The following items are considered Eligible Expenses under this Visioncare Benefit.

- Routine Eye Examinations up to a maximum of $75 every 24 months.

  If medically necessary, eye examinations up to a maximum of $75 every 12 months subject to a medical recommendation due to complication resulting from a medical condition.

- Eyeglass frames and lenses (or contact lenses selected in place of lenses and frames) up to but not exceeding $300 in any 24 month period.

- Contact lenses (up to 3 sets at a cost of $200 per set) during the lifetime of the insured if prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way, and if visual acuity can be improved to at least 20/40 level with contact lenses but not with ordinary eye glasses, and limited to one such expense in any 24 month period.

Exclusions

- Treatment furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits.

- Eye tests or examinations required by an employer, school or government for screening purposes.

- Sunglasses or safety glasses (prescription or non-prescription).

DENTALCARE BENEFIT

Although the Dentalcare 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”, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred, and will be limited to the maximums specified in the Highlight of Benefits section at the applicable provincial dental fee schedule rate.

The Plan covers necessary dental treatment by a dentist, physician or other qualified personnel under the direct supervision of the dental or medical profession (e.g. dental assistants and dental hygienists) and will also cover services rendered by specialists, dental mechanics, denturologists, denturists, denture therapists, etc, where permitted by law to deal directly with the public. If there is no fee schedule for these practitioners in your province, payment will be based on the Ontario Dental Association fee guide for General Practitioners.

- You pay 20% of the Basic Treatment expenses, 30% of Major Treatment expenses, and 50% of Orthodontic Treatment expenses. The insurance company pays the rest.

- The maximum amount that the plan will pay for covered expenses in any one year is

$1,500 for any one person for Basic and Major Treatment combined and $2,500 lifetime for Orthodontic Treatment.

Coverage Ceases

Your Dentalcare coverage terminates at the earlier of age 70, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 739. Actively Working Members are eligible to have their Dental coverage extended past age 70 up to the extent of the Member's Hour Bank with no ability to self-pay. For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, or retirement.

Predetermination of Dental Claims

If your dentist has recommended dental treatment that is expected to cost more than $500, you must have your dentist prepare a pre-treatment plan.

Send the pre-treatment plan to the Plan Administrator. We will send you a statement of the amount payable by the insurance plan which will allow you to determine your own financial obligation prior to the commencement of treatment.

Extension of Benefits

Benefits are not payable for expenses incurred after the date your insurance or your dependant's insurance under this benefit provision terminates, except that where dentures, crowns or endodontic work are eligible expenses and where an impression

for such procedures has been taken prior to the date your insurance of your dependant's insurance terminates, eligible expenses in connection with such procedure incurred within 30 days after the termination of insurance are payable.

With respect to orthodontia, the Insurer will pay benefits for expenses, incurred after the date your insurance or your dependant's insurance under this benefit provision terminates, only in respect of a course of orthodontic treatment:

- which commenced while your dependant's insurance was in force, and

- for which the company commenced payment of benefits prior to the date of termination of insurance,

up to but not exceeding the amount which would have been paid in the 30 day period immediately following said termination of insurance had this insurance remained in force during such period.

Covered Expenses

BASIC TREATMENT: rendered or prescribed by a physician, dental hygienist, dentist or oral surgeon, or rendered by a dental assistant under the direct supervision of a physician, dentist or oral surgeon.

- The following services (a) to (d) inclusive, each limited to once per calendar year

  a) routine oral examinations;
  b) prophylaxis (the cleaning of teeth);

c) posterior, bilateral and bite-wing x-rays;
d) topical application of fluoride solutions

- Full-mouth series of x-rays; limited to one set in any 24 month period.

- Extractions and alveolectomy at the time of tooth extraction.

- Amalgam fillings, silicate, acrylic and composite restorations, stainless steel crowns and replacement thereof after 12 months.

- Dental surgery including diagnostic and laboratory procedures required in relation to dental surgery.

- General anaesthesia required in relation to dental surgery.

- Necessary treatment for relief of dental pain.

- The cost of medication and its administration when provided by injection in the dentist's office.

- Initial provision of space maintainers for missing primary teeth, and habit breaking appliances.

- Oral hygiene instruction for brushing, massaging, embrasure cleaning (limited to one adult per family).

- Preformed stainless steel crowns and repairs thereof.

- Relining, rebasing and repair of existing dentures (after 3 months from insertion).

- Treatment for periodontal and other diseases of the gum and tissues of the mouth.

- Endodontic treatment (root canal therapy).

- Addition of teeth to partial denture to replace extracted natural teeth.

MAJOR RESTORATIVE TREATMENT: rendered or prescribed by a physician, dentist or oral surgeon, or rendered by a dental mechanic.

- Provision of crowns (inlays, onlays, or veneers) if teeth cannot be restored satisfactorily by use of a filling material and gold inlays if no other material is satisfactory.

- Provision of an initial prosthodontic appliance (e.g. fixed bridge restoration, removable partial or complete dentures).

- Replacement of an existing prosthodontic appliance if:

    a) The replacement appliance is required because at least one additional natural tooth is necessarily extracted after the date you or your dependants become insured under this benefit provision and

the existing appliance cannot be made serviceable.

If the existing appliance can be made serviceable, only the expense for that portion of the replacement appliance which replaces the teeth extracted after the date you or your dependants first became insured, shall be covered.

b) The replacement appliance replaces an existing appliance which is at least 5 years old and cannot be made serviceable.

c) The replacement appliance is a permanent appliance which replaces an existing temporary appliance installed less than 24 months prior to replacement but after the date you or your dependant first become insured under this benefit provision; in the event the amount assessed in respect of the temporary appliance will be used to reduce the benefit assessment for the permanent appliance.

Should the existing temporary appliance be more than 24 months old, it will be regarded as a permanent installation and subject to the same replacement provisions as a permanent appliance.

Should the existing temporary appliance be replaced by another temporary appliance, then the second temporary

appliance will be regarded as a permanent appliance with respect to any subsequent replacements.

d) The replacement appliance is required as a result of the installation of an initial opposing denture after the date you or your dependant become insured under this benefit provision.

- Procedures involving the use of gold if such treatment could not have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

- If such treatment could have been rendered at a lower cost by means of a reasonable substitute, only the expense that would have been incurred for treatment by means of the reasonable substitute shall be covered.

- Denture adjustments (after 6 months from insertion) and denture repairs.

- Repair and recementing of crowns and inlays.

- Tissue conditioning.

- Repairs to existing bridgework.

Exceptions

Expenses incurred for the following shall in no event be eligible expenses:

- Dental services not listed under eligible expenses.

- Services and supplies, or portion thereof, which are covered by a government health plan or any other government plan, or for which a government or government agency prohibits the payment of benefits.

- Services and supplies provided by a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group.

- Services and supplies required as a result of any intentionally self-inflicted injury, including but not limited to injuries sustained by the placement of objects in the mouth.

- Services and supplies required as the direct result of war (declared or undeclared), or engaging in a riot or insurrection.

- Services and supplies rendered principally for cosmetic purposes including, but not limited to facings on crowns and pontics posterior to the second bicuspid.

- Services and supplies rendered for full mouth reconstruction, for a vertical

dimension correction, or for correction of a temporomandibular joint dysfunction.

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

- Charges resulting from missed or broken appointments.

- Any course of treatment which began or was arranged prior to the effective date of your insurance or your dependant's insurance with respect to these benefits.

- Expenses incurred as the result of injury of disease sustained during the commission of a felony.

- Replacement of dentures which are lost or stolen.

- Dental treatment which is not necessary dental treatment. It is provided, however, that the company shall consider as eligible expenses, that portion of the expense which would have been incurred for an alternate form of treatment which would qualify as necessary dental treatment.

- Charge resulting from the initial placement, replacement or repairs to a duplicate prosthodontic appliance.

- Transitional dentures and temporary crowns.

DEPENDANT ORTHODONTIC BENEFIT

Payment of Benefit

If an insured dependant who is 6 to 18 years of age shall require necessary orthodontic treatment, commencing while insured under this benefit, the insurance company will pay, in accordance with all conditions, exceptions and other terms of the policy, the resulting eligible expenses actually incurred.

- You pay 50% of the Orthodontic expenses. The insurance company pays up to $2,500 maximum per lifetime for each of your eligible dependant children.

Eligible Orthodontic Expenses

Eligible orthodontic expenses are necessary orthodontic treatment rendered by a certified orthodontist including the provision of orthodontic appliances for the correction of class I, class II or class III malocclusions in relation to primary, mixed or permanent dentition.

A charge will be considered to have been incurred on the date the insured dependant received the orthodontic care for which the charge is made.

Exceptions

No amount will be payable under this benefit for charges:

1) for orthodontic care rendered or supplied by a dentist employed by a government or at the expense of a government agency thereof;

2) for the repair or replacement of an orthodontic appliance;

3) for orthodontic care which is wholly cosmetic;

4) for an appointment that an insured dependant fails to keep;

5) for a course of orthodontic care which commenced prior to the effective date of a dependant's insurance under this benefit;

6) which result from a dental disease, defect or injury arising out of or in the course of an insured dependant's employment;

7) which are not reasonable and customary charges, or which are in excess of charges customarily made or that would have been made in the absence of insurance under this plan;

8) which result from injury or disease sustained during the commission of a felony;

9) services and supplies rendered for the correction of any congenital or developmental malformation which is not class I, class II or class III malocclusion.

Notwithstanding item 5 above, a course of orthodontic care which was covered by a dental policy issued by a previous insurance carrier to the policyholder and which terminated concurrently with the effective date of the group dental policy issued by Great-West Life Life, is considered to be eligible under the Orthodontic Benefit up to the lesser amount of the benefit payable by the group dental policy issued by:

- Great-West Life Life, and by
- the previous carrier's group dental policy, had such policy remained in force.

Pre-Treatment Estimate of Charges

You may obtain a written estimate from the Plan Administrator of the maximum amount of charges for which payment will be made for any proposed course of orthodontic treatment by submitting, prior to the commencement of treatment, x-rays, if and when requested, and written notice on a form supplied by the Plan Administrator outlining such course and including charges.

Special Conditions applicable to Orthodontic Treatment

For purposes of payment only, the eligible expenses for orthodontic treatment shall be deemed to be incurred on a monthly basis, commencing with the date on which such treatment is first rendered and subsequently thereafter on the monthly anniversary of such date during the continuance of the treatment period. The Plan Administrator will require submission of receipts, or other proof acceptable to

the Insurer, of such continuance of treatment in order to make payment.

Single Charge Basis

If the estimated cost of orthodontic treatment stated in the treatment plan does not include a separate estimate for initial appliances, the amount of each monthly eligible expense of orthodontic treatment is deemed to be:

- the total estimated eligible expenses in respect of the orthodontic treatment, divided by

  the number of months of the treatment period.

Itemized Charge Basis

If the estimated cost of orthodontic treatment stated in the treatment plan includes a separate estimate for initial appliances, the amount of the monthly eligible expenses for orthodontic treatment is deemed to be:

1) for the first month of treatment, the lesser of:

   a) the estimated eligible expenses for such appliance, or
   b) 25% of the total estimated eligible expenses in respect of the orthodontic treatment;

2) for each subsequent month of treatment the difference between the total estimated eligible expenses and the eligible expenses calculated for the first month of treatment

number (1) above, divided by the under of subsequent months of the treatment plan.

The amount of the monthly eligible expenses as determined above is subject to adjustment if the actual expense and/or period of treatment differ from the estimate given in the treatment plan.

Termination of Coverage

An insured dependant's insurance will automatically terminate:

1) in accordance with the termination of dependant's insurance section of the policy, or
2) on the date the insured dependant attains 18 years of age,whichever first occurs.

PREFERRED VISION SERVICES (PVS)

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network provider.

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependants.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program

- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed

- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery

- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

CONTINUATION OF HEALTH BENEFITS FOR DEPENDANTS

In the event of your death, the health benefits (Dental, Vision and Extended Health) for your dependants as described in this booklet will be continued for a period of two years or until your spouse remarries, whichever is the earlier.

- If your surviving children cease to qualify as eligible dependants (as defined earlier in this booklet), the health benefits being continued for your children under this provision will terminate automatically on the date they no longer qualify.

- If a dependant is disabled on the date his/her insurance under this continuation provision would otherwise terminate, his/her insurance payments will be continued until the earliest of the following:

  - the date on which his/her disability ends,
  - the date which is 90 days from the date his/her insurance terminated.

Please Note: If he/she is in the hospital on the last day of this 90 day period, the insurance payments will be continued until he/she is discharged from the hospital, or until maximum benefits have been paid.

GENERAL LIMITATIONS

Your health insurance does not cover services and supplies in the following situations:

- Injury sustained while working for pay or profit.
- Illness for which you or your dependants are covered under Workers' Compensation or similar program.
- Services received in a government hospital unless you are required to pay for such services.
- Services to which the patient is entitled without charge, or for which there would be no charge if there were no insurance.
- Services or portion thereof provided under any government sponsored hospital or medical care program.
- Aesthetic surgery (cosmetic surgery for beautification purposes).
- Services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits.
- Services received from a medical department maintained by the employer, a

mutual benefit association, labour union, trustee or similar type of group.

- Service, including part-time or temporary service in the armed forces of any country.

- Services required due to war (declared or undeclared), insurrection, or participation in a riot.

- Services required due to any intentional self-inflected injury or disease, while sane or insane.

This booklet is a summary of the principal features of the plan, but Group Policy No. 165013 (Great-West Life Assurance Company) and ACE INA (Policy AB10406516) issued to the Trustees of the Local Union 739 Health and Welfare Trust Fund and the Self-Insured Policy are the governing documents. In the event of any variation between the information in this summary and the provisions of the policies the latter will prevail.