OPERATING ENGINEERS
HEALTH & WELLNESS 955

# Health & Wellness Plan

(Effective January 1, 2025)

January 1, 2025

January 1, 2025

Dear Brothers, Sisters and Kin:

The Board of Trustees of the Operating Engineers Local 955 Health & Wellness Trust Fund regularly reviews its benefit programs and amends them from time to time to ensure that they continue to provide value and serve your needs. We are pleased to provide you with the new Health & Wellness Plan booklet with up-to-date information as of January 1, 2025.

This booklet includes 2025 benefit improvements, and procedural changes as a result of our change in benefits provider to Alberta Blue Cross.

You should be familiar with your Health & Wellness benefits to take full advantage of what they can offer. We encourage you to take this opportunity to review this booklet.

Additional information is available in the Health & Wellness section of the IUOE Local 955 website at www.oe955.com.

If you have any questions or require more information, please contact the Trust Office.

Yours in solidarity,

Chris Flett
Chair, Board of Trustees
Operating Engineers Local 955
Health & Wellness Trust Fund

# TABLE OF CONTENTS

# INTRODUCTION

The Operating Engineers Local 955 Health & Wellness Trust Fund maintains a benefit plan (Plan) to support and protect members and their families with Extended Health Care, Dental, Life Insurance, Accident Insurance, and Disability benefits. This booklet outlines different benefits provided by the Plan, effective January 1, 2025.

This booklet is intended to provide an overview of the benefits available under the Plan. It is a summary of legal contracts and therefore does not contain all of the Plan details. The complete Plan text is available for inspection by Plan members at the Trust Office by appointment only.

**If there is a discrepancy or misunderstanding in the interpretation of the wording of this booklet, benefits will be paid according to the official Plan documents and applicable contracts, policies, and legislation. To avoid discrepancy or misunderstanding, please feel free to contact the Trust Office to seek clarification and ensure coverage is available.**

The Board of Trustees, made up of four Union representatives and four Employer representatives, oversees the Plan. **The Trustees reserve the right to amend or discontinue this Plan at any time.**

Additional information is available on the IUOE Local 955 website www.oe955.com and the Alberta Blue Cross website www.ab.bluecross.ca.

The Trust Office and Alberta Blue Cross staff are available to answer any questions you may have about your benefits.

## Contact Information

| | **Trust Office** | **Alberta Blue Cross** |
|---|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) | 1-800-661-6995 |
| **Direct:** | 780-483-9550 | 780-498-8000 |
| **Email:** | benefits@oe955.com<br>disability@oe955.com | Through ‘Contact Us’ on the Alberta Blue Cross app or website at www.ab.bluecross.ca |

# HEALTH & WELLNESS PLAN OVERVIEW

## Eligibility

The Health and Wellness Plan provides Core or Extended benefits to eligible members of IUOE Local 955. Whether you have Core or Extended benefits is based on the Health and Wellness contribution rate of the collective agreement you work under. At January 1, 2025, the Core Plan is provided to members with contribution rates of less than $2.05 per hour. The Extended Plan is provided to members with contribution rates of $2.05 per hour and over.

To qualify for benefits you must be a member in Good Standing of IUOE Local 955, and satisfy one of the following requirements:

- Core Plan: earn at least 270 Adjusted Hours from contributing employers within six months of joining the Union;
- Extended Plan: earn at least 350 Adjusted Hours from contributing employers within six months of joining the Union; or
- self-pay to your Hour Bank for reduced benefits (only Extended Health Care and Dental).

Your coverage begins on the first day of the month following the month in which the required number of Adjusted Hours have been received in the Trust Office, for example, if we receive the required Adjusted Hours in September, your benefits would start October 1st. You will receive a notice informing you when your coverage has begun. It is your responsibility to ensure your employer is making the appropriate contributions on your behalf. Call the Trust Office to confirm employer contributions. It is also your responsibility to make self-pay contributions on time if you do not have enough hours in your Hour Bank.

Officers or employees of the Union or Trust Funds are also eligible for benefits under this Plan subject to their collective agreement.

**ADJUSTED HOURS**

You receive Adjusted Hours in your Hour Bank based on the contributions made on your behalf by your employer. The per-hour rate that your employer contributes is set by your collective agreement.

The Trustees set the conversion rate to calculate Adjusted Hours, and it increases over time. For 2025, $1.90 of contributions = 1 Adjusted Hour.

For example, if you work 200 hours and your employer's contribution rate is $1.75 per hour you will be credited with 184.21 Adjusted Hours in your Hour Bank.

200 hours x $1.75 = $350
$350 / $1.90 = 184.21 Adjusted Hours

## Self-Paying for Benefits

To qualify to self-pay for benefits, you must be a member in Good Standing of IUOE Local 955 and make the necessary payment arrangements (prior to the expiry of your Hour Bank) with the Trust Office. Self-pay members should ensure their payments are received by the 20th of each month to pay for the following month's coverage. You are eligible to make self-payments for a maximum of 12 months following the depletion of your Hour Bank.

**Self-pay members are not entitled to Life Insurance, Accident Insurance, Short-Term Disability, Long-Term Disability or Health Spending Accounts.** Self-pay members wishing to maintain or obtain life insurance can visit Manulife's Personal Benefits website (www.manulife.ca/personalbenefits) for information on optional life insurance.

**SELF-PAY ONLINE**

Go to www.oe955.com and log into your member portal anytime to self-pay for your benefits.

**BE ON TIME**

If you are making self-payments, it is critical that the Trust Office receives them on time. If not, your drug card will be deactivated and your coverage will be terminated.

## Disabled Members

You will only have Short-Term or Long-Term Disability coverage if you are eligible for that coverage when you become disabled.

If you are in receipt of Short-Term or Long-Term Disability, your premiums for Health & Wellness benefits will be waived and hours will not be deducted from your Hour Bank until you to return to work or are no longer eligible for disability benefits.

## Maintaining Your Coverage

The monthly charge for coverage is deducted from your Hour Bank. The monthly charge will vary depending on whether you are in the Core Plan or the Extended Plan:

- To remain eligible for coverage under the Core Plan, you must have at least 135 Adjusted Hours in your Hour Bank before the end of every month to pay the premium for the following month.
- To remain eligible for coverage under the Extended Plan, you must have at least 175 Adjusted Hours in your Hour Bank before the end of every month to pay the premium for the following month.

There is no additional charge for family coverage.

Adjusted Hours are credited to your Hour Bank in proportion to the contribution made by your employer (for example, for 2025 $1.90 of employer contribution = 1 Adjusted Hour). The hourly contribution rate for your employer is set by the applicable collective agreement.

If you are in the Core Plan, you may accumulate a maximum of 1,350 Adjusted Hours in your Hour Bank. If you are in the Extended Plan, you may accumulate a maximum of 1,750 Adjusted Hours in your Hour Bank. Any Adjusted Hours above 1,350 or 1,750 respectively will be transferred to the General Account.

You may not opt out of the Plan. The monthly charge for coverage is automatically deducted from your Hour Bank.

**HOUR BANK**

The Hour Bank is an account like your bank account, except instead of tracking the ins and outs of your money, we track your Adjusted Hours.

When contributions are received from your employer, we add Adjusted Hours to your account. Every month that you receive benefits, Adjusted Hours are taken out to "pay" for the benefits provided.

## Termination of Coverage

If you have less than the Adjusted Hours required to maintain coverage in your Hour Bank at the end of the month, your coverage stops and any remaining hours will be transferred to the General Account unless you self-pay. **Your coverage will be reinstated only after you re-qualify for Health & Wellness benefits by accumulating the required number of Adjusted Hours for initial eligibility within a six-month period and continue to be a member in Good Standing.**

**DO NOT LET YOUR BENEFITS SLIP AWAY – SELF-PAY**

If you have less than the required Adjusted Hours in your Hour Bank and your coverage is about to terminate, you may make a personal contribution – called "self-pay". You may self-pay monthly for a maximum of 12 consecutive months.

Self-Pay Premiums:

Effective January 1, 2025, the self-pay premium is $225/month.

## Naming a Beneficiary

A beneficiary is any person or persons designated by you to receive benefits provided by the Plan in the event of your death. Under the Plan you must designate a beneficiary for your Life Insurance and Accident Insurance. You can only change your named beneficiary by completing and submitting a new registration form. This change is not valid until it has been received by the Trust Office.

The registration form can be found on the IUOE Local 955 website at www.oe955.com.

**NAME A BENEFICIARY**

It is very important to name a beneficiary. If you do not, your death benefits will be paid to your Estate.

**UNDERAGE BENEFICIARY**

Remember to appoint a Trustee to act on behalf of underage beneficiaries.

## Family Coverage

There is no additional charge for family coverage.

Your Spouse and dependent children are covered for Extended Health Care and Dental benefits. Your Spouse is also covered under the Life Insurance benefit.

You can only have one person covered as your Spouse at any one time.

Payment or reimbursement cannot be made until the Trust Office receives your registration form indicating any dependents to be covered and your designated Life Insurance and Accident Insurance beneficiary.

Immediately notify the Trust Office in writing if there is any change to your family status. For example, a new common-law relationship, marriage, the birth of a child, relationship breakdown or divorce.

If your coverage stops, your Spouse and dependents' coverage also stops. See the "Termination of Coverage" section for more information. However, if you die while covered under the Plan, your Spouse and dependents continue to be covered under the Plan for one year from the date of your death.

**DEPENDENT DEFINITION**

"Dependent" means a person who is:

- a member's spouse; or
- an unmarried child who appears on one parent's provincial health care card. If the dependent child lives in a province where individual health care cards are issued, the child must have provincial health care coverage.

The Health & Wellness Plan defines "Spouse" as the person to whom you are legally married and is not living separate and apart from you or the person with whom you have lived in a common-law or marriage-like relationship for at least one year. Otherwise, the person you are legally married to, if they have been living separate and apart from you for less than three years.

"Child" means the natural child, step-child, legally adopted child or legal ward (but not a foster child) of you or your Spouse who:

- lives with you and is primarily dependent on you or your Spouse for support;
- is under age 21, or under age 25 and in full time attendance at a recognized school, college or university; or
- is any age if physically or mentally disabled and is incapable of self-sustaining employment.

## Changing Personal Information

If you change your home address, email address, phone number or banking information, it is important to notify the Trust Office immediately so that communication or benefits payable to you will not be interrupted. Changes do not become effective until received by the Trust Office.

## Travel Card

The IUOE Local 955 has reciprocal agreements with other Operating Engineers Locals in Canada so contributions made on your behalf can be transferred to your "home" Local while you are working in other provinces.

## Coordinating Benefits with Other Plans

If you or your dependents are insured under another plan for Extended Health Care and/or Dental benefits, you may be able to receive up to 100% reimbursement for your expenses. By coordinating benefits, the two plans share responsibility for reimbursing your expenses.

Alberta Blue Cross will determine "who pays first" in this way:

- **For members:** Submit your expenses first to the Operating Engineers Local 955 Health & Wellness Plan. Then, submit the remaining portion of any expense to the other plan.
- **For partners**: Submit your expenses first to your employer's plan. Then, submit the remaining portion of any expense to the Operating Engineers Local 955 Health & Wellness Plan.
- **For children**: Submit your Dependent children's claims first to the plan of the parent whose birthday occurs first in the calendar year (not necessarily the oldest parent). Any remaining expenses are then submitted to the other parent's plan.

**CONFUSED?**

The rules around coordination of benefits can be confusing. If unsure, call Alberta Blue Cross and explain your circumstances so they can help you determine which plan would be first payor for a claim.

All providers in Canada follow the same rules to establish which provider is first payor.

For example, if you as a member have a tooth pulled at the dentist, our Plan will reimburse 80% of the eligible expense. You may then submit the claim to your Spouse's plan to be reimbursed for the other 20%.

If you have coverage with other Alberta Blue Cross plans such as seniors' coverage, contact Alberta Blue Cross to discuss who to submit claims to first.

## Making a Claim

Please review each benefit section within this booklet for details around making claims for benefit coverage.

**Claims can be made online through the Alberta Blue Cross mobile app or member site, or directly submitted by your practitioner.**

**If a paper claim needs to be manually submitted, ensure you complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.**

Claim forms for manual submissions are available on the Alberta Blue Cross website, www.ab.bluecross.ca.

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and to submit claims.

For Disability, Life Insurance, or Accident Insurance related claims, contact the Trust Office immediately for the applicable forms and guidance when applying.

# EXTENDED HEALTH CARE
## (CORE AND EXTENDED)

### Eligibility

Check the *Health & Wellness Plan Overview* section at the beginning of this booklet for the details on eligibility.

**MONEY SAVING TIP**

If you are covered under another plan, check "Coordinating Benefits with Other Plans" in the Health & Wellness Plan Overview section for information on how to possibly receive up to 100% reimbursement for eligible out-of-pocket expenses.

### Coverage Details

The Extended Health Care benefits under the Plan pays for some expenses that are not covered by provincial health care plans or that exceed the provincial plan maximums.

If you die while you are covered under this Plan, your Spouse and dependents continue their Extended Health Care benefits for one year from the date of your death.

### Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. The following are some examples of expenses **not** covered:

- expenses payable under the Workers Compensation Act (or similar), a government health care plan or another group insurance or health & wellness plan;
- services or items required as a result of civil disorder, war or commission of a criminal offence; or
- cosmetic surgery or treatment unless required as a result of an accident and the surgery or treatment begins within 90 days of the accident.

**WHAT IS COVERED?**

Benefit plans have detailed lists of eligible expenses and exclusions. If you have a special circumstance, or you are not sure about coverage, contact the Trust Office or Alberta Blue Cross.

### Expenses Caused by a Third Party

If you incur medical expenses (as defined by the Plan and described in this section of the booklet) as a result of an accident, you are obligated to pursue any responsible third party at your own expense, if a valid claim exists.

If you recover money from a third party for medical expenses, you must then repay all Extended Health Care benefits received, up to the amount recovered.

## Prescription Drugs

The Plan's prescription drug coverage has a co-pay provision. This means the Plan pays 80% of eligible drug costs, including dispensing fees, and you pay 20%.

The maximum reimbursement for drugs is $12,000 for members with single coverage, and $15,000 for members with family coverage. The Plan will cover dispensing fees in line with the Alberta Pharmacy Agreement (currently a maximum of $12.15 per prescription).

**MONEY SAVING TIP**

You can save money by shopping at a pharmacy with lower dispensing fees. You also save money by asking the pharmacist to fill your prescription with a generic drug rather than the name brand drug.

## Prescription Drug Coverage Details

The Plan covers:

- generic medications requiring a prescription. If you require the use of a name brand drug, your physician will be required to fill out a special authorization form which will be reviewed by Alberta Blue Cross;
- some over the counter drugs with a prescription;
- other medications, including contraceptives, anti-obesity drugs, weight loss drugs, anabolic steroids, serum, etc. that require a prescription and subject to Alberta Blue Cross standards; and
- needles, syringes, and diabetic supplies (including Freestyle Libre).

**DRUG STEP THERAPY**

As per Alberta Blue Cross standards, patients are expected to start treatments at lower strength medications before moving on to stronger medications.

The maximum amount payable for drugs taken for the treatment of erectile dysfunction is $800 per calendar year.

If you would like to buy more than a three-month supply of medication you must have the purchase pre-authorized through the Trust Office.

### Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. The following are some examples of expenses **not** covered:

- services, treatments or supplies payable under another benefit in this Plan;
- food, food supplements, vitamins or health foods;
- condoms ;
- alcohol swabs, surgical dressings, first aid supplies or batteries;
- experimental or fertility drugs;
- delivery charges;
- nicotine replacement products such as patches or gum;
- cosmetic or hygienic products;
- costs associated with administering injectable drugs;
- charges from a doctor for completion of forms, reports or missed appointments; and
- cannabis, in any form.

## Alberta Blue Cross Cards

Once you are eligible for benefits under the Plan and have completed a registration form, your Alberta Blue Cross card will be available online. Show the card to the pharmacist with your prescription. The pharmacist uses the card to access information about the drugs covered under the Plan and what amount you are responsible for paying. Your personal information remains confidential and secure. Your card can also be provided to other providers that are able to direct bill electronically such as dentists, etc.

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and access your benefit card.

If you require a paper copy of your card, you can request one through the Alberta Blue Cross member site, call centre or by contacting the Trust Office.

**DIGITAL SELF-SERVICE**

You can access your prescription drug card through the Alberta Blue Cross mobile app or member site at www.ab.bluecross.ca.

The Alberta Blue Cross mobile app or member site can be used for submitting claims, checking your remaining benefit balances, reviewing conditions on particular benefits, and accessing booklets, among other things.

## How to Make a Prescription Drug Claim

Provide your Alberta Blue Cross card to your pharmacist when filling your prescription. If you do not have your Alberta Blue Cross card with you when you have your prescription filled and would like to be reimbursed for expenses covered under this benefit, you can submit a claim through the Alberta Blue Cross mobile app or member site, or with the physical claim form. You must do so within the earliest of 365 days following the date you incurred the expense or 30 days following your termination of benefit coverage.

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and submit claims.

If your Spouse is covered under another plan and has their own drug card, talk to your pharmacist about coordinating the two cards. If this is not possible, submit your claim to be reimbursed for any amount not covered by your Spouse's plan after you receive your Explanation of Benefits from the primary insurer. **See "Coordinating Benefits with Other Plans" in the Health & Wellness Plan Overview section for more information.**

If you are over 65, provincial health care is the first payor for drug claims. If a balance remains after provincial health care pays, use your Alberta Blue Cross card or submit a paper claim or online on the Alberta Blue Cross mobile app or member site to be reimbursed for the remaining amount.

**TIME SENSITIVE TIP – TERMINATIONS**

Any claims for expenses incurred up to your last day of coverage must be submitted within 30 days of your coverage termination date.

**BE CLAIM SMART**

Do not use your Alberta Blue Cross card for:

- your Spouse if she or he is covered by another plan; or
- your dependents if their expenses should be claimed from your Spouse's plan first.

  Once your claim is processed by the primary insurer, you can submit any outstanding charges for coverage through the OE955 plan.

## Medical Supplies, Equipment, Prosthetics and Other Medical Services

The Plan pays 100% of eligible expenses after provincial health care has paid its share, if any. The following Extended Health Care benefits are subject to a maximum combined **overall annual limit of $800** per person.

**IF YOU ARE COLLECTING WCB**

In the case of work-related disabilities, all expenses must be submitted to the Workers' Compensation Board for reimbursement.

### Accidental Dental

The Plan will cover the cost to repair natural teeth damaged in an accident outside of work.

### Medical Supplies, Equipment and Prosthetics

Subject to Alberta Blue Cross standards, you are covered for 100% of a variety of medical needs, such as:

**YOUR REQURED MEDICAL EQUIPMENT NOT LISTED?**

The list provided is a list of the more commonly claimed items. If you have an item that is not listed but is medically necessary, please contact Alberta Blue Cross to see if coverage is provided and what conditions may apply.

- ostomy supplies;
- oxygen and the cost of its administration, including breathing support equipment and pulmonary aids;
- plasma or blood transfusions;
- rental (or purchase if more economical) of a respirator/ventilator, aerosol compressor, alternating pressure pump, blood pressure monitor, coagulation monitor, extremity/lymphedema pump, insulin infusion pump, passive motion machine, peak flow meter, pulse meter, seating aid and kidney/renal dialysis equipment;
- canes, walkers, crutches, splints, casts, catheters, trusses;
- elastic support stockings with a 20-30mmHg gradient level or higher, to an annual maximum of $25 per person;
- stump socks, to an annual maximum of $250 per person;
- breast prosthesis and two surgical brassieres per year following a mastectomy; and
- wigs for medical conditions causing hair loss.

A note from a physician or nurse practitioner is required for coverage of the following, subject to Alberta Blue Cross standards:

- rental (or purchase, where more economical) of therapeutic equipment such as wheelchairs and hospital beds. Electric wheelchairs are reimbursed up to the cost of a manual wheelchair;
- Continuous glucose monitoring (CGM) systems for dependents under 19, (limit of one every 24 consecutive months). Limits for CGM supplies as per Alberta Blue Cross standards.
- artificial eyes or limbs, or braces for back, arm, leg or neck.

## Neuromuscular/TENS Machine:

You are covered up to a lifetime maximum of $700 per person.

## Orthopedic Shoes:

- 50% of the cost of orthopedic shoes up to a maximum of $400 per person in a calendar year when prescribed by a physician, nurse practitioner, podiatrist or chiropractor.
- Service provider must be a podiatrist, pedorthist or orthotist. All claims must be accompanied by the fabrication form, a GAIT analysis and/or biomechanical assessment.
- No coverage for off-the-shelf orthopedic devices.

**MEDICAL SUPPLIES, EQUIPMENT, PROSTHETICS AND OTHER MEDICAL SERVICES**

All the benefits covered on this page are included in the $800 annual maximum for medical supplies, equipment, prosthetics and other medical services.

## Orthotics:

- 100% for arch supports, molds or orthotic devices with a written prescription, to a maximum of $300 every 24 months for adults and $300 every 12 months for each dependent child.
- Prescriptions can be from a physician, nurse practitioner, podiatrist, physiotherapist or chiropractor.
- Service provider must be a physician, physiotherapist, podiatrist, occupational therapist, chiropractor, chiropodist or hospital.
- All claims must be accompanied by the fabrication form, a GAIT analysis and/or biomechanical assessment.
- No coverage for sports orthotics and off-the-shelf orthotics.

## Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. The following are some examples of expenses **not** covered:

- medical expenses incurred outside Canada;
- non-medical items such as alcohol swabs, batteries, bandages, first aid supplies, condoms ;
- products or medications of an exclusively cosmetic nature;
- treatment or supplies payable under another benefit under this Plan;
- supports of a preventative nature required for sports activities; and
- expenses for work-related disabilities payable by the Workers' Compensation Board.

## Addiction Services

Participation in a residential addiction treatment program in Canada in provincially licenced addiction centres is covered for up to $40 per day. The Plan will also cover up to $75 for medical examinations required for registration into the program. Coverage is limited to $3,000 during a member's lifetime and to 3 registration exams. Addiction Services coverage is available to Union members only.

## Mental Health Support

Plan pays 100% of eligible expenses over and above the amount paid by provincial health care, up to $1,500 per person per calendar year for registered psychologists, social workers and internet based cognitive behavioural therapy ( iCBT).

## Private Duty Nurse

Plan pays 100% for a Private Duty Nurse (registered nurse or licensed practical nurse) up to $10,000 per year up to a lifetime maximum of $25,000 per person, subject to Alberta Blue Cross standards.

## Breathing Devices

Coverage is available to cover the cost of breathing devices such as a Continuous Positive Airway Pressure (CPAP) machine or mandibular devices and supplies, up to a maximum of $2,000 per person per lifetime.

## Vision Care

The vision care benefit provides coverage for:

- prescription glasses or contact lenses up to a maximum of $300 per person per 24 consecutive month period;
- up to $75 for the cost of one eye examination per person per 24 consecutive month period; and
- laser eye surgery limited to $1,000 per lifetime, for Union members only.

Eligible vision care expenses are defined by the Plan as purchase of frames, lenses, contact lenses, intra-ocular lenses, repairs and eye examinations performed by a licensed optometrist or ophthalmologist.

*Note: You may claim a maximum of $300 for vision care over a 2 year period..*

**AVOID DELAYS – BE COMPLETE**

Please include a copy of your eye prescription when submitting claims for vision care expenses.

### Limitations

The following are **not** covered:

- sunglasses with non-corrective lenses; and
- corrective lens, contact lens or prosthetic lens after cataract surgery.

## Hearing Aids

This benefit provides coverage for the purchase, servicing and repairs of hearing aids to a maximum of $1,500 per person in 60 consecutive months. The hearing aids must be recommended by a qualified doctor, nurse practitioner or audiologist and dispensed by an audiologist or hearing aid practitioner.

### Limitations

Batteries are **not** covered.

## Ambulance

This benefit covers 100% of eligible expenses over and above the amount paid by provincial health care, such as:

- transportation from the point of injury or illness to the nearest hospital;
- response fee where treatment is provided with no transportation; and
- emergency transportation between hospitals if necessary to obtain appropriate treatment.

### Limitations

Air ambulance services are **not** covered:

## Hospital

Provincial health care plans pay the cost of ward accommodation in both acute care and convalescent hospitals. This Plan pays the difference between the ward cost and room and board charges by an acute care hospital equivalent to the cost for semi-private accommodation at $96 per day. Charges for a private room are reimbursed at the semi-private room rate. The Plan also pays the cost of convalescent hospitals up to $96 per day, to an annual maximum of $12,000 per person.

**HOSPITAL**

Hospital means an institution which is legally licensed to care for and treat sick/injured persons, has organized facilities for diagnosis, major surgery and 24-hour nursing service.

## Diagnostic and Lab Procedures

You are covered for some diagnostic and lab procedures, that are not covered through your provincial healthcare, subject to Alberta Blue Cross standards. The covered procedures could change over time as new procedures are deemed eligible by Alberta Blue Cross through its screening process. Please contact Alberta Blue Cross to inquire if your screening is covered.

## Paramedical Coverage Details

The Plan pays 100% of eligible expenses after provincial health care has paid its share, if any. Coverage is subject to $300 per registered practitioner, to a maximum combined **overall annual limit of $1,000** per person:

Registered practitioners include: acupuncturist, chiropodist, chiropractor, dietician, massage therapist, naturopath, osteopath, physiotherapist, podiatrist and speech therapist.

## Out-of-Country Travel Insurance

You are covered for eligible emergency medical expenses while travelling outside of your province of residence.

- Eligible expenses will be reimbursed at 100% for trips of up to 30 days.
- Emergency expenses covered up to $5 million per incident per person.
- Maximum reimbursement of non-emergency referral expenses of $50,000 per person per lifetime.

It is important that you carry your Alberta Blue Cross card, which includes your travel coverage information, with you while travelling.

### How to Make an Extended Health Care Claim

To be reimbursed for expenses, provide your Alberta Blue Cross card to your service provider for direct billing, or submit claims through the Alberta Blue Cross mobile app or member site within 365 days following the date you incurred the expense, or within 30 days of termination of benefit coverage.

**If a paper claim needs to be manually submitted, ensure you complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.** Claim forms for manual submissions are available on the Alberta Blue Cross website: www.ab.bluecross.ca

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and submit claims.

#### EMERGENCY TRAVEL

Before incurring a medical expense while you are traveling, be sure to contact the emergency travel number listed on your Alberta Blue Cross card. As much as reasonably possible, it is important that the insurer is aware of the medical issue before you pay for any medical expenses. They will have expertise that can help you navigate services wherever you are in the world.

#### TRAVELLING AFTER AGE 74?

If you are older than 74 when you commence travel a stability clause applies. If you recently had a procedure or health incident, you may not be covered for a related incident while traveling.

#### ALBERTA BLUE CROSS MEMBER SITE

Log into the Alberta Blue Cross member site at www.ab.bluecross.ca to access everything you need to know about your coverage, how to submit claims, sign up for direct deposit and more.

#### THERE IS AN APP FOR THAT

You are able to submit claims directly through the Alberta Blue Cross mobile app.

## Contact Information

| | **Trust Office** | **Alberta Blue Cross** |
|---|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) | 1-800-661-6995 |
| **Direct:** | 780-483-9550 | 780-498-8000 |
| **Email:** | benefits@oe955.com | Through ‘Contact Us’ on the Alberta Blue Cross app or at www.ab.bluecross.ca |

# DENTAL BENEFITS
(CORE AND EXTENDED)

## Eligibility

Check the *Health & Wellness Plan Overview* section at the beginning of this booklet for the details on eligibility.

## Coverage Details

The Plan covers a portion of dental expenses for you and your family.

## Basic & Extensive Dental Coverage Details

The maximum combined Basic and Extensive reimbursement for each covered person is $1,800 per year. If your coverage begins after June 30th, the maximum reimbursement under this benefit is $900 for the balance of the calendar year, less prior dental claims paid in the calendar year through the Plan.

Reimbursement rates for dental procedures are defined by each provincial dental fee guide. Lab fees are covered at 60%.

### Basic Dental

The Plan provides 80% reimbursement of eligible expenses under Basic Dental coverage, all subject to reasonable price, usage and frequency limits, for:

- Various diagnostic services including:
  - recall exams once every 9 months for adults or 6 months for children;
  - complete oral exams once every 36 months; and
  - bitewing imaging every 9 months for adults or 6 months for children.
- Various preventative services including:
  - 8 units of scaling/root planing every 9 months for adults or 6 months for children;
  - polishing;
  - fluoride treatment; and
  - pit and fissure sealants for children.
- Restorative Services including fillings;
- Periodontic benefits

**CHILD BENEFITS**

Children have different dental needs than adults. The Plan recognizes that and provides different coverage limits for children under 19.

**DENTAL REIMBURSEMENT RATES**

There are provincial Fee Guides that provide standard rates of reimbursement for every dental service. Your Dental benefit is based on the amount set out in the Fee Guide for the province in which the service was received.

Each dentist sets their own rates for the services they provide.

You are responsible for paying any extra that the dentist charges above the Fee Guide rate, so it can benefit you to compare costs from different dental offices. There is a pricing comparison tool available on the Alberta Blue Cross mobile app for dentists in Alberta.

Example:

For a 9-month checkup, a dentist charges $200 for an examination and an x-ray. The eligible expense (according to the provincial Fee Guide) in this example is $128.45. As such, your reimbursement would be 80% of $128.45 = $102.76.

- Oral surgery including:
  - General anesthesia, nitrous oxide, etc. in conjunction with oral surgery.
- Endontics including:
  - 1 root canal per tooth every 24 months.
- Removable Appliances including:
  - Complete or partial dentures, 1 upper and/or lower every 60 months.
- Denture Services including:
  - Rebasing, resetting and adjustments of dentures.

**REPLACEMENT OF EXISTING PARTIAL OR COMPLETE DENTURES:**

The existing complete or partial dentures are at least five (5) years old and cannot be made serviceable.

### Extensive Dental

The Plan provides 60% reimbursement of eligible expenses under Extensive Dental coverage, all subject to reasonable price, usage and frequency limits, for:

- Crowns and creation of fixed bridgework;
- inlays and onlays;
- relining, rebasing or repairing of existing fixed bridgework;
- implants; and
- some other necessary procedures not specifically listed here.

**REPLACEMENT OF EXISTING FIXED BRIDGEWORK OR CROWN:**

The existing crown or fixed bridgework is at least five (5) years old and cannot be made serviceable

## Orthodontic Services Coverage Details

The most common form of orthodontic treatment is braces and is only available to dependent children under 19

The Plan provides 50% reimbursement of eligible expenses of the treatment plan up to the lifetime maximum payout of $3,500.

Prior to commencement of your treatment, you or the orthodontic office must submit a copy of your orthodontic treatment plan to Alberta Blue Cross at OrthoTP@ab.bluecross.ca.

### Example

If the total cost of a treatment plan is $6,000, your initial payment was $2,000, and you made 20 additional monthly payments of $200, your reimbursement at the end of the treatment would be $3,000. It would be paid out over the treatment period, provided your benefit coverage remained active.

## Treatment Plan (Pre-authorization)

When the total cost associated with proposed dental work is expected to exceed $1,000, it is required that a treatment plan (pre-authorization) be filed for benefit determination prior to the date treatment is rendered.

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

## Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call Alberta Blue Cross. The following are examples of expenses **not** covered:

- general anaesthesia with non-surgical procedures;
- treatment for temporomandibular joint (TMJ) dysfunction;
- alveolar bone preservation;
- charges for missed appointments, completion of claim forms or surgical facility fees;
- cosmetic surgery or treatment (such as whitening);
- expenses incurred while outside of Canada; and
- services required as a result of self-inflicted injuries.

**TIME SENSITIVE TIP – TERMINATIONS**

Any claims for expenses incurred up to your last day of coverage must be submitted within 30 days of your coverage termination date.

## How to Make a Dental Claim

Most dental claims are submitted electronically by the dental office. You can also submit a claim form to Alberta Blue Cross.

If submitting your claim manually, your dentist may allow you to assign benefits (that is, if the dentist agrees to be paid directly from Alberta Blue Cross). If so, indicate this on the claim form by signing all assigned areas before submitting to Alberta Blue Cross.

If your dentist does not allow you to assign benefits, you must pay the dentist when you receive treatment and then submit your claim form online, completed by the dental office and signed by you, to the Alberta Blue Cross mobile app or member site.

**ALBERTA BLUE CROSS MEMBER SITE**

Log into the Alberta Blue Cross member site at www.ab.bluecross.ca to access everything you need to know about your coverage, how to submit claims, sign up for direct deposit and more.

**If a paper claim needs to be manually submitted, ensure you complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.** Claim forms for manual submissions are available on the Alberta Blue Cross website: www.ab.bluecross.ca

**THERE IS AN APP FOR THAT**

You are able to submit claims directly through the Alberta Blue Cross Mobile App for all Extended Health Care and Dental Care claims.

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and submit claims.

## Contact Information

| | **Trust Office** | **Alberta Blue Cross** |
|---|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) | 1-800-661-6995 |
| **Direct:** | 780-483-9550 | 780-498-8000 |
| **Email:** | benefits@oe955.com | Through ‘Contact Us’ on the Alberta Blue Cross app or at www.ab.bluecross.ca |

# LIFE INSURANCE
(CORE AND EXTENDED)

## Eligibility

The benefits described apply to IUOE Local 955 members in Good Standing covered for Health & Wellness benefits who are **not on self-pay**.

Check the *Health & Wellness Plan Overview* section at the beginning of this booklet for the details on eligibility.

## Coverage Details

Life Insurance provides a tax-free lump sum benefit for your beneficiary(ies) in the event of your death or, to you in the event of the death of your Spouse.

*Tax Note: The premiums paid for term life coverage are considered a taxable benefit by the Federal government. Each year you will receive a T4 slip from the Trust Office that shows the taxable benefit you must report as income on your tax return.*

### Life Insurance for Members

If you die while covered under the Plan, or within 31 days after your coverage stops, your beneficiary will receive $100,000. Under the Life Insurance benefit, you can name any beneficiary you want, or change your beneficiary at any time by completing a new registration form available from the Trust Office.

### Life Insurance for Your Spouse

If your Spouse dies while covered under the Plan, or within 31 days after your coverage stops, you will receive $5,000.

### Life Insurance if You Become Disabled

Your Life Insurance continues if you become disabled before age 65 and while covered by the Plan. If your disability lasts longer than 104 weeks and you qualify for Long-Term Disability payments you will continue to be covered for Life Insurance while you are in receipt of LTD benefits. For members currently receiving Short-Term or Long-Term Disability, your Life Insurance coverage is the amount provided by this Plan at the time of your disability.

**NAME A BENEFICIARY**

It is very important to name a beneficiary. If you do not, benefits will be assigned to your Estate.

**SPOUSE DEFINITION**

The Health & Wellness Plan defines "Spouse" as the person to whom you are legally married and is not living separate and apart from you or the person with whom you have lived in a common-law or marriage-like relationship for at least one year. Otherwise, the person you are legally married to, if they have been living separate and apart from you for less than three years.

## Compassionate Assistance Benefit

Terminal illness can be devastating to your family, both financially and emotionally. In certain circumstances, the Compassionate Assistance Benefit allows you to receive an advance against your Life Insurance benefit while living, to help pay for medical costs. If you are terminally ill and you are certain to die within 12 months, you may request a one-time lump sum payment to a maximum of $50,000.

If you are approved for this benefit, your Life Insurance benefit is reduced by:

- the amount paid out under the Compassionate Assistance Benefit; and
- accrued interest on any funds advanced.

A special claim form for this benefit is available from the Trust Office.

Should you have utilized this benefit, and your benefits coverage ceases prior to death, **you are responsible for repaying the lump-sum payment plus interest to the insurer (Manulife)**.

## Conversion Option

If you lose your coverage under the Plan because you are no longer eligible, you have 31 days to convert your Life Insurance and your Spouse's Life Insurance to individual policies, without providing proof of insurability. It is your responsibility to pay the premium on any new policy.

The Trust Office will provide you with a contact at the insurer for information on this option.

## Termination of Coverage

Your coverage under this benefit stops on the earliest of:

- the date you started self-paying for benefit coverage;
- the date you are no longer eligible for coverage under the Plan;
- the date you enter full-time service of any naval, military or air force; or
- the date you exercised the conversion option.

Your Spouse **does not** have this Life Insurance coverage if:

- they no longer meet the definition of Spouse as defined by the Plan;
- you (the member) are no longer eligible for coverage under the Plan; (however, if you die, your Spouse continues to be covered under this benefit for one year);
- you enter full-time service of any naval, military or air force;
- they have exercised the conversion option; or
- you are self-paying for benefit coverage.

## How to Make a Life Insurance Claim

The Trust Office provides the required forms and assistance in making a Life Insurance claim. Before the Life Insurance benefit can be paid, the following must be provided to the Trust Office:

- a death certificate; and
- proof that the person making the claim is entitled to payment under this benefit.

If no beneficiary has been appointed, or your beneficiary predeceases you, the benefit will be paid to your Estate. **See "Naming a Beneficiary" in the Health & Wellness Plan Overview section for more information.**

The Trust Office is available to answer any questions you may have about your benefits.

## Contact Information

| | **Trust Office** |
|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) |
| **Direct:** | 780-483-9550 |
| **Email:** | benefits@oe955.com |

# ACCIDENT INSURANCE (AD&D)
## (CORE AND EXTENDED)

## Eligibility

The benefits described apply to IUOE Local 955 members in Good Standing covered for Health & Wellness benefits and who are **not on self-pay**.

Check the *Health & Wellness Plan Overview* section at the beginning of this booklet for the details on eligibility.

## Coverage Details

This insurance provides a one-time, lump sum payment if you die or are dismembered as a direct result of an accident, whether the accident occurs at work or not. The accidental death benefit is $100,000.

**NAME A BENEFICIARY**

It is very important to name a beneficiary. If you do not, benefits will be assigned to your Estate.

Accidental dismemberment means the loss (severance) or loss-of-use of a hand, foot, fingers, toes, leg, or arm, or the total loss of speech, sight or hearing. The amount paid for an accidental dismemberment is determined by the extent of the loss, with the benefit payable shown as a percentage of $100,000 below.

| | |
|---|---|
| 200% | • Quadriplegia (total paralysis of both upper and lower limbs)<br>• Paraplegia (total paralysis of both lower limbs)<br>• Hemiplegia (total paralysis of upper and lower limbs of one side of the body) |
| 100% | • Death<br>• Loss or loss of use of both hands or both feet<br>• Loss of sight of both eyes<br>• Loss of hearing in both ears and speech<br>• Loss or loss of use of one hand and one foot |
| 75% | • Loss or loss of use of one arm or one leg |
| 66⅔% | • Loss or loss of use of one hand or one foot<br>• Loss of speech or hearing in both ears<br>• Loss of sight of one eye |
| 33⅓% | • Loss or loss of use of thumb and index finger of the same hand or at least four fingers on one hand |
| 16⅔% | • Loss of hearing in one ear |
| 12½% | • Loss of all toes of one foot |
| 5% | • Loss of finger (amount per finger) |

*Note: Payment will not be made for more than one body part affected by the same accident. If more than one body part is lost, payment will be made for the one with the largest percentage payable. The maximum benefit payable for any one accident is 100%, except for the paralysis benefits noted above.*

## Expense Benefits

The Plan covers additional amounts for expenses related to accidents including payments for:

- Repatriation
- Rehabilitation
- Day Care Benefit
- Transportation of a Family Member
- Home Alteration & Vehicle Modification

The Trust Office is available to answer any questions you may have around these expenses and their coverage.

## Termination of Coverage

Your coverage under this benefit stops on the **earliest** of:

- the date you are no longer eligible for coverage under the Plan;
- the date you started self-paying for benefit coverage; or
- the date you enter full-time service of any naval, military or air force.

## Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. Accident Insurance benefits are **not** paid if the accidental injury or death is a result of any of the following:

- intentionally self-inflicted injuries or suicide or attempted suicide;
- participation in a rebellion, war, riot or civil disorder;
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease or the medical treatment of any illness or disease, or bodily or mental infirmity;
- the committing of or attempt to commit an assault or criminal offence; or
- injuries sustained while operating a motor vehicle, either while illegally under the influence of any intoxicant or if the member's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury.

## How to Make an Accident Insurance Claim

A claim under the Accident Insurance benefit must be submitted within 365 days from the date of the accident. Contact the Trust Office for claim forms.

# Contact Information

| | **Trust Office** |
|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) |
| **Direct:** | 780-483-9550 |
| **Email:** | benefits@oe955.com |

# SHORT-TERM DISABILITY
## (CORE AND EXTENDED)

## Eligibility

The benefits described apply to IUOE Local 955 members in Good Standing covered for Health & Wellness benefits who are **not on self-pay or have received funds** from the Pension Trust Fund.

**TIME SENSITIVE TIP – COVERAGE EXPIRY**

Any claims must be made within 90 days of the event that caused your disability. Be sure to contact the Trust Office as soon as possible if you are disabled – even if you think you may go back to work after a short period.

## Coverage Details

The Short-Term Disability benefit provides you with income for up to 104 weeks if you are unable to work due to illness or injury and are under the full-time care of a doctor.

If you are unable to work after 104 weeks, you may apply for Long-Term Disability benefits.

Benefits shall continue for Extended Health Care Benefits and Dental Benefits without deduction of hours from your Hour Bank provided the necessary forms have been submitted as may be required by the Trustees.

## Monthly Benefit

The Short-Term Disability benefit is equal to the Employment Insurance sickness benefit rate (for example, $695 per week in 2025).

**WORKERS COMPENSATION**

If you are collecting a benefit from the Workers Compensation Board be sure to apply for Short-Term and Long-Term Disability. You may receive a waiver of premiums for your other benefits. Contact the Trust Office for more information.

Your Short-Term Disability benefits are integrated with the Employment Insurance Sickness benefit. If you qualify for EI Sickness benefits, you will receive that benefit from weeks 2 through 27 of your Short-Term Disability period. Thereafter, the Plan will continue your disability payments if you are still disabled. **You must apply for EI Sickness benefits separately from your application for the Plan's Short-Term Disability coverage.**

Your Short-Term Disability coverage stops on the **earliest** of the following dates:

- you no longer meet the definition of disability;
- you have received 104 weeks of Short-Term Disability benefits;
- you fail to provide written proof of continued disability as required by the disability adjudicator;
- you enter the full-time service of any naval, military or air force;
- you have received funds from the Pension Trust Fund; or
- you die.

The benefit amount is reduced by any disability income or other benefit that you receive from:

- Canada/Quebec Pension Plan;
- Workers Compensation Act (or similar legislation)
- a motor vehicle insurance contract;
- any disability insurance plan;
- any income received from any employer (except certain rehabilitation employment income); and
- the Employment Insurance Sickness benefit program.

If you become disabled and are able to return to work, but within two weeks become disabled again from the same or a related cause, it is considered a continuation of the previous disability period.

## Payment of Benefit

Weekly payments begin immediately if the disability is the result of an accident, or from the eighth day if the disability is due to illness.

If you are disabled for a fraction of a week, your entitlement is pro-rated based on the number of days you are disabled in that week.

## Rehabilitation

While a disability can be life-altering, disabled members are encouraged to return to the workforce if at all possible. Your Plan provides active early intervention rehabilitation services. You may be contacted by a rehabilitation coordinator to help you recover and get back to work. In some cases, you may require additional training.

**REHABILITATION EMPLOYMENT**

Any employment for wage or profit, or course of training that has been approved by your rehabilitation coordinator, and provides remuneration, allowance or other payment.

Any job for which you receive pay while you are disabled must first be approved by your rehabilitation coordinator to qualify as rehabilitation employment.

Your Short-Term Disability may be reduced if you receive income from rehabilitation employment.

Failure to participate in a recommended rehabilitation program may result in termination of Short-Term Disability.

## Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. You are **not** covered for this benefit if your disability is the result of any of the following examples:

- you are not under the regular care and following the advice of a doctor;
- intentionally self-inflicted injury;
- participation in a rebellion, war, riot or civil disorder;

- alcoholism or drug addiction, unless you are successfully continuing treatment at an approved facility;
- participation in any act that prolongs or aggravates the disability; and
- committing a criminal act.

Short-Term Disability benefits will not be paid if any of the following apply to you:

- you have received funds from the Pension Trust Fund;
- you are self-paying at the time of your disability;
- you are on maternity or parental leave when you become disabled (except as required by legislation);
- you are receiving maternity of parental benefits under the Employment Insurance Act;
- you are receiving similar benefits under any other group insurance or health and wellness plan;
- you are entitled to Long-Term Disability benefits;
- you work or otherwise engage in any activity for remuneration or profit (unless you are participating in rehabilitation employment);
- you are an inmate of a penitentiary or jail; or
- you are on leave of absence or living outside Canada (unless approved by the Trustees).

## How to Make a Short-Term Disability Claim

To claim the Short-Term Disability benefit, contact the Trust Office for an application package. **Your claim must be filed with the Trust Office within 90 days of your date of disability or your claim will be declined.**

The Trust Office is available to answer any questions you may have about your benefits.

**WE'VE GOT A GUIDE FOR THAT!**

Check out our Disability Process Guide on www.oe955.com which can help you navigate and understand the steps and timing when applying for disability benefits.

## Contact Information

| | **Trust Office** |
|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) |
| **Direct:** | 780-483-9550 |
| **Email:** | benefits@oe955.com |
| | disability@oe955.com |

# LONG-TERM DISABILITY
(EXTENDED ONLY)

## Eligibility

The benefits described apply to IUOE Local 955 members in Good Standing covered for Health & Wellness benefits who:

- have qualified for and received 104 weeks of Short-Term Disability; and
- are not on self-pay or have received funds from the Pension Trust Fund.

## Coverage Details

The Long-Term Disability benefit provides you with income if you cannot work in any occupation due to a continuous disability (illness or injury) that requires you to be under the regular care of a doctor.

Benefits shall continue for Extended Health Care Benefits and Dental Benefits without deduction of hours from your Hour Bank provided the necessary forms have been submitted as may be required by the Trustees.

### Definition of Disability

You are continuously and wholly prevented by illness or accidental injury from working at your regular job, or any job for which you are qualified or for which you could become reasonably qualified through training, education or experience.

## Monthly Benefit

Monthly Long-Term Disability benefits are as follows:

- $0 (Nil) if you have not accumulated at least 350 Adjusted Hours in the year immediately preceding your date of disability.
- $2,140 if you have accumulated at least 350 Adjusted Hours in the year immediately preceding your date of disability.
- $2,750 if you have accumulated at least 350 Adjusted Hours in each of the two years immediately preceding your date of disability.

**WORKERS COMPENSATION**

If you are collecting a benefit from the Workers Compensation Board be sure to apply for Short-Term and Long-Term Disability. You may receive a waiver of premiums for your other benefits. Contact the Trust Office for more information.

Your Long-Term Disability coverage stops on the **earliest** of the following dates:

- you turn 65 years old;
- you have received funds from the Pension Trust Fund;
- you are no longer disabled or fail to provide requested proof of continued disability;
- you fail to participate in rehabilitation employment;
- you enter the full-time service of any naval, military or air force; or
- you die.

The benefit amount is reduced by any disability income or benefit that you receive from:

- Canada/Quebec Pension Plan;
- Workers Compensation Act (or similar legislation);
- a motor vehicle insurance contract;
- any disability insurance plan;
- any employee pension plan; and
- any income received from any employer (except certain rehabilitation employment income).

If you receive income from any employer, your Long-Term Disability benefit may be reduced by earnings from employment.

Once a claim has been approved, your Long-Term Disability benefit is **not** reduced by:

- income from a personal, non-employment related insurance policy (other than a disability benefit paid through motor vehicle insurance);
- income or benefits you were receiving before becoming disabled; or
- cost of living or similar adjustments to legislated plans.

## Payment of Benefits

Long-Term Disability benefit payments are made at the end of each month from the insurance company.

If you are disabled for a portion of any month, the benefit is prorated according to the number of days you were disabled during that month.

Long-Term Disability benefit payments are made until one of the following occurs:

- you are no longer disabled as defined by the Plan;
- you are no longer under the regular care of a doctor;
- you have received funds from the Pension Trust Fund;
- you reach age 65 (or age 62 if you became disabled before January 1, 2001);
- you fail to provide the Trustees with satisfactory written proof of your continuing disability;
- you refuse to engage in rehabilitation employment; or
- you die.

Payments are **not** made under this benefit:

- if you are not residing in Canada (unless otherwise approved by the Trustees);
- for charges for certificates or letters from doctors;
- while you work for remuneration or profit other than that described earlier in this section; or
- if you are an inmate of a jail or penitentiary.

## Rehabilitation

While a disability can be life-altering, disabled members are encouraged to return to the workforce if at all possible. Your Plan provides active early intervention rehabilitation services. You may be contacted by a rehabilitation coordinator to help you recover and get back to work. In some cases you may require additional training.

**REHABILITATION EMPLOYMENT**

Any employment for wage or profit, or course of training that has been approved by your doctor and provides remuneration, allowance or other payment.

Any job for which you receive pay while you are disabled must first be approved by your rehabilitation coordinator to qualify as rehabilitation employment.

Your Long-Term Disability benefits may be reduced if you receive income from rehabilitation employment.

Failure to participate in a rehabilitation program may result in a termination of Long-Term Disability benefits.

## Third Party Liability

If you become disabled as a result of an accident and if a valid claim exists, you are obligated to pursue any responsible third party at your own expense. If you recover money from a third party, you must repay all Long-Term Disability benefits received, up to the amount recovered. At the sole discretion of the Trustees, another amount may be accepted.

## Limitations

The list of exclusions and allowable items on any benefit plan is long and detailed. If you have a special circumstance, or you are not sure about coverage call the Trust Office. For example, you are **not** covered for:

- intentionally self-inflicted injury or sickness;
- disability resulting from participation in or as a consequence of a rebellion, riot, disorderly conduct, war, civil disorder or committing of a criminal offense;
- disability resulting from substance abuse, including alcoholism and drug addiction, unless the Member is participating in a recognized substance withdrawal program;; or
- disability prolonged or aggravated by participation in any activity medically determined to extend or intensify the disability.

## How to Make a Long-Term Disability Claim

The Trust Office will help you submit a Long-Term Disability claim. There are important requirements and deadlines to be aware of. **To guard against a break in income, apply for Long-Term Disability benefits at least 8 weeks before you expect payments to begin, while you are in receipt of Short-Term Disability.**

The Trust Office is available to answer any questions you may have about your benefits.

**TIME SENSITIVE TIP**

To ensure your income is not interrupted when you move from Short-Term to Long-Term Disability, be sure to apply early – we recommend 8 weeks before Short-Term Disability ends.

## Contact Information

| | **Trust Office** |
|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) |
| **Direct:** | 780-483-9550 |
| **Email:** | benefits@oe955.com |
| | disability@oe955.com |

# Health Spending Account
(EXTENDED ONLY)

## Eligibility

Check the *Health & Wellness Plan Overview* section at the beginning of this booklet for the details on eligibility.

## Coverage Details

A Health Spending Account (HSA) is an innovative way to complement your benefits. The HSA, administered in accordance with Canada Revenue Agency (CRA) guidelines enables you to pay for medical and dental expenses not otherwise covered by the Plan – with non-taxable dollars. The Account can be used to cover expenses incurred by you or your covered dependents. For all expenses, you can only claim the part of the expense that you or your covered dependents have not been and will not be reimbursed for and are considered eligible medical expenses under the Income Tax Act. These are expenses that would have qualified as a Medical Expense Tax Credit. Additional information is available here: https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-330-331-eligible-medical-expenses-you-claim-on-your-tax-return.html

Examples of allowable expenses:

- Co-payment amounts for health and dental expenses;
- The cost of procedures not covered by provincial health plans;
- Expenses in excess of the coverage for vision, paramedical practitioners, psychologists, etc.

## Expiry

In accordance with CRA's guidelines, your HSA has a 1-year balance carry-forward provision.

For example, if you do not use all of your 2025 HSA during 2025, any unused balance will carry over into 2026. If at the end of 2026, you still have not used the carried over 2025 balance, the unused 2025 balance will be forfeited. You have a 90-day grace period to submit claims for the prior year, for example, claims for 2025 must be submitted by March 31, 2026.

## How to Make an HSA Claim

To be reimbursed for expenses covered under this benefit, submit the following online to the Alberta Blue Cross mobile app or member site:

- official receipts;
- a copy of your doctor's prescription, where applicable.

Claims must be submitted to Alberta Blue Cross within the year you incurred the expense, or within 90 days of the end of the year the expense was incurred. If your coverage terminates, you must submit claims within the month following your termination date. Claims can be submitted through the app, website or on a physical claim form.

**If a paper claim needs to be manually submitted, ensure you complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.** Claim forms for manual submissions are available on the Alberta Blue Cross website: www.ab.bluecross.ca

If your home address is listed as Quebec, Alberta Blue Cross has partnered with Telus Adjudicare. Please refer to the Telus Adjudicare handout at www.oe955.com explaining how to register and submit claims.

**THERE IS AN APP FOR THAT**

You are able to submit claims directly through the Alberta Blue Cross mobile app for all HSA claims. When submitting claims through the app, check off the box requesting for any unpaid amounts to be paid from your HSA to avoid having to submit a second claim.

## Contact Information

| | **Trust Office** | **Alberta Blue Cross** |
|---|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) | 1-800-661-6995 |
| **Direct:** | 780-483-9550 | 780-498-8000 |
| **Email:** | benefits@oe955.com | Through 'Contact Us' on the Alberta Blue Cross app or website at www.ab.bluecross.ca |

## FURTHER INFORMATION

Health & Wellness benefits can be complicated. This booklet is intended to provide an overview of the benefits available but cannot possibly cover every situation. The complete Plan text is available for inspection at the Trust Office by appointment only. If you are unclear about anything, the Trust Office is available to help. In addition, Alberta Blue Cross is available to help for Extended Health Care and Dental benefits.

Additional information is available on the IUOE Local 955 Health & Wellness website www.oe955.com and Alberta Blue Cross website www.ab.bluecross.ca.

The Trust Office and Alberta Blue Cross are available to answer any questions you may have about your benefits.

| | **Trust Office** | **Alberta Blue Cross** |
|---|---|---|
| **Toll Free:** | 1-800-222-6410 (in Alberta) | 1-800-661-6995 |
| **Direct:** | 780-483-9550 | 780-498-8000 |
| **Email:** | benefits@oe955.com<br>disability@oe955.com | Through 'Contact Us' on the Alberta Blue Cross app or website at www.ab.bluecross.ca |

## NOTES