



OPERATING ENGINEERS LOCAL 955

Health & Wellness Benefits



February 1, 2021

Dear Brothers and Sisters:

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 they continue to provide value and serve your needs.

We are pleased to provide you with the new Health & Wellness Benefits booklet with up-to-date information as of February 1, 2021.

You should be familiar with your Health & Wellness benefits in order 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



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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. Each section of this booklet outlines a different benefit provided by the Plan, effective February 1, 2021.

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 ClaimSecure website www.claimsecure.com.

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

Contact Information

	Trust Office	ClaimSecure
Toll Free:	1-800-222-6410 (in Alberta)	1-888-513-4464
Direct:	780-483-9550	
Email:	benefits@oe955.com	service@claimsecure.com



HEALTH & WELLNESS PLAN OVERVIEW

Eligibility

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

- 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 350 Adjusted Hours have been received in the Trust Office. You will receive a notice telling 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.

Self-Paying for Benefits

To qualify for benefits, you must be a member in Good Standing of the Union and make the necessary payment arrangements (prior to the expiry of your Hour Bank) with the Trust Office. 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, Weekly Indemnity, and Long Term Disability benefits.** 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.

Disabled Members

You will only have Weekly Indemnity or Long Term Disability coverage if you have hours in your Hour Bank the month you become disabled.

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

If you are in receipt of Long Term Disability benefits, you may apply to have the premiums waived. Premiums for some Health & Wellness benefits (Extended Health Care, Dental, Life Insurance, and Accident Insurance) may be waived for disabled members, but it is not automatic – it is your responsibility to apply for this waiver when you apply for Long Term Disability benefits.

ADJUSTED HOURS

You accumulate Adjusted Hours in your Hour Bank in proportion to the contribution 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. Currently \$1.80 of employer contribution = 1 Adjusted Hour.

For example, if you work 200 hours and your employer's contribution rate is \$1 per hour you will be credited with 111.11 Adjusted Hours in your Hour Bank.

$$200 \text{ hours} \times \$1 = \$200$$

$$\$200 / \$1.80 = 111.11$$

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.



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 remitting a new form. This change is not valid until it has been received by the Trust Office.

The IUOE Local 955 website contains the applicable registration form available at www.oe955.com.

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. 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. See the "Termination of Coverage" section for more information.

Maintaining Your Coverage

The monthly charge for coverage is deducted from your Hour Bank. To remain eligible for coverage under the Plan, you must have at least 150 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 (\$1.80 of employer contribution = 1 Adjusted Hour). The hourly contribution rate for your employer is set by the applicable collective agreement.

You may accumulate a maximum of 1,500 Adjusted Hours in your Hour Bank. Any Adjusted Hours above 1,500 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.

NAME A BENEFICIARY

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

UNDERAGE BENEFICIARY

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

DEPENDENT DEFINITION

"Dependent" means a person who is not a member and 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 Operating Engineers 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.

Termination of Coverage

If you have less than 150 Adjusted Hours 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 350 Adjusted Hours within a six-month period and continue to be a member in Good Standing.**

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.

The Plan determines “who pays first” in this way:

- **By Membership:** 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. Your spouse submits his or her expenses to his or her own plan first.
- **By Birthday:** 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.

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%.

DO NOT LET YOUR BENEFITS SLIP AWAY – SELF-PAY

If you have less than 150 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 February 1, 2021, the self-pay premium is \$175/month.



Making a Claim

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

Be sure to complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.

Claim forms are available on the following websites:

- www.oe955.com
- www.claimsecure.com

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

Contact Information

	Trust Office	ClaimSecure
Toll Free:	1-800-222-6410 (in Alberta)	1-888-513-4464
Direct:	780-483-9550	
Email:	benefits@oe955.com	service@claimsecure.com



EXTENDED HEALTH CARE

Eligibility

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

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 **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 self-inflicted injuries;
- 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.

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.

At the sole discretion of the Trustees, another amount may be accepted.

MONEY SAVING TIP

If you are covered under another group 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.

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 ClaimSecure.



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 to a maximum of \$12.30 per prescription. Pharmacy mark-ups will be covered to a maximum of 7%.

MONEY SAVING TIP

You can save money by shopping at a pharmacy with low 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 ClaimSecure);
- medication, including oral contraceptives, anti-obesity drugs, serum and injectibles that require a prescription; and
- needles, syringes, glucometer (limit of one every consecutive 24 months), and/or chemical diagnostic aids for treatment of diabetes. Please contact ClaimSecure for information on diabetic supplies.

The maximum amount payable for drugs taken orally for the treatment of erectile dysfunction is \$800 per calendar year. Only Plan members are eligible for this coverage.

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 **not** covered:

- services, treatments or supplies payable under any other benefit in this Plan;
- food or food supplements;
- vitamins or health foods;
- intrauterine devices, contraceptive implants, 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 injectible drugs; and



- charges from a doctor for completion of forms, reports or missed appointments;
- cannabis, in any form.

Pay-Direct Drug Cards

Once you are eligible for benefits under the Plan and have completed a registration form, ClaimSecure pay-direct prescription drug cards are ordered for you and your spouse and sent to your home address. (Single members receive just one card.) Show the card to the pharmacist with your prescription. The pharmacist uses it to access information by computer about the drugs covered under the Plan and what amount you are responsible for paying. Your personal information remains confidential and secure.

How to Make a Prescription Drug Claim

If you do not have your ClaimSecure pay-direct card with you when you have a prescription filled, to be reimbursed for expenses covered under this benefit, submit the following to ClaimSecure within 365 days following the date you incurred the expense, or within 90 days of termination of benefit coverage:

- official receipts (cash register receipts are not acceptable – the Drug Identification Number must appear on the receipt);
- a copy of your doctor’s prescription, where applicable; and
- your completed, signed claim form.

If you are over 65, provincial health care is the first payer for drug claims. If a balance remains after provincial health care pays, either use your ClaimSecure pay-direct card or submit a paper or claim online to ClaimSecure for the outstanding amount.

If your spouse is covered under another insurance plan and has their own drug card, talk to your pharmacist about coordinating the two cards. If this is not possible, submit a paper claim to be reimbursed for any amount not covered by your spouse’s plan. **See “Coordinating Benefits with Other Plans” in the Health & Wellness Plan Overview section for more information.**

Paramedical, Medical Supplies, Equipment, and Prosthetics Coverage Details

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 per year:

- Paramedical Coverage
- Social Worker
- Addiction Services
- Accidental Dental
- Medical Supplies, Equipment and Prosthetics

TIME SENSITIVE TIP – TERMINATIONS

Any claims for expenses incurred up to your last day of coverage must be submitted within 90 days of your coverage termination date.

BE CLAIM SMART

Do not use your ClaimSecure pay-direct prescription drug 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.

IF YOU ARE COLLECTING WCB

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



The Extended Health Care benefits outlined on this page are subject to an overall combined **annual limit of \$800 per person.**

Paramedical

The following paramedical practitioners are covered for up to \$300 per person per practice area including \$25 per practitioner for an x-ray examination:

- Osteopath
- Podiatrist
- Registered Dietician
- Reflexologist
- Massage Therapist
- Physiotherapist
- Naturopath
- Chiroprapist
- Acupuncturist
- Speech Therapist
- Chiropractor

Social Worker

Services provided by an Accredited Social Worker are covered for up to \$600 per person.

Addiction Services

Participation in the Alberta Alcohol and Drug Abuse Commission (for Union members only) is covered for up to \$40 per day. The Plan will cover up to \$75 for medical examinations required for registration into a program. Coverage is limited to \$3,000 during a member's lifetime.

Accidental Dental

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

Medical Supplies, Equipment, and Prosthetics

You are covered for 100% of the cost for the following items **when prescribed by a doctor:**

- ostomy supplies;
- oxygen and the cost of its administration, including breathing support equipment and pulmonary aids;
- plasma or blood transfusions;
- rental of (or purchase, where more economical) therapeutic equipment such as wheelchairs, hospital beds, respiratory and kidney dialysis equipment;
- artificial eyes or limbs, canes, walkers, crutches, splints, casts, catheters, trusses or braces for back, arm, leg or neck;
- breast prosthesis and two surgical brassieres per year following a mastectomy; and
- cancer wigs for members and their immediate family members who have received radiation or chemotherapy for the treatment of cancer.

ACCREDITED SOCIAL WORKER

Accredited Social Workers are registered with the Alberta College of Social Workers or equivalent authority. Contact ClaimSecure if you are uncertain about your Social Worker's accreditation.



The Extended Health Care benefits outlined on this page are subject to an overall combined **annual limit of \$800 per person.**

The following items have limited coverage. You are **reimbursed for**:

Orthopedic Shoes:

- 50% of the cost of orthopedic shoes up to a maximum of \$400 per person in a calendar year when ordered by a Chiropodist, Podiatrist or General Practitioner. All claims must be accompanied by a GAIT analysis and/or biomechanical exam;
- No coverage for off-the-shelf orthopedic devices.

Orthotics:

- arch supports, molds or orthotic devices (excluding sports orthotics) to a maximum of \$300 every 24 months for adults and \$300 every 12 months for each dependent child when ordered by a doctor. All claims must be accompanied by a GAIT analysis and/or biomechanical exam;
- elastic support stockings, to a maximum of \$25 per person, per year; and
- stump socks, to a maximum of \$250 per year;
- 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 **not** covered:

- medical expenses incurred outside Canada;
- non-medical items such as alcohol swabs, batteries, bandages, first aid supplies;
- intrauterine devices, contraceptive implants or 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.



Clinical Psychologist Coverage Details

Plan pays 100% of eligible expenses over and above the amount paid by provincial health care, up to \$1,000 per person per calendar year.

Private Duty Nurse Coverage Details

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 in the following circumstances:

- the nurse must be ordered by the attending doctor; and
- the nurse must not be a member of the immediate family.

Sleep Apnea Coverage Details

Coverage is available to cover the cost of a Continuous Positive Airway Pressure (CPAP) machine up to a maximum of \$2,000 and limited to one machine per lifetime. Supplies are not covered by the Plan.

Vision Care Coverage Details

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; and
- up to \$75 for the cost of one eye examination per person per 24 consecutive month period.

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

Note: You may claim a maximum of \$300 for glasses, contact lenses and intra-ocular lenses in a period of 24 consecutive months beginning in the year you make your first claim. However, if you do not make a claim of any kind for a period of 24 consecutive months, your claim period begins again when you do submit a claim.

Limitations

The following are **not** covered:

- Laser eye surgery;
- non-corrective lenses;
- repairs to glasses; or
- sunglasses with non-corrective lenses.

AVOID DELAYS – BE COMPLETE

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



Hearing Aids Coverage Details

This benefit provides coverage for the purchase of hearing aids to a maximum of \$750 per person in any 36 consecutive month period. The hearing aids must be recommended by a qualified doctor.

Limitations

The following are **not** covered:

- servicing or repairs to hearing aids; or
- batteries.

Ambulance Coverage Details

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

- transportation from the point of injury or illness to the nearest hospital; or
- emergency transportation between hospitals if necessary to obtain appropriate treatment.

Limitations

The following are **not** covered:

- Air ambulance.

Hospital Coverage Details

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 up to a maximum of 365 days for one period of disability. 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.

You are covered for:

- a maximum of 365 days in an acute care hospital during any one period of disability; or
- a maximum of 120 days in a convalescent hospital during any one period of disability, when admitted within 14 days of being in an acute care hospital.

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.



Emergency Travel Health Insurance Coverage Details

If you incur emergency medical expenses while travelling outside of your province of residence, you are covered for eligible expenses up to a maximum of \$5 million per trip. Eligible expenses will be reimbursed at 100% during trips of 30 days or less. It is important that you carry your travel health card with you while travelling.

For additional information, please contact Trust Office prior to travelling.

How to Make an Extended Health Care Claim

To be reimbursed for expenses covered under this benefit, submit the following to ClaimSecure within 365 days following the date you incurred the expense, or within 90 days of termination of benefit coverage:

- official receipts;
- a copy of your doctor's prescription, where applicable; and
- your completed, signed claim form.

Be sure to complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.

Claim forms are available on the following websites:

- www.oe955.com
- www.claimsecure.com

You may submit your claim online at www.claimsecure.com through your eProfile; through the ClaimSecure App available for Android and iOS smart phones; by dropping it off at the Trust Office; or by mail to:

ClaimSecure Inc.
P.O. Box 6500, Station A
Sudbury, ON P3A 5N5

Contact Information

	Trust Office	ClaimSecure
Toll Free:	1-800-222-6410 (in Alberta)	1-888-513-4464
Direct:	780-483-9550	
Email:	benefits@oe955.com	service@claimsecure.com

EMERGENCY TRAVEL

Before incurring a medical expense while you are traveling, be sure to contact the insurance provider listed on your travel card. It is important the insurer is aware of the medical issue before you pay for any medical expenses.

CLAIMSECURE MEMBER LOG-IN

Log into your ClaimSecure eProfile to get everything you need to know about your coverage, how to submit claims, sign up for direct deposit and more. Visit www.claimsecure.com to log in.

THERE IS AN APP FOR THAT

You are able to submit "photo" claims directly through the ClaimSecure App for all Extended Health Care and Dental Care claims.



DENTAL BENEFITS

Eligibility

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

Coverage Details

The Plan covers part of dental and orthodontic expenses for you and your family.

Basic & Major Dental Coverage Details

The maximum combined Basic and Major 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.

Reimbursement rates for dental procedures are defined by each provincial dental fee guide. Lab fees are covered at 50%.

Basic Dental

The Plan provides 80% reimbursement of eligible expenses under Basic Dental coverage:

- a routine dental exam, cleaning, fluoride treatment and bitewing x-rays once every 9 months (6 months for a dependent child) to the date of the service;
- 8 units of scaling per recall examination;
- full mouth x-rays (panoramic x-rays) every 2 years to the date of the service;
- as you need them:
 - extractions;
 - fillings (amalgam, silicate, acrylic and composite);
 - root canal (and other endodontic treatment);
 - common surgical procedures such as extraction of impacted teeth, removal of tumors, cysts, neoplasms, incision and drainage of abscess and any diagnostic x-rays, lab procedures and general anaesthetic required for dental surgery;
 - provision of habit-breaking appliances and space maintainers for missing primary teeth; and
 - periodontics treatment.

DENTAL REIMBURSEMENT RATES

The insurance industry has a fee guide that provides 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 insurance guide rate, so it pays to shop around.

Example:

For a 9-month checkup, a dentist charges \$200 for an examination, an x-ray and a filling. The eligible expense (according to the provincial fee guide) in this example is \$153.20. As such, your reimbursement would be 80% of \$153.20 = \$122.56.



Major Dental

The Plan provides 60% reimbursement of eligible expenses under Major Dental coverage:

- crowns, including gold and porcelain veneer restoration where other material is not suitable;
- inlays and onlays (note: the use of gold will only be covered for procedures including three or more surfaces);
- creation of fixed bridgework, removable partial or complete dentures;
- relining, rebasing, or repairing of an existing fixed bridgework, removable partial or complete denture;
- services of a licensed denturist when practicing within the scope of his or her license;
- some other necessary oral surgical procedures not specifically listed here.

Orthodontic Services Coverage Details

The most common form of orthodontic treatment is braces.

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

Just prior to commencement of your treatment, you or the orthodontic office must submit a copy of your orthodontic treatment plan to ClaimSecure by mail or electronically.

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 \$500, 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.

REPLACEMENT OF EXISTING FIXED BRIDGEWORK OR REMOVAL OF PARTIAL OR COMPLETE DENTURES IS ONLY COVERED IF ONE OR MORE OF THE FOLLOWING APPLY:

- Necessitated by an extraction while covered under this plan
- The existing crown or fixed bridgework is at least five (5) years old and cannot be made serviceable
- The existing complete or partial dentures are at least three (3) years old and cannot be made serviceable
- The existing appliance is temporary and replaced with a permanent appliance within twelve (12) months
- Payment was not made under the Plan for previous work on the appliance.



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 **not** covered:

- general anaesthesia with non-surgical procedures;
- treatment for temporomandibular joint (TMJ) dysfunction;
- charges for implants;
- 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;
- injury as a direct result of insurrection, war, service in the armed forces or participation in a riot; and
- services required as a result of self-inflicted injuries.

How to Make a Dental Claim

You may claim your dental expenses in two ways:

- submit a dental claim form, filled out by the dental office, to ClaimSecure; or
- show your pay-direct card and your dentist can submit your claim electronically.

If your dentist allows you to assign benefits (that is, if the dentist agrees to be paid directly from ClaimSecure) indicate this on the claim form by signing all assigned areas before you/they mail it to ClaimSecure.

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, completed by the dental office and signed by you, to ClaimSecure before the end of the following 365 day period.

Be sure to complete and sign all claim forms. The number one reason claims are returned or payments are delayed is incomplete forms.

Claim forms are available on the following websites:

- www.oe955.com
- www.claimsecure.com

TIME SENSITIVE TIP - TERMINATIONS

Any claims for expenses incurred up to your last day of coverage must be submitted within 90 days of your coverage termination date.



You may submit your claim online at www.claimsecure.com through your eProfile; through the ClaimSecure App available for Android and iOS smart phones; by dropping it off at the Trust Office; or by mail to:

ClaimSecure Inc.
P.O. Box 6500, Station A
Sudbury, ON P3A 5N5

Contact Information

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

ClaimSecure
1-888-513-4464
service@claimsecure.com

CLAIMSECURE MEMBER LOG-IN

Log into your ClaimSecure eProfile to get everything you need to know about your coverage, how to submit claims, sign up for direct deposit and more. Visit www.claimsecure.com to log in.

THERE IS AN APP FOR THAT

You are able to submit “photo” claims directly through the ClaimSecure App for all Extended Health Care and Dental Care claims.



LIFE INSURANCE

(MEMBER AND SPOUSE)

Eligibility

The benefits described apply to Operating Engineers 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 information 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.

NAME A BENEFICIARY

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

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 32 weeks and you qualify for Long Term Disability payments, Life Insurance premiums may be waived but it is not automatic – it is your responsibility to apply for this waiver when you apply for Long Term Disability benefits. For members currently receiving Weekly Indemnity or on Long Term Disability, your Life Insurance coverage is the amount provided by this Plan at the time of your disability.



Compassionate Assistance Benefit

Terminal illness can be devastating financially, as well as emotionally, to your family. The Compassionate Assistance Benefit allows you, in certain circumstances, 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.

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 began 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:

- he or she no longer meets 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;
- he or she has exercised the conversion option;
- 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 Trustees:

- 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.

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)

Eligibility

The benefits described apply to Operating Engineers 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. Death benefits are paid to your beneficiary.

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 claim is determined by the extent of the loss. A complete schedule follows, with the benefit payable shown as a percentage of \$100,000.

Schedule of Losses

Death	100%
Loss or loss of use of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of hearing in both ears and speech	100%
Loss or loss of use of one hand and one foot	100%
Loss or loss of use of one arm or one leg	75%
Loss or loss of use of one hand or one foot	66⅔%
Loss of speech or hearing in both ears	66⅔%
Loss of sight of one eye	66⅔%
Loss or loss of use of thumb and index finger of the same hand or at least four fingers on one hand	33⅓%
Loss of hearing in one ear	16⅔%
Loss of all toes of one foot	12½%
Loss of finger (amount per finger)	5%

NAME A BENEFICIARY

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



Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200%

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 began 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 commotion;
- 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.

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



WEEKLY INDEMNITY

Eligibility

The benefits described apply to Operating Engineers Local 955 members in Good Standing covered for Health & Wellness benefits who are **not on self-pay or drawing a pension** from the Pension Trust Fund.

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

Coverage Details

The Weekly Indemnity benefit provides you with income for up to 32 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 32 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 Weekly Indemnity benefit is equal to the Employment Insurance sickness benefit rate (\$562 per week in 2019).

Your Weekly Indemnity coverage stops on the **earliest** of the following dates:

- you are not a member in Good Standing;
- you draw your pension from the Pension Trust Fund;
- you have no hours in your Hour Bank and you have not self-paid;
- 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 other benefit that you receive from:

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

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.

WORKERS COMPENSATIONS

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



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.

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 Weekly Indemnity benefits may be reduced if you receive income from rehabilitation employment.

Failure to participate in a recommended rehabilitation program may result in termination of Weekly Indemnity benefits.

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:

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

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.



Weekly Indemnity will **not** be paid if any of the following apply to you:

- you have drawn your pension (monthly or lump sum) 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 or 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 Weekly Indemnity Claim

To claim the Weekly Indemnity 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.

Contact Information

Trust Office

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



LONG TERM DISABILITY

Eligibility

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

- have qualified for and received 32 weeks of Weekly Indemnity Insurance; and
- are not on self-pay or drawing a pension (monthly or lump sum) from the Pension Trust Fund.

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

Coverage Details

The Long Term Disability benefit provides you with income if you cannot work due to a permanent, 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 considered disabled if:

- during the first 24 months of your disability you are permanently, 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; or
- you are unable to do your regular job as a result of sickness or injury, and one of the following situations applies to you:
 - during the first 30 months of disability (including the 32 weeks before Long Term Disability benefits begin) you participate in a rehabilitation program;
 - you are working in another job that provides less than your monthly Long Term Disability benefit, in which case, any wages or compensation you receive are deducted from your benefit; or
 - you lose your employment working in another industry or have completed a rehabilitation program, and are seeking appropriate employment (in this case, benefits are paid for a maximum of 32 weeks).



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.

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

- you turn 65 years old;
- you are no longer in Good Standing;
- you draw your pension (monthly or lump sum) 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 group 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 payment 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.

WORKERS COMPENSATIONS

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



Payment of Benefits

Long Term Disability payments are made at the end of each month from the insurance company (Manulife).

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 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 draw your pension (monthly or lump sum) 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 a member in Good Standing of the Union;
- 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.

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.

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.



Third Party Liability

If you become disabled 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, 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. 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 or committing of a criminal offence;
- disability caused by addiction to non-medical consumption of drugs or alcohol (unless you are under treatment at an approved facility); 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 12 weeks before you expect payments to begin, while you are in receipt of Weekly Indemnity.**

Premiums for some Health & Wellness coverage (Extended Health Care, Dental, Life Insurance, and Accident Insurance) may be waived for disabled members, but it is not automatic – it is your responsibility to apply for this waiver when you apply for Long Term Disability benefits.

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 Weekly Indemnity to Long Term Disability, be sure to apply early – we recommend 12 weeks.

CONTINUE YOUR HEALTH CARE COVERAGE

Premiums for your Health & Wellness benefits may not be required while you are on Long Term Disability, but you must apply. Contact the Trust Office to apply.

Contact Information

Trust Office

Toll Free: 1-800-222-6410 (in Alberta)

Direct: 780-483-9550

Email: benefits@oe955.com

