

2017

LiUNA Local 183 Members' Benefit Fund (Construction Division)



Benefits Booklet

LiUNA! LOCAL 183

Feel the Power

**LIUNA LOCAL 183
MEMBERS BENEFIT FUND**



**THIS BOOKLET CONTAINS IMPORTANT INFORMATION AND SHOULD BE KEPT
IN A SAFE PLACE FOR FUTURE REFERENCE.**

JUNE 2017

WELCOME

This booklet describes the conditions of eligibility, coverage and claims procedures under the LiUNA Local 183 Members Benefit Fund, which for descriptive ease is referred to in this booklet as the Trust Fund.

Effort has been made to ensure that the coverage descriptions in this booklet are consistent with the group insurance policies issued by the Insurance Companies and with related government Health coverages. However, this booklet is not, in itself, a legal contract, so it follows that the terms of the insurance policies, and of the governing legislation, take precedence in case of dispute. As well, in an effort to treat all members fairly and to guard the Trust Fund assets against abuse, the Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund.

The Trustees hope that the benefit coverage, provided by the Trust Fund, is of real value to you and your eligible dependants. Should you require additional information, please contact your plan's Administrative Agent.

Please read this booklet carefully and keep it for future reference.

The Board of Trustees

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HOW THE TRUST FUND WORKS

The benefits provided by the Trust Fund are purchased from insurance companies with contributions made by your employer on your behalf. These contributions are made to the Trust Fund as a result of a Collective Bargaining Agreement.

The booklet describes benefits available under the Trust Fund.

The Trustees are responsible for the design of the benefit package provided by the Trust Fund and for the allocation of the contributions made to the Trust Fund. To help carry out their duties, the Trustees have appointed various people such as accountants, consultants and lawyers to provide them with professional advice. The Trustees meet with these advisors from time to time to review matters that arise in the running of the Trust Fund. The Trustees make all decisions that are necessary at these meetings by taking a vote amongst themselves. The plan's Administrative Agent performs the daily administrative functions of the Trust Fund.

It is hoped that the Trust Fund will be continued indefinitely, but as is customary in group insurance plans, the right of change or discontinuance at any time must be reserved. Please note that any benefit that is provided at a particular time cannot be guaranteed for any specific period of time, unless required by legislation. The Trustees reserve the right to amend, suspend, delete or terminate any benefit at any time as in their discretion they deem appropriate.

The Trustees have the power to disentitle any person to past, present or future benefits and to take any further action they deem appropriate, including denying membership in a Plan, to any person where the member or persons claiming through the member are found by the Trustees to be abusing the Plan or making false or improper claims under the Plan.

PROTECTING THE PLAN

The benefits provided by the Trust Fund are designed to its maximum for the members and eligible dependants of the LiUNA Local 183 Members Benefit Fund. Inflating drug costs and therapies affect the Plan and its purpose. Members can help maintain the Plan with the following steps to ensure the Plan is able to continue to offer quality benefits:

- Coordination of coverage with your spouse can ensure that each plan is maximized to its full potential. Please ensure to advise the Administrative Agent of other coverage available to you.
- The Plan has been designed to help the members and their eligible dependants and to ensure suitable health care access. Please remember to use it when you need it and to use it prudently.
- Prior to sending a claim under the plan for items and services, take some time to shop and compare to help keep a limit on costs.

THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete an Application Card, which you can obtain from your Administrative Agent or online at www.183membersbenefits.ca. On this card, you name the beneficiary/beneficiaries, to whom your Life Insurance should be paid, in the event of your death. Members should list all dependants that are eligible for insurance.

If you have already completed an Application Card and you have no desire to change your beneficiary/beneficiaries, it is not necessary for you to complete another card. You may change your named beneficiary/beneficiaries, subject to Provincial Law, by written request, filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the Plan for any payment(s) made before such request is received by the Administrative Agent.

Please be sure to fully complete and sign the Application Card, and return it to the Administrative Agent. It is extremely important that a completed Application Card be on file, since claims cannot be paid on behalf of you, or your eligible dependants.

After your insurance becomes effective, it is necessary for you to notify the Administrative Agent of any change in your dependant or marital status. This information is necessary so that your coverage can be adjusted accordingly.

CHANGE OF YOUR DEPENDANT OR MARITAL STATUS

You must complete a new Application Card to update your status. For example, if you were a single member when your insurance commenced and you get married at a later date, or you were married at the time insurance commenced and sometime later your family includes a child.

You must advise the Administrative Agent within 31 days of a change in your dependent status. Failure to do so could jeopardize the coverage of a newly acquired dependent.

This information is important to ensure uninterrupted coverage and avoidance of any delays in the assessment of claims.

PERSONAL INFORMATION

Any personal information collected by the Trustees and the Administrative Agent is used only to the extent required by law. To authorize an individual to have access to your personal information, you must complete an Authorization to Release Personal Information Form and return it to the Administrative Agent. Only authorized persons have access to your personal information when required for coverage purposes.

MEMBER ELIGIBILITY

WHO MAY BE INSURED

This Plan is for Members:

- who are covered under a Provincial Health Insurance Plan.
- in Good Standing with LiUNA Local 183.
- of a Bargaining Unit represented by LiUNA Local 183.
- who work for a Contributing Employer and where the Collective Agreement makes provisions for contributions to the Members Benefit Fund.

HOUR BANK ACCOUNT

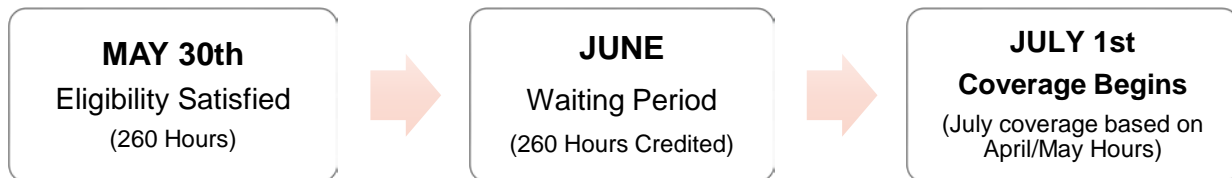
The Administrative Agent keeps an account of the hourly contributions made by your employer on your behalf. Hours are stored (banked) for future use when more than the 130 hour monthly requirement are worked and submitted by your employer for your monthly benefit coverage.

INITIAL BENEFIT COVERAGE

You will become eligible for benefits provided by the Plan as follows:

- On the 1st day of the 2nd month following the date you have accumulated two months of the monthly requirement (260 hours) made by your employer on your behalf as outlined by the Board of Trustees.
- Example: If a member works 130 hours in April and 130 hours in May, the eligibility requirements are met as at May 30th with 260 hours and benefit coverage will commence on July 1st.

HOUR BANK:



- Coverage continues automatically for each month provided you have the required minimum of 130 hours in your Hour Bank Account. The Administrative Agent will deduct the monthly requirement of 130 hours from your Hour Bank Account monthly.

HOUR BANK ACCOUNT MAXIMUM

The maximum number of hours you can accumulate in your Hour Bank Account is 3,120 hours. This number represents a maximum of 24 consecutive months of coverage.

If you earn in excess of 3,120 hours in your Hour Bank Account, the excess is transferred to the general reserve of the Members Benefit Fund.

SELF-PAY PROVISION

Should your coverage terminate because you are unemployed and have recall rights you will be given the option to continue your coverage by making self-payments to the Members Benefit Fund on the following basis:

- Monthly payments in the amount of \$95.00 plus 8% Retail Sales Tax for a total of \$102.60 per month.
- You have the option to make self-payments for a maximum of 12 consecutive months provided you remain a Member in Good Standing with LiUNA Local 183.
- You are entitled to the same benefits you enjoyed while you were employed with the exception of Short Term Disability, Long Term Disability and Long Term Care Benefits.
- Self-payments must be made within 31 days of the termination of your coverage and must be made on a continuous basis. Retroactive self-payments will not be accepted.
- Your Union Dues with LiUNA Local 183 must be maintained and in a current status.
- The Trustees may adjust the self-payment amount from time to time.

The cheque should be made payable to "Local 183 Members Benefit Fund" and mailed to:

**Local 183 Trust Administration
205 - 1263 Wilson Avenue
Toronto, ON M3M 3G2**

You should be sure to print your name and Union ID Number on the back of your cheque to ensure that your account is properly credited.

If you choose to pay directly, as provided for above, it is your responsibility to contact the Administrative Agent and make the necessary payments by the 15th of each month. Coverage is terminated if you fail to make the necessary payments on time.

WORKPLACE SAFETY INSURANCE BOARD (WSIB)

If a member becomes disabled due to a work-related injury and are eligible for Workplace Safety and Insurance Board (WSIB) benefits, the member and eligible dependents will remain covered for the Plan's benefits in which their hour bank will be frozen for a maximum period of 12 months from the date of disability while in receipt of WSIB benefits under the Workplace Safety and Insurance Act. Members must report their WSIB claim number and submit Proof of Acceptance of their claim by WSIB to the Administrative Agent as soon as possible. Members have one (1) year from the date of the accident to report their WSIB claim to the Administrative Agent and are to continue to remain a member in Good Standing with LiUNA Local 183.

RE-EMPLOYMENT FOR A PENSIONER

If you are a Retiree covered under the Labourers' Local 183 Retiree Benefit Trust Fund who is receiving a monthly pension from the LiUNA Labourers' Pension Fund or the B.M.I.U.C. Local 1 Pension Fund and you return to work with a participating employer, your coverage under the Labourers' Local 183 Retiree Benefit Plan will pause and you will begin to generate eligibility under LiUNA Local 183 Members Benefit Fund and will be classed as an Active Member. Once you accumulate enough hours in your Hour Bank Account under the LiUNA Local 183 Members Benefit Fund, you will be considered to be an Active Member under the LiUNA Local 183 Members Benefit Fund and not a Retiree. You cannot have active benefit coverage as an Active Member and a Retiree at the same time.

Coverage will terminate if a Retiree enters into an active working relationship with an entity **contrary** to the interests of LiUNA Local 183. Coverage under the Labourers' Local 183 Retiree Benefit Trust Fund will reactivate once you are no longer employed/working in the industry and benefits exhaust under the LiUNA Local 183 Members Benefit Fund.

TERMINATION OF COVERAGE

Coverage for you and your dependents will terminate on the earliest of, the date:

- On the last day of the month that you have less than the monthly 130 hour requirement or you do not make the necessary self-payment to maintain your coverage.
- On the last day of the month you stop making self-payments or are not permitted to make future self-payments.
- You cease to be a member in Good Standing of LiUNA Local 183.
- Upon your attainment of age 65 with respect to Long Term Disability Benefits; age 70 for Short Term Disability Benefits, Accidental Death & Dismemberment, Occupational Accidental Death & Dismemberment, Hospital Cash, Critical Illness, Special Medical/Hospital Coverage while in Canada and Permanent Total Disability Accident Benefits; age 75 for Life Insurance, Dependent Life Insurance and Special Needs Life Insurance; and age 80 for Emergency Out of Province coverage.
- Coverage for your dependents will terminate on the date such dependents cease to be eligible.
- When your coverage terminates, you may have a small balance in your Hour Bank Account (less than 130 hours) which will be cancelled if hours are not received by the Administrative Agent within 12 months of the date of termination.
- You enter Military Service.
- This Plan is discontinued.

REINSTATEMENT OF COVERAGE

If you were previously covered by the Plan and have been terminated and subsequently return to work in which a Collective Agreement requires your employer to contribute to the Members Benefit Fund, you will be covered by the Plan:

- On the first day of the second month following the date you have accumulated 130 hours of the required monthly deduction in your Hour Bank Account, or

If you are out-of-benefit for a period greater than 12 consecutive months, you will be treated as a new member and you will be covered by the Plan:

- On the first day of the second month following the date you have accumulated 260 hours of the required deduction in your Hour Bank Account.

CHANGES IN PLAN ELIGIBILITY

The requirements under the Member eligibility may be amended by the Board of Trustees at any time without prior notice to individuals affected, including current active members and those not yet eligible as of the effective date of any amendment.

The Board of Trustees reserve the right to change or terminate any or all of the benefit coverages under the Plan and amend the eligibility provisions from time to time.

INCOME TAX

Under current tax law Life Insurance, Accidental Death and Dismemberment, Occupational Accidental Death and Dismemberment, Permanent Total Disability Accident, Long Term Care, Critical Illness, and Hospital Cash premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for these benefits in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Benefits received from the plan are not taxable with the exception of Short Term Disability, Long Term Disability, Bereavement Pay, Parental Leave, and Jury Duty Benefit payments which are also reported on the T4A form received from either the Administrative Agent or directly from the insurer.

Any premiums paid for the above referenced benefits on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

CONTINUATION OF EXTENDED HEALTH CARE AND DENTAL CARE COVERAGE UPON YOUR DEATH - DEPENDENTS

Extended Health Care and Dental Care Benefits will continue beyond the date of your death while payments for such coverage are made by the Trust Fund on behalf of your eligible dependents, provided you were eligible for benefits at the date of death, but not beyond the earliest of:

- The date such dependents cease to be eligible.
- The date your surviving spouse remarries (children will continue to be covered).
- The date coverage for your dependents terminates as per the definition of dependent or for any other reason.
- The date your child attains the age of 21 or the age of 25 provided they are attending an accredited school, college, or university as a full time student.
- The date following the exhaustion of any balance in your Hour Bank Account at the date of your death, coverage will continue for surviving spouse to a maximum of 10 years or the attainment of age 55.
- Extension of coverage for surviving spouse to the attainment of age 55 should your death be as a result of an occupational accident. You will be required to provide annual proof to the Administrative Agent.

CONTINUATION OF EXTENDED HEALTH CARE AND DENTAL CARE COVERAGE FOR INCAPACITATED CHILDREN

Extended Health Care and Dental Care Benefits will continue beyond the date an unmarried child attains the limiting age of 21 or 25 provided they are attending an accredited school, college or university as a full time student, provided proof is submitted to the Administrative Agent within 31 days after such date that such child:

- Is incapable of supporting themselves due to a physical or psychiatric disorder.
- Become so incapacitated prior to attainment of the limiting age.
- Is chiefly dependent upon you for support and maintenance.
- Thereafter such proof must be submitted to the Administrative Agent as required, but not more often than yearly.

EXTENSION OF EXTENDED HEALTH CARE, DENTAL CARE, EMERGENCY OUT OF PROVINCE AND LIFE INSURANCE COVERAGE DUE TO DISABILITY

If you are totally disabled on the date your insurance terminates, entitlement to **Extended Health Care, Dental Care, Emergency Out of Province and Life Insurance benefits** will be the same as though such insurance had not terminated provided you submit proof to the Administrative Agent for as long as you remain continuously disabled, and are currently in receipt of Short Term Disability, Long Term Disability, Workers Safety Insurance Board (WSIB) and / or Canada Pension Plan (CPP) Disability Benefits, as follows:

- Members on Short Term Disability will be required to remit a monthly payment of \$95.00 plus 8% R.S.T, a total of \$102.60 for continuous benefit coverage up to a maximum of twenty-four (24) months following the exhaustion of your Hour Bank Account provided you remain in receipt of Short Term Disability Benefits for disabilities on or after October 1, 2011;
- Members on Workers Safety Insurance Board (WSIB) Disability Benefits will be fund assisted for benefit coverage from the date of disability for a maximum of twelve (12) consecutive months provided you remain in receipt of WSIB benefits. Your Hour Bank Account is frozen during the twelve (12) month period. Following the twelve (12) month period and exhaustion of your Hour Bank Account, members are required to remit a monthly payment of \$95.00 inclusive of 8% R.S.T. for benefit coverage listed above provided you remain in receipt of Worker Safety Insurance Board disability benefits. You have one (1) year from the date of the accident to report your WSIB claim to the Administrative Agent;
- Members on Long Term Disability will be required to remit a monthly payment of \$95.00 inclusive of 8% R.S.T. for continuous benefit coverage provided you remain in receipt of benefits for disabilities on or after October 1, 2011;
- Members on Canada Pension Plan (CPP) Disability Benefits will have their benefit coverage on a complimentary basis for disabilities on or after October 1, 2011;
- Eligibility for benefits will be conditional on you remaining a Member in Good Standing with LiUNA Local 183 and you becoming disabled on or after October 1, 2011;
- You will be required to provide proof that you continue to be in receipt of the above benefits on an annual basis;
- Coverage will terminate on the date of your death, return to employment, recovery or the attainment of age 65 for all benefits.

DEPENDANT ELIGIBILITY

Your dependents become eligible for coverage when you become eligible or, if acquired later, upon becoming your dependent provided they are covered under a Provincial Health Insurance Plan. If your spouse also has coverage through their employer, you must co-ordinate your benefits through this plan with your spouse's plan. You must advise the Administrative Agent if you or your dependents are covered under another plan, such as your spouse's benefit plan.

To be eligible for benefits, your eligible dependents include your spouse and dependent children as identified below.

SPOUSE

- Spouse means a husband or wife by virtue of a valid civil or religious ceremony.
- Common Law Spouse means a person living with the member for a minimum of 12 consecutive months and will be deemed to be the member's spouse if such person is publicly represented as the member's spouse.
- Same-sex spouses are eligible provided that the relationship includes continuous cohabitation of a minimum of 12 consecutive months and public representation of married status.
- Divorced spouses are not eligible for coverage.

DEPENDANT CHILDREN

- Dependent child means a natural or legally adopted child; or a stepchild or other child who is dependent upon the member for support and lives with the member in a regular parent/child relationship.
- Dependent children must be 20 years of age or younger (children from 21 years of age but under age 25 will be covered provided they are attending an accredited school, college or university as a full-time student. Annual proof of student registration (original) must be provided to the Administrative Agent).
- Dependent children must be dependent on you for support, unmarried and not employed at a regular full-time job.

SUMMARY OF PLAN BENEFITS

Following is a summary of your benefit coverage. The booklet provides further details.

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>LIFE INSURANCE (page 21)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • Member - \$150,000 • Spouse - \$20,000 • Dependent Child - \$10,000 <p>Interment Benefit:</p> <ul style="list-style-type: none"> • Member - \$10,000 <p>Special Needs Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Member - \$100,000 	<ul style="list-style-type: none"> ✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 75
<p>ACCIDENTAL DEATH & DISMEMBERMENT (page 23)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • Member - \$200,000 • Spouse - \$60,000 • Dependent Child - \$8,000 	<ul style="list-style-type: none"> ✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 70
<p>OCCUPATIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (page 26)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • Member - \$200,000 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage terminates at the attainment of age 70
<p>SHORT TERM DISABILITY (page 29)</p>	<p>Weekly Benefit Maximum:</p> <ul style="list-style-type: none"> • Maximum of \$500 per week. 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage terminates at the attainment of age 70

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>SHORT TERM DISABILITY (page 29)</p>	<p>Benefits are payable from:</p> <ul style="list-style-type: none"> • 1st day accident or hospitalization of a minimum of 18 hours • 8th day illness / disease / sickness <p>Benefit Duration:</p> <ul style="list-style-type: none"> • Maximum of 104 weeks or to the attainment of age 70 <p>Integration:</p> <ul style="list-style-type: none"> • 15 Week Employment Insurance Sickness Benefits 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage terminates at the attainment of age 70
<p>LONG TERM DISABILITY (page 32)</p>	<p>Monthly Benefit Maximum:</p> <ul style="list-style-type: none"> • Years 1-5 - \$ 1,000 per month • Years 6-10 - \$ 600 per month <p>Benefits are payable from:</p> <ul style="list-style-type: none"> • 104 weeks from the date of disability <p>Benefit Duration:</p> <ul style="list-style-type: none"> • Maximum of 10 years, recovery or the attainment of age 65 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage Terminates at the attainment of age 65
<p>PERMANENT TOTAL DISABILITY ACCIDENT (page 35)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • Member - \$300,000 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage terminates at the attainment of age 70
<p>LONG TERM CARE (page 37)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • \$50 per day indemnity benefit • \$100 per day for eligible expenses 	<ul style="list-style-type: none"> ✓ Members and their spouse

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>LONG TERM CARE (page 37)</p>	<ul style="list-style-type: none"> Lifetime Maximum \$175,000 	<ul style="list-style-type: none"> ✓ Members and their spouse
<p>SECOND OPINION MEDICAL BENEFIT - CARENAV (page 40)</p>	<p>Services for serious illnesses:</p> <ul style="list-style-type: none"> Review and Second Opinion Care Coordination Out of Country Care Coordination 	<ul style="list-style-type: none"> ✓ Members and their spouse
<p>CRITICAL ILLNESS (page 41)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> Member - \$ 25,000 Spouse - \$ 5,000 Over 65 years of age – 50% of the above amounts <p>Survival Period from date of diagnosis:</p> <ul style="list-style-type: none"> 30 days 	<ul style="list-style-type: none"> ✓ Members and their spouse ✓ Coverage terminates at the attainment age 70
<p>HOSPITAL CASH BENEFIT (page 44)</p>	<p>Daily Benefit Maximum:</p> <ul style="list-style-type: none"> Maximum of \$150 per day. <p>Benefits are payable after:</p> <ul style="list-style-type: none"> 3 consecutive days of hospitalization <p>Benefit Duration:</p> <ul style="list-style-type: none"> Maximum of 120 consecutive days 	<ul style="list-style-type: none"> ✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 70
<p>EXTENDED HEALTH CARE BENEFITS (page 46)</p>	<p>Any dollar amount shown as a "limit" in this summary refers to a maximum eligible charge, and not a maximum benefit</p> <hr/> <p>Lifetime Maximum:</p> <ul style="list-style-type: none"> \$1,000,000 each insured family member 	<ul style="list-style-type: none"> ✓ Members and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>EXTENDED HEALTH CARE BENEFITS (page 46)</p>	<p>Prescription Drugs:</p> <ul style="list-style-type: none"> • Prescription Drug Benefit Card • 100% Reimbursement • Opioids – Lifetime maximum of \$50,000 for eligible opioids. • Smoking Cessation – One (1) course treatment up to a maximum of \$350 per member, per lifetime. • Twinrix ® vaccination (3 doses) for protection against Hepatitis A & B once per lifetime. • Zostavax ® vaccination (1 dose) for the prevention of Shingles up to \$210 per lifetime. <p>Coinsurance Levels:</p> <ul style="list-style-type: none"> • 50% Orthotics • 100% Other Covered Charges <p>Paramedical Services Limits:</p> <ul style="list-style-type: none"> • Clinical Psychologist, Psychotherapist, Occupational Therapist, Podiatrist/Chiropodist, Massage Therapist, Physiotherapist, Naturopath, Osteopath, Chiropractor or Acupuncturist up to a maximum of \$50 per visit up to an overall combined practitioner maximum of \$1,000 per calendar year. • Speech Therapist to a maximum of \$200 per visit. 	<p>✓ Members and eligible dependents</p>

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>EXTENDED HEALTH CARE BENEFITS (page 46)</p>	<p>Medical Services and Supplies:</p> <ul style="list-style-type: none"> • Orthopedic Shoes: 1 pair every 24 months to an overall maximum of \$500 (must be custom made by a Foot Care Specialist and prescribed by licensed physician (M.D.) or specialist). • Orthotics: 1 pair reimbursement at 50% up to a maximum of \$250 per calendar year (must be custom made by a Foot Care Specialist and prescribed by licensed physician (M.D.) or specialist). • Hearing Aids: \$750 every 36 months for one set (including replacement, repairs and batteries). • Nursing Services: \$5,000 lifetime maximum. • Ambulance services: outpatient services. • Vision Care: Maximum combined benefit of \$400 once every 24 months for one (1) set of eyeglasses (lenses/frames combined) <u>or</u> Contact Lenses including one (1) eye exam. • \$100 Replacement Lenses <u>only if as a result of a prescription change or damage to lenses</u> within the same 24 months under Vision Care. • Corrective Laser Eye Surgery: \$1,000 / once per lifetime. • Cataract Surgery: Intra-ocular lens (IOL) single focal to a maximum of \$250 per eye per lifetime; multi-focal to a maximum of \$600 per eye per lifetime. 	<p>✓ Members and eligible dependents</p>

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>EXTENDED HEALTH CARE BENEFITS (page 46)</p>	<ul style="list-style-type: none"> Limb braces, crutches, prosthesis services, wheelchair, hospital bed or oxygen equipment. 	<ul style="list-style-type: none"> ✓ Members and eligible dependents
<p>SPECIAL MEDICAL / HOSPITAL COVERAGE WHILE IN CANADA (page 55)</p>	<p>Benefit:</p> <ul style="list-style-type: none"> Reasonable and Customary Hospital Charges, Physician / Surgeon Fees and Health Examinations <p>Benefit Maximum:</p> <ul style="list-style-type: none"> \$25,000 per occurrence \$250,000 Lifetime Maximum 	<ul style="list-style-type: none"> ✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 70
<p>DENTAL CARE BENEFITS (page 58)</p>	<p>Co-Insurance Levels:</p> <ul style="list-style-type: none"> Routine Care - 100% Complete Dentures - 100% Partial Dentures - 80% Crowns, Bridgework and Implants – 100% Orthodontics – 60% <p>Annual Maximums (per calendar year):</p> <ul style="list-style-type: none"> \$3,000 per individual <p>Orthodontic Lifetime Maximum: (dependent children under the age of 18)</p> <ul style="list-style-type: none"> \$2,500 per lifetime <p>Dental Ontario Dental Association (ODA) Fee Guide:</p> <ul style="list-style-type: none"> 2014 ODA Fee Guide 	<ul style="list-style-type: none"> ✓ Members and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>EMERGENCY OUT-OF-PROVINCE MEDICAL (page 64)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • \$5,000,000 Lifetime Maximum under age 70 • \$1,000,000 Lifetime Maximum age 70 to 74 • \$ 500,000 Lifetime Maximum age 75 to age 80 • Trips are limited to a maximum accumulation of 90 consecutive days 	<ul style="list-style-type: none"> ✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 80
<p>BEREAVEMENT PAY (page 67)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • \$250 per day <p>Benefit Duration:</p> <ul style="list-style-type: none"> • Maximum of 3 business days 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage is not under the Health & Welfare Plan
<p>PARENTAL LEAVE (page 69)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • \$250 per day <p>Benefit Duration:</p> <ul style="list-style-type: none"> • Maximum of 3 business days 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage is not under the Health & Welfare Plan
<p>JURY DUTY (page 70)</p>	<p>Benefit Maximum:</p> <ul style="list-style-type: none"> • \$200 per day <p>Benefit Duration:</p> <ul style="list-style-type: none"> • Maximum of 100 days 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage is not under the Health & Welfare Plan
<p>MEMBER FAMILY ASSISTANCE PLAN (page 71)</p>	<p>Services:</p> <ul style="list-style-type: none"> • Confidential Counseling Services 	<ul style="list-style-type: none"> ✓ Members and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
<p>REGISTERED EDUCATION SAVINGS PLAN (R.E.S.P.)</p>	<p>Benefit:</p> <ul style="list-style-type: none"> • Lifetime benefit contribution of \$500 made payable to a RESP account on behalf of Member to a child or grandchild born on or after January 1, 2017. • Affidavit must be completed for Members requesting on behalf of a grandchild. 	<ul style="list-style-type: none"> ✓ Members Only ✓ Coverage is not under the Health & Welfare Plan

LIFE INSURANCE

BENEFITS

You and your eligible dependents are covered for life insurance as follows:

LIFE INSURANCE	
Member Category	Coverage
Active Members under age 75 <ul style="list-style-type: none"> - Life Insurance - Interment Benefit 	\$150,000 \$ 10,000
Dependents <ul style="list-style-type: none"> - Spouse - Children (over 14 days of age) 	\$ 20,000 \$ 10,000
SPECIAL NEEDS LIFE INSURANCE	
Member Category	Coverage
Active Members under age 75	\$100,000

In the event of your death at any time while covered, the amount above will be paid to your named beneficiary, if living, otherwise to your estate. You may change your beneficiary whenever you like (subject to any legal restrictions) by giving written notice to the Administrative Agent.

To be eligible for the Special Needs Life insurance you must have dependent children for whom you are receiving a Federal Disability Tax Credit from Canada Revenue Agency.

CONVERSION OPTION

If coverage for you or your spouse terminates, you or your spouse may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required within 31 days of the date coverage terminates. Contact the Administrative Agent for details.

EXTENSION OF BENEFITS

If you or your spouse dies within 31 days of the date Life Insurance terminates, the amount that could have been converted will be paid as a death benefit even if no application for conversion was made.

BENEFICIARY

For member death benefits, you may name a beneficiary (ies) and, from time to time, change such named beneficiary (ies), subject to Provincial Law, by written request filed at the office of the Administrative Agent, to take effect as of the date such request was executed, but without prejudice to the Plan for any payments made before such request is received.

INTERMENT BENEFIT

In the event of your death, a one-time Interment Benefit of \$10,000 will be paid to your named beneficiary at the time of death, in advance of the Life Insurance Benefit to cover any burial expenses incurred. A death certificate from the funeral home must be submitted. You may change your beneficiary whenever you like (subject to any legal restrictions) by giving written notice to the Administrative Agent.

INCOME TAX

Under current tax law, Life Insurance premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Life Insurance premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

ACCIDENTAL DEATH AND DISMEMBERMENT

If you suffer any of the losses shown below, and are under the age of 70, as the result of an injury caused solely by external, violent and accidental means and submit a claim within 365 days of the date of such injury, **you and your eligible dependents** may be eligible to receive a benefit as follows:

BENEFITS

FOR LOSS OF:	Member (\$)	Spouse (\$)	Children (\$)
Life (Principle Sum)	200,000	60,000	8,000
Both Hands or Both Feet	200,000	60,000	32,000
Entire Sight of Both Eyes	200,000	60,000	32,000
One Hand and One Foot	200,000	60,000	32,000
One Hand and Entire Sight of One Eye	200,000	60,000	8,000
One Foot and Entire Sight of One Eye	200,000	60,000	8,000
Speech and Hearing in Both Ears	200,000	60,000	32,000
One Arm or One Leg	150,000	45,000	16,000
One Hand or One Foot	150,000	45,000	8,000
Entire Sight of One Eye	150,000	45,000	6,000
One Entire Finger of Either Hand	33,333	10,000	1,334
Speech or Hearing in Both Ears	150,000	45,000	16,000
Thumb and Index Finger of Same Hand	66,666	20,000	2,667
Four Fingers of the Same Hand	66,666	20,000	2,667
Hearing in One Ear	66,666	20,000	2,667
All Toes of the Same Foot	50,000	15,000	2,000
Thumb of Either Hand	50,000	15,000	2,000
Brain Death	200,000	60,000	8,000
Partial Loss of Finger	10,000	0	0

FOR LOSS OF USE OF:	Member (\$)	Spouse (\$)	Children (\$)
Both Arms or Both Feet or Both Hands or Both Legs	400,000	120,000	16,000
One Hand or One Foot	150,000	45,000	6,000
One Arm or One Leg	150,000	45,000	6,000
Thumb and Index Finger of the Same Hand	66,666	20,000	2,667

FOR TOTAL PARALYSIS OF:	Member (\$)	Spouse (\$)	Children (\$)
Quadriplegia / Paraplegia / Hemiplegia	600,000	180,000	80,000

DEFINITIONS

"Loss" shall mean, with respect to hand or foot, actual severance through or above the wrist or ankle joint; with respect to arm or leg, actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or loss of four fingers of the same hand, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers of the hand); with respect to loss of entire finger actual severance through or proximal to the first phalange; with respect to partial loss of finger, actual severance through or above the distal phalange but not through or above the proximal phalange with regard to toes, the actual severance through or above the matatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If the insured suffers complete severance of a hand, foot, arm or leg as described above, the benefit amount specified above will be paid even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to Quadriplegia (paralysis of both upper and lower limbs), Paraplegia (paralysis of both lower limbs) and Hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the insurer.

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

ADDITIONAL BENEFITS

BENEFITS	Maximum Benefit Up to (\$)
Repatriation (Return Home) Benefit	15,000
Rehabilitation Benefit	15,000
Family Transportation Benefit	15,000
Spousal Occupational Training Benefit	15,000
Home Alteration & Vehicle Modification	10% of Insured Person's Principle Sum
Day Care and Special Education Benefit	5% of Insured Person's Principle Sum up to 5,000
Parental Care Benefit	10% of Insured Person's Principle Sum up to 5,000
Seat Belt Benefit	10% of Insured Person's Principle Sum
Identification / Critical Illness Benefit	10% of Insured Person's Principle Sum up to 10,000
In-Hospital Indemnity	1% of Insured Person's Principle Sum per month
Bereavement	1,000
Cosmetic Disfigurement (Third Degree Burn)	25,000

* Contact the Administrative Agent for more information.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane.
- War or any act thereof.
- Flying in aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, pipeline inspection or power line inspection.
- Flying as pilot or crew member in any aircraft or device for aerial navigation.
- Full-time, active duty in the armed forces.

INCOME TAX

Under current tax law, Accidental Death and Dismemberment premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Accidental Death and Dismemberment premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

OCCUPATIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

If you suffer any of the losses shown below and are under the age of 70, as the result of an injury caused solely by external, violent and accidental means while on the premises of your employer, in the course of your job, making a business trip authorized by your employer or reporting to the union hall then travelling to your worksite, and submit a claim within 365 days of the date of such injury, **you** may be eligible to receive a benefit as follows:

BENEFITS

FOR LOSS OF:	Member (\$)
Life (Principle Sum)	200,000
Both Hands or Both Feet	200,000
Entire Sight of Both Eyes	200,000
One Hand and One Foot	200,000
One Hand and Entire Sight of One Eye	200,000
One Foot and Entire Sight of One Eye	200,000
Speech and Hearing in Both Ears	200,000
Brain Death	200,000
One Arm or One Leg	150,000
One Hand or One Foot	150,000
Entire Sight of One Eye	150,000
One Finger of Either Hand	50,000
Speech or Hearing in Both Ears	150,000
Thumb and Index Finger of Same Hand	66,666
Four Fingers of the Same Hand	66,666
Hearing in One Ear	66,666
All Toes of the Same Foot	50,000
Thumb of Either Hand	50,000
Four Fingers of Same Hand	66,666

FOR LOSS OF USE OF:	Member (\$)
Both Arms or Both Feet or Both Hands or Both Legs	400,000
One Hand or One Foot	150,000
One Arm or One Leg	150,000
Thumb and Index Finger of the Same Hand	66,666

FOR TOTAL PARALYSIS OF:	Member (\$)
Quadriplegia / Paraplegia / Hemiplegia	600,000

DEFINITIONS

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

"**Loss**" as used with reference to Quadriplegia (paralysis of both upper and lower limbs), Paraplegia (paralysis of both lower limbs) and Hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"**Loss of Use**" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the insurer.

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

ADDITIONAL BENEFITS

BENEFITS	Maximum Benefit Up to (\$)
Repatriation (Return Home) Benefit	15,000
Rehabilitation Benefit	15,000
Spousal Occupational Training Benefit	15,000
Home Alteration & Vehicle Modification	10% of Insured Person's Principle Sum
Special Education Benefit	5% of Insured Person's Principle Sum up to 5,000
Parental Care Benefit	10% of Insured Person's Principle Sum up to 5,000
Day Care Benefit	5% of Insured Person's Principle Sum up to 5,000

* Contact the Administrative Agent for more information.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Travel to/from the insured person's place of residence to the worksite.
- Intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane.
- War or any act thereof.
- Flying in aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, pipeline inspection or power line inspection.
- Flying as pilot or crew member in any aircraft or device for aerial navigation.
- Full-time, active duty in the armed forces.

INCOME TAX

Under current tax law, Occupational Accidental Death and Dismemberment premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Occupational Accidental Death and Dismemberment premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

SHORT TERM DISABILITY

If you become disabled while covered because of either an illness or accidental injury that is non-occupational and you cannot perform your job duties and are under the age of 70, **you** may be entitled to Short Term Disability benefits as follows:

ELIGIBILITY

To be eligible for this benefit **you** must be:

- Disabled due to a **non-occupational** illness or injury.
- Seen by, treated by, and under the continued care of a licensed physician (M.D) in Canada.
- Covered and be actively at work on the day in which you become disabled (if you are laid-off, on vacation or unemployed then you are not eligible for this benefit).
- Absent from work for more than the waiting period of 7 days (if disabled as a result of a **non-occupational accident** then the 7 day waiting period does not apply).
- Hospitalized for at least 18 hours due to an illness, benefits are payable from the 1st day of hospitalization.
- Under the age of 70.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- Maximum benefit of \$500 per week.
- If you qualify for Employment Insurance (EI) Accident and Sickness benefits, the Short Term Disability Benefit will be frozen when Employment Insurance (EI) Accident and Sickness benefits begin. If you continue to be disabled after exhaustion of your Employment Insurance (EI) Accident and Sickness benefits (maximum 15 weeks), the Plan will resume its Short Term Disability payments to you for a total period of protection of 104 weeks of benefit payments including the period covered by Employment Insurance (EI) Accident and Sickness benefits provided you remain disabled and provide ongoing medical documentation to support your disability.
- If you do not qualify for Employment Insurance (EI) Accident and Sickness benefits, Short Term Disability benefit will be payable as long as you remain disabled up to a maximum of 104 weeks of benefit payments.
- Benefits are paid to a maximum of 104 weeks, inclusive of any weeks paid by Employment Insurance (EI) Accident and Sickness or Employment Insurance (EI) benefits or recovery.

- You may be required to report for a medical examination as often as is reasonable, by a licensed physician (M.D.) of the insurer's choice. Failure to report may result in termination of your benefit payments.
- Be sure to apply for Employment Insurance (EI) Accident and Sickness benefits immediately upon becoming disabled.
- Physician fees incurred during the initial application process may be eligible for reimbursement upon approval.

SUBSEQUENT DISABILITIES

A new waiting period and benefit duration will start, if you return to active full-time work for:

- Four (4) weeks before you again become disabled because of the same or a related cause.
- One (1) week before you again become disabled because of a different or an unrelated cause.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Any day you do any kind of work for pay or profit.
- The period you are entitled to pregnancy or parental leave of absence by statute, contract or employer agreement, except where benefits are provided during the post-natal recovery period.
- The period of illness or injury for which benefits are payable under Employment Insurance (EI) or Employment Insurance (EI) Accident and Sickness Benefits.

No benefit will be paid for any disability that results from or is contributed to by:

- War, whether declared or not.
- Insurrection, rebellion or participation in a riot or civil commotion.
- Purposely self-inflicted injury.
- Your commission of, or attempt to commit, an assault or a criminal offense.
- Any injury or illness caused or contributed to by a motor vehicle accident. This applies to motor vehicle accidents which occur in Ontario and Quebec.
- Failure to report for a medical examination as required substantiating your benefit entitlement.

INCOME TAX

Under current tax law, Short Term Disability benefit payments are taxable to the member in the calendar year in which it was received. Members who were in receipt of Short Term Disability benefit payments in the previous calendar year will receive a T4A every February that indicates the total amount of received in the prior year.

Any Short Term Disability benefit payments received on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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LONG TERM DISABILITY

If you remain totally disabled while covered and are under the age of 65, have received the maximum benefit under the Short Term Disability benefit and are unable to return to active full time employment, then **you** may be eligible for Long Term Disability as follows:

ELIGIBILITY

To be eligible for this benefit, **you** must be:

- Seen by, and treated by, a licensed doctor (M.D.) in Canada.
- Totally disabled and under the ongoing care of a licensed doctor (M.D.) in Canada.
- Totally disabled due to a non-occupational illness or injury.
- Absent from work for more than the waiting period of 104 weeks.
- Coverage will terminate at age 65.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- Maximum benefits of \$1,000 per month for the first 5 years after you become eligible for the benefit and remain totally disabled.
- Should you remain totally disabled after the first 5 years then you may be eligible for a monthly benefit of \$600 for the next 5 years.
- Benefits are paid to a maximum of 10 years, recovery or to the attainment of 65 years of age.
- You may be required to report for a medical examination as often as is reasonable, by a licensed doctor (M.D.) in Canada. Failure to report for a medical examination may result in termination of your benefit payments.
- Benefit payments may be terminated if you are not receiving accepted standard professional treatment for the condition being treated and where appropriate treatment by a relevant and certified specialist.

DEFINITION OF DISABILITY

Totally Disabled means that solely because of a non-occupational illness or non-occupational accidental bodily injury, you are unable to work and continue the duties of any occupation for which you are suited because of your education, training or experience.

RECURRENT DISABILITY

If you return to full-time work and become disabled due to the same or related cause, a new waiting period and benefit duration will start as follows:

- When you return to active full-time work after being totally disabled, the period for which you began working and the subsequent disability must be less than 24 months.
- The above will be deemed to be one period of total disability with only the initial waiting period applying, provided the first period begins while you are covered under this benefit.

RECOVERY OF BENEFITS

If you receive a benefit under this plan in excess of what should have been paid, the insurer has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- The period you are entitled to pregnancy or parental leave by statute, contract or employer arrangement.
- Any day for which you are entitled to benefits under the Short Term Disability Benefit or any illness or injury which benefits are payable under the Provincial Automobile Insurance Act.
- War, whether declared or not.
- Insurrection, rebellion or participation in a riot or civil commotion purposely self-inflicted injury.
- Commission of, or attempt to commit, any assault or criminal offence.
- Chronic alcoholism or use of narcotics, barbiturates or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated.
- Any injury or illness caused or contributed to by a motor vehicle accident. This applies to motor vehicle accidents which occur in Ontario and Quebec.

INCOME TAX

Under current tax law, Long Term Disability benefit payments are taxable to the member in the calendar year in which it was received. Members who were in receipt of Long Term Disability benefit payments in the previous calendar year will receive a T4A every February that indicates the total amount of received in the prior year.

Any Long Term Disability benefit payments received on behalf of the member must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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PERMANENT TOTAL DISABILITY ACCIDENT BENEFIT

If you become totally and permanently disabled as the result of an accident, are under the age of 70 and are unable to engage in your occupation or employment, **you** may be eligible for the Permanent and Total Disability Accident benefit as follows:

ELIGIBILITY

To be eligible for this benefit, **you** must be:

- Continuously disabled and unable to work for a period greater than 1 year due to being disabled as the result of an accident.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- A maximum benefit of \$300,000.

DEFINITION OF DISABILITY

You must be totally and permanently disabled as the result of being in an accident, which means the complete inability, after 1 year of continuous total disability, to engage in any occupation or employment for which you are fitted by reason of education, training or experience for the remainder of your life.

The inability to perform your own occupation must commence within 30 days from the date of the accident.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for any accidental injuries you sustain as a result of any of the following:

- Flying in an aircraft, vehicle or device for aerial navigation:
 - For test or experimental purpose that you are operating, learning to operate or serving as a crew member;
 - That is operated by or under the direction of any military authority (this does not include transport type aircraft which is operated by the Canadian Air Transport Command or any other countries similar type of air transport service).
- Intentionally self-inflicted injuries, suicide or any attempt, while sane or insane.
- Declared or undeclared war or any act thereof.

- Losses occurring while the insured person is serving on full-time active duty in the Armed Forces of any country or international authority.
- Any injury or illness that is the result of non-accidental means.

INCOME TAX

Under current tax law, Permanent Total Disability Accident Benefit premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Permanent Total Disability Accident Benefit premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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LONG TERM CARE INSURANCE

If you or your eligible spouse suffers from a prolonged or chronic illness and are over the age of 18, **you or your eligible spouse** may be eligible for Long Term Care Benefits as follows:

ELIGIBILITY

To be eligible for this benefit, **you or your eligible spouse** must be:

- Not needing Long Term Care at that time you become eligible for Long Term Care coverage.
- Not be able to perform at least 2 of the 6 “activities of daily living” without assistance due to a loss of functional capacity.
- Require “substantial supervision” to protect your health and safety due to a cognitive impairment.

BENEFITS

If you have met the eligibility requirements, **you or your eligible spouse** may be eligible for the following benefits:

- A maximum daily indemnity benefit of up to **\$50 per day** if you qualify as needing long term care.
- A maximum daily reimbursement benefit of up to **\$100 per day** toward the cost of eligible long term care expenses (provided supporting documentation is submitted to substantiate the expenses).
- The lifetime maximum benefit is \$175,000 per person.

ELIMINATION PERIOD

For each period during which you or your spouse needs long term care, no benefit is payable for the first 90 days. This waiting period, or “elimination period”, begins on the first documented date that the person is considered to need long term care. After this 90 day period, benefits will be payable for the rest of the qualifying period of care.

If the person who needs long term care recovers and then needs care once again, the second period of care will be considered a continuation of the first one if the two periods are less than 180 days apart and are due to related causes. For periods of care that do not meet these conditions, a new elimination period will apply each time.

ACTIVITIES OF DAILY LIVING

- **Bathing:** washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** the ability to maintain control of bladder function, or when unable to maintain control of the bowel or bladder function, the ability to perform associated personal hygiene (including care for catheter or colostomy bag).
- **Dressing:** putting on and taking off all necessary items of clothing and any necessary braces, fasteners or artificial limbs.
- **Eating:** feeding oneself by getting food, already prepared and made available, into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- **Toileting:** getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
- **Transferring:** moving into or out of a bed, chair or wheelchair with or without the use of equipment.
- **Substantial Supervision:** continual supervision which may include cueing by verbal the chronically ill person from threats to health or safety (such as may be a result from wandering).

EXCLUSIONS AND LIMITATIONS

The Plan does not cover or pay benefits for any claim, care or treatment directly or indirectly related to:

- Home care services and home health care services provided by an immediate family member (e.g., spouse, daughter or son), who may or may not be a nurse, unless provided through an agency;
- Confinement, services or care received while in a hospital that is not a long term care facility (charges that exceed what the provincial health plan covers, such as private duty nursing, may be covered by this Plan);
- Neurosis, psychoneurosis, psychopathy, psychosis or any other mental or nervous disorder without demonstrable organic disease. Note: Brain disorders with demonstrable organic cause (such as Alzheimer's Disease and related dementia) are covered if symptoms are exhibited or a diagnosis is made;
- Alcoholism, drug addiction or other chemical dependence; however, this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment by a physician in the course of treatment for an injury or sickness;
- Confinement, services or care for which no charge is normally made in the absence of insurance;
- Care or treatment provided outside of Canada or the United States;

- Any charges for the comfort and convenience of the chronically ill person such as, but not limited to televisions, telephones, beauty care and entertainment. Also excluded are any charges for medications;
- War or act of war (whether declared or undeclared);
- Participation in a felony, riot or insurrection;
- Service in the armed forces or units auxiliary thereto;
- Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
- Commission of any attempt to commit a criminal act; or
- An injury sustained because of involvement in an illegal occupation.

INCOME TAX

Under current tax law, Long Term Care premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Long Term Care premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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SECOND OPINION MEDICAL BENEFIT - CARENAV

If you or your eligible spouse suffers from a prolonged or chronic illness and are over the age of 55, you and your eligible spouse may be eligible for Second Opinion Medical Benefit - CareNav as follows.

CareNav provides you with the knowledge to understand your diagnosis and treatment options. Through connecting your treating physicians with world-renowned professional specialists, CareNav offers the finest medical expertise to confirm or modify a diagnosis and provide care when you are diagnosed with a serious illness.

CareNav provides access to the most prominent specialists world-wide. This can make the difference between early detection and a speedy recovery instead of a long difficult illness.

The CareNav services are available to you upon diagnosis of a serious illness. These services include:

- Review & Second Opinion – CareNav provides a thorough review of your relevant medical records by world-class specialists to provide a confirmation of the diagnosis.
- Care Coordination – If you cannot locate a specialist, CareNav will find the best one suited to your specific needs. If out-of-town travel is required, referrals, appointments and accommodations will be arranged.
- Out-of-Country Care Coordination – Should out-of-country care become necessary, CareNav will provide you with Care Coordination services to help you locate the best facility and professional care you require.

To access the CareNav special assistance services you can contact their toll free number at 1-866-450-6434.

CRITICAL ILLNESS

If you or your eligible spouse become diagnosed with a critical illness and are under the age of 70, **you or your eligible spouse** may be eligible for the Critical Illness benefits as follows:

ELIGIBILITY

To be eligible for this benefit, **you or your eligible spouse** must be:

- Covered at the time of diagnosis and be diagnosed by a licensed physician (M.D.) in Canada.
- Survive for at least 30 days after diagnosis of the illness has been made.

INSURED CONDITIONS

- Diagnoses must be made in Canada for one (1) of the following eligible conditions:

ELIGIBLE CRITICAL ILLNESS CONDITIONS:		
Life Threatening Cancer	Coronary Artery Bypass Graft	Alzheimer's Disease
Multiple Sclerosis	Loss of Sight, Speech or Hearing	Benign Brain Tumor
Heart Attack	Major Organ Transplant	Heart Valve Replacement
Kidney (Renal) Failure	Paralysis - Quadriplegia	Motor Neuron Disease
Stroke	Paraplegia, Hemiplegia	Parkinson's Disease
Coma	Severe Burn	Aplastic Anemia
Aortic Surgery	Loss of Independent Existence	Occupational HIV Infection

BENEFITS

If you or your spouse have met the eligibility requirements, **you or your eligible spouse** may be eligible for the following benefits:

- Member - A maximum benefit of \$25,000.
- Spouse - A maximum benefit of \$ 5,000.
- The amount payable will be reduced by 50% if you are age 65 or older on the date the benefit becomes payable.

NON-LIFE THREATENING CANCER

Non-Life Threatening Cancers that are positively diagnosed by a licensed physician (M.D.) in Canada and supported with a pathological report will be subject to 25% of the benefit amount. Only one claim per non-life threatening condition is permitted as per below:

- Malignant melanoma to a depth of 0.75 mm or less, excluding malignant melanoma in situ;

- Basal or squamous cell carcinoma that has spread beyond the deepest layer of skin and has not metastasized;
- Stage A Colon Cancer;
- Carcinoma in situ;
- Early prostate cancer diagnosed as T1a or T1b; or
- Any tumor in the presence of any Human Immunodeficiency (HIV).

SECOND EVENT BENEFIT

If the Insured Individual is diagnosed with Cancer for which the Critical Illness benefit has been paid and the Insured Individual has thereafter been actively at work for at least 90 days and is subsequently diagnosed with a Heart Attack, Stroke, Coronary Artery Bypass Graft, Alzheimer's Disease, Coma, Loss of Sight, Speech or Hearing, Motor Neuron Disease, Multiple Sclerosis, Parkinson's Disease, Quadriplegia, Paraplegia, Hemiplegia, Aplastic Anemia, Severe Burn, Aortic Surgery or Occupational HIV Infection then a Second Event Benefit equal to the Benefit Amount will be payable. The Second Event Benefit is subject to the Insured Individual surviving for 30 days after the diagnosis of the second event.

If the Insured Individual is diagnosed with a Heart Attack, Stroke, Aortic Surgery or Coronary Artery Bypass Graft for which the Principal Sum has been paid and the Insured Individual has thereafter been actively at work for at least 90 days and is then diagnosed with Cancer, Alzheimer's Disease, Coma, Loss of Sight, Speech or Hearing, Motor Neuron Disease, Multiple Sclerosis, Parkinson's disease, Quadriplegia, Paraplegia, Hemiplegia, Aplastic Anemia, Severe Burn or Occupational HIV Infection then a Second Event Benefit equal to the Principal Sum will be payable. The Second Event Benefit is subject to the Insured Individual surviving 30 days after the diagnosis of the second event.

The Second Event Benefit is payable only once. Payment of Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, while sane or insane.
- Declared or undeclared war, or any act of declared or undeclared war.
- Participation or commission of or attempt to commit a felony.
- Voluntary participation in any riot or civil insurrection.
- Any illness specifically excluded from the definition of any critical illness.

INCOME TAX

Under current tax law, Critical Illness premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Critical Illness premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

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HOSPITAL CASH

If **you or your eligible dependents** become hospitalized and are under the age of 70, you may be eligible to receive a daily cash benefit for the duration of your hospital stay.

ELIGIBILITY

To be eligible for this benefit, **you or your eligible dependents** must be:

- Admitted to a recognized hospital anywhere for a minimum of 3 consecutive days.
- Hospital stays of less than 3 days do not qualify for this benefit. Once you have been confined to a recognized hospital for more than 3 consecutive days, your benefit will include the first 3 consecutive days.
- Dependent children must be over the age of 14 days to be eligible.

BENEFITS

If you have met the eligibility requirements, **you or your eligible dependents** may be eligible for the following benefits:

- A maximum daily benefit of \$150.
- A maximum benefit period of 120 consecutive days.

DEFINITION OF HOSPITAL

“**HOSPITAL**” means an incorporated or licensed hospital having accommodation for resident bed patients, a laboratory, a registered graduate nurse always on duty and an operating room where surgical operations are performed by a legally qualified physician or surgeon. The term “Hospital” shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness. The term “Hospital” shall also include a rehabilitation hospital when recommended by a physician, and if you are transferred directly from a hospital to a rehabilitation hospital. Only in the event where a concurrent transfer from a hospital to a rehabilitation hospital is not feasible will a grace period of 14 days be provided for the admittance to a rehabilitation hospital.

The Hospital Cash Benefit is available for claims incurred outside of Canada so long as the standard definition of “hospital” is met and the valid discharge papers are submitted to the Administrative Agent.

SUBSEQUENT HOSPITALIZATION

If under the unfortunate circumstance you require further hospital confinement, or your situation requires more than one period of hospitalization for the accident or illness, then the full benefit will be reinstated provided that at least 61 days has elapsed from your last paid hospitalized day.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, while sane or insane.
- Declared or undeclared war, or any act of declared or undeclared war.
- Flying in an aircraft, vehicle or device for aerial navigation:
 - For test or experimental purpose that you are operating, learning to operate or serving as a crew member;
 - That is operated by or under the direction of any military authority (this does not include transport type aircraft which is operated by the Canadian Air Transport Command or any other countries similar type of air transport service).
- Losses occurring while the insured person is serving on full-time active duty in the Armed Forces of any country or international authority.
- Any injury or illness that is the result of non-accidental means.

INCOME TAX

Under current tax law, Hospital Cash premiums paid to an insurance company are taxed as income to the member in the calendar year in which it was received. Members who were covered for this benefit in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of premium paid in the prior year.

Any Hospital Cash premiums paid on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

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EXTENDED HEALTH CARE

If **you or your eligible dependents** incur reasonable and customary expenses for any of the services and supplies listed below, you will be reimbursed for the eligible expenses as described. These services and supplies must be recommended by a legally qualified physician in Canada, where indicated, and received while you are insured for either an illness, including pregnancy, or injury that is non-occupational.

MAXIMUM LIFETIME BENEFIT

The maximum amount payable under this benefit is \$1,000,000 per eligible dependent. This amount applies separately to you and each eligible dependent.

PERCENTAGE PAYABLE

This is the percentage of covered charges that are paid.

- 50% for custom made orthotics
- 100% for all other eligible covered expenses.

PRESCRIPTION DRUGS BENEFIT

You and your eligible dependents are covered for prescription drug charges as follows:

- Prescription drugs must be medically necessary and used to treat a bona fide, serious medical condition.
- Prescription drugs must be prescribed by a licensed physician (M.D.) or dentist or other professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or licensed physician (M.D.) legally authorized to dispense such drugs in Canada.
- Prescription drugs must be approved for sale by the Canadian Government and must contain a Drug Identification Number (DIN).
- Prescriptions drugs are limited to a maximum of a 3-month supply at any one time.
- Eligible opioids medication will be covered up to a lifetime maximum benefit of \$50,000.
- You and your eligible spouse will be provided a **Prescription Drug Benefit Card** that you **must present to your pharmacist** when purchasing your prescription drugs for you and your eligible dependents.

PRESCRIPTION DRUG BENEFIT CARD

Once you satisfy the eligibility requirements, you and your eligible spouse will be provided with a Prescription Drug Benefit Card to be used as follows:

- For the purchase of all your eligible prescription drug expenses.
- It is critical that the Administrative Agent have complete, accurate and up-to-date information on you and your dependents.
- In the event your Prescription Drug Benefit Card does not work at the pharmacy due to incomplete information, please contact the Member Services Department **Toll Free at 1-888-790-3534**.
- If you are **not** in benefit at the date of your prescription drug purchase, your Prescription Drug Benefit Card will not work and you will be required to purchase the medication directly at the pharmacy.
- Should your Prescription Drug Benefit Card not function at the pharmacy and you are in benefit, you may purchase the medication and submit the drug receipt along with a completed claim form for assessment to Member Benefit Card Services Department.
- Prescribed drugs must be approved and used for the purpose identified by Health Canada.
- Certain drugs that are medically necessary and appropriate for the plan to cover need to be pre-approved prior to purchase. Please contact the Member Services Department at 1-888-790-3534 for more information.

WHAT PRESCRIPTION DRUGS/MEDICATIONS ARE NOT ELIGIBLE

The prescription drug plan does not reimburse the following:

- Drugs that can be purchased as over the counter medication or without a prescription.
- Drugs that are associated with dietary, anti-obesity, health foods, nutritional products, anabolic steroids, experimental drugs, vitamins, supplements, homeopathic medications, immunizations, injectibles, fertility, erectile dysfunction and inter-uterine devices (IUD).
- Drugs that are used for non-medically necessary purposes and provided directly by a physician or hospital.
- Prescribed drugs for sale in Canada not approved by Health Canada will not be reimbursed by the benefit plan if purchased outside of Canada.
- Lost, damaged, stolen or spoiled prescription drugs **will not** be covered by the drug plan.
- Any drugs purchased outside of Canada.

GENERIC SUBSTITUTION

Many brand name drugs on the market have a generic equivalent. In Canada, a generic drug has the same active ingredients as the brand name drug.

It is recommended that you ask your physician to prescribe a less expensive generic equivalent drug if one is available. This does not mean that your health care will be negatively impacted because, in Canada, the generic drug has the same active chemical ingredients as a brand name drug.

Generic substitution is the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your physician and is the normal practice of many pharmacists for a limited number of drugs.

DISPENSING FEES

Dispensing fees are a significant cost to the member and the benefit plan. Members can help keep costs down by shopping around, as some drug stores can charge more than twice as much as others.

TRILLIUM DRUG PROGRAM

The Trillium Drug Program helps to cover the cost of drugs if your drug costs are high compared to income level. Serious illnesses can have higher than normal drug costs; therefore, a member can combine benefits from the Program and their benefit plan to cover up to 100% of costs along with a deductible. The Trillium Drug Program covers drugs that are approved under the Ontario Drug Program (ODB).

The following criteria are to be met in order to qualify:

- The LiUNA Local 183 Members Benefit Drug Plan does not cover 100% of the prescription drug costs;
- Must have valid coverage through the Ontario Health Insurance Plan (OHIP);
- Must not be covered under the Ontario Drug Benefit (ODB) Program.

For more information on the Trillium Drug Program, please call 1-800-575-5386.

ONTARIO DRUG BENEFIT (ODB) PROGRAM

Active members living in Ontario that are over 65 years of age can qualify for the Ontario Drug Benefit (ODB) Program, a government paid prescription drug expense program that provides access to about 3,200 drugs. The Members Benefit Drug Plan will reimburse members the \$100 Ontario Drug Benefit deductible and up to a maximum of \$6.11 per prescription for Ontario Drug Benefit dispensing fee charges.

Pharmacies will coordinate reimbursements directly with the Ontario Drug Benefit Program.

For more information on the Ontario Drug Benefit (ODB) Program, please call 1-866-811-9893.

HEALTH PRACTITIONERS

You and your eligible dependents are covered for charges by the following health practitioners:

- Clinical Psychologist, Psychotherapist, Occupational Therapist, Podiatrist / Chiropract, Massage Therapist, Physiotherapist, Naturopath, Osteopath, Chiropractor and Acupuncturist up to a maximum charge of \$50 per visit up to an overall combined practitioner maximum of \$1,000 per calendar year.
- Speech Therapy up to a maximum charge of \$200 per visit.
- Psychoanalyst who is a licensed physician (M.D.) if the insured person is not hospitalized (for Quebec residents only).
- Treatments by a Physiotherapist, Massage Therapist and Speech Therapist must be prescribed by a licensed physician (M.D.) in Canada as to duration and type and claims must be accompanied by a M.D. referral. If the treatment is required for more than 1 year, a M.D. referral is required on an annual basis.

AMBULANCE

You and your eligible dependents are covered for transportation by a licensed ambulance. Covered charges are in excess of the amount payable under your Provincial Health Plan, excluding air or rail ambulance service. Ambulance transportation coverage is as follows:

- From the place of injury (or where illness struck) to the nearest hospital where treatment is available.
- Directly from the first hospital where treatment is given to the nearest hospital for needed specialized treatment not available at the first hospital.
- From a hospital to a convalescent hospital / rehabilitation hospital.

DENTAL CARE FOR ACCIDENTAL INJURY

You and your eligible dependents are covered for services by a legally qualified Dentist for prompt repair of sound natural teeth when required because of a non-occupational injury or loss caused solely by external and accidental means within Canada.

Accidental Dental services must be commenced within 90 days of the accident causing the injury or loss and be completed within 12 months from the date of the accident.

ORTHOPEDIC SHOES

You and your eligible dependents are covered for custom made orthopedic shoes as follows:

- One (1) pair every 24 months up to a maximum reimbursement of \$500.
- Custom made Orthopedic shoes must be prescribed by a licensed Physician (M.D.) or specialist and dispensed by a Pedorthist, Orthotist, Podiatrist or Chiropodist in Canada.
- Custom made Orthopedic shoes (including repairs) must be specially designed and molded to correct a diagnosed physical impairment, provided that the following information is supplied:
 - A diagnosis, including a list of symptoms and the primary complaint;
 - A description of the physical findings from the clinical examination;
 - A brief description of the abnormal walking pattern associated with the diagnosis (a gait analysis); and
 - Confirmation that the product has been custom made.

ORTHOTICS

You and your eligible dependents are covered for custom made Orthotics as follows:

- One (1) pair up to 50% of their purchase price to an overall maximum benefit of \$250 per calendar year.
- Custom made Orthotics must be prescribed by a licensed Physician (M.D.) or specialist in Canada and dispensed by a Pedorthist, Orthotist, Podiatrist or Chiropodist and must be specially designed and molded to correct a diagnosed physical impairment, provided that the following information is supplied:
 - A diagnosis, including a list of symptoms and the primary complaint;
 - A description of the physical findings from the clinical examination;
 - A brief description of the abnormal walking pattern associated with the diagnosis (a gait analysis); and
 - Confirmation that the product has been custom made.

HEARING AIDS

You and your eligible dependents are covered for Hearing Aids as follows:

- To a maximum benefit of \$750 every 36 months for one set of hearing aids when provided by a certified clinical audiologist in Canada including any replacement, repair charges and batteries.

VISION CARE

You and your eligible dependents are covered for Vision care services as follows:

- Maximum combined benefit of \$400 once every 24 months includes one (1) set of eyeglasses (lenses and frame combined) or contact lenses in lieu of eyeglasses. Included in the vision care benefit is one (1) eye exam. Remaining balances cannot be applied to future claims.
- One (1) set of replacement lenses up to a maximum of \$100 only if your prescription changes or lenses become damaged within the same twenty-four (24) month period covered under Vision Care, as per above.
- Corrective Laser Eye surgery up to a lifetime maximum reimbursement of \$1,000.
- Following Cataract Surgery, Intra-ocular lens (IOL) is covered up to a lifetime maximum of \$250 for single focal lens per eye and \$600 for multi focal lens per eye, IOL measurements and physician fees **not** covered.
- All lenses must be prescribed by a legally qualified optometrist or ophthalmologist in Canada and must be for the correction of vision defects.
- A completed claim form must be submitted with the original paid receipts including final payment date and a copy of the original prescription.
- Eyeglasses or contact lenses must be purchased in Canada, Laser Eye surgery and Cataract Surgery must be performed in Canada.

You will not be reimbursed for the following:

- Nonprescription reading glasses, sunglasses, tinted other than (type 1 or 2) glasses, anti-reflective coatings or safety glasses.

OUT OF HOSPITAL NURSING

You and your eligible dependents are covered for Nursing care services as follows:

- Home nursing care performed by a legally qualified Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.), Registered Practical Nurse (R.P.N.) or Victorian Order Nurse (V.O.N.) in Canada.
- Your nurse cannot be related to you by blood or marriage or a member of your family and not normally a resident in your home.

- Services must be ordered by a licensed physician (M.D.) in Canada as medically necessary for a disability that requires the specialized training of a nurse.
- Home Nursing care will be eligible up to a maximum lifetime benefit of \$5,000.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Prior to incurring any major expenses, you should submit details to the Administrative Agent to determine payable benefits. In any event, a letter will be required by a licensed physician (M.D.) describing the nature of the disability and type, medical need and estimated duration of any required durable medical equipment.

You and your eligible dependents are covered for the rental of or at the Insurers discretion, the purchase of Durable Medical Equipment and Supplies as follows:

- Respiratory equipment, kidney dialysis equipment, oxygen, hypodermic needles and catheters.
- Wheelchairs, Hospital Beds, Iron Lungs or similar mechanical equipment.
- Splints, Canes, Crutches, Walkers, Trusses, Casts and Dennis Browne splints.
- Rigid or Semi-Rigid Back, Neck, Arm or Leg Braces once (1) every five (5) years per limb.
- Non-dental prosthesis such as artificial limbs and eyes, including replacement if required due to a change in physical condition.
- Injectables, needles, syringes, diabetic testing agents, insulin, glucometers and infusion pumps when patient is insulin dependent.
- Apnea monitors.
- One (1) external breast prosthesis to a maximum of \$500 per breast per lifetime.
- Two pairs of surgical brassieres, per calendar year.
- Two pairs of custom graduated compression stockings with a minimum compression factor of 20mmgh or higher per calendar year.
- Wig once per lifetime up to a maximum of \$500.
- Sclerotherapy (Vein Injections) is limited to \$20 per visit up to a maximum of \$2,500 per calendar year.

The Durable Medical Equipment and Supplies benefit does not cover the following:

- Items for personal comfort, convenience, exercise, safety, self-help or environmental control.
- Items which may be used for non-medical reasons, such as but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, whirlpool baths or saunas.

ONTARIO ASSISTIVE DEVICES PROGRAM (ADP)

The Ontario Assistive Devices Program (ADP) may provide reimbursement for certain expenses up to 75% of the cost. Eligible items are breast, limb and eye prosthesis, respiratory equipment, communication aids, ostomy supplies, visual aids, wheelchairs, etc. Claims for these types of services must be forwarded to ADP with the balance being submitted to the Plan for consideration.

INSULIN PUMPS

The Ontario Assistive Devices Program (ADP) provides funding assistance to eligible Ontario residents of all ages with type 1 diabetes. The program covers 100% of the cost of an insulin pump (up to a maximum of \$6,300) paid directly to the supplier on behalf of the recipient. The program will also cover \$2,400 (\$600 every three months) per year for supplies paid directly to the recipient. Members and eligible dependents that do not qualify for Adult Insulin Program should submit their claim for an insulin pump for pre-approval under the LiUNA Local 183 Members' Benefit Fund.

OSTOMY SUPPLIES

The Ontario Assistive Devices Program (ADP) provides funding assistance to eligible Ontario residents that have a permanent colostomy, ileostomy, urostomy, ileal conduit or continent pouch/reservoir. The program does not pay for supplies for persons with a temporary ostomy. The program will pay \$600 (\$300 every six months) per year directly to the recipient for supplies if eligible. Any additional costs should be submitted to the LiUNA Local 183 Members' Benefit Fund for consideration.

For more information on the Ontario Assistive Devices Program (ADP), please call 1-800-268-6021.

OVERALL LIFETIME BENEFIT MAXIMUM RESTORATION / REINSTATEMENT

The maximum amount payable under this benefit is set out under the Summary of Benefits. This amount applies separately to you and each member of your family.

On each January 1, up to \$1,000 of the Overall Lifetime Benefit Maximum which has been paid by the insurer will be restored. When an insured person's maximum is at least \$1,000 lower than the Overall Lifetime Maximum, such person may have it reinstated to the Overall Lifetime Benefit Maximum by submitting evidence of such person's insurability satisfactory to the insurer.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- For drugs, sera or injectible drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis.
- Any expenses incurred and submitted for cosmetic/lifestyle purposes.
- If the payment is prohibited by law.
- That a covered person may obtain as a benefit under any governmental plan or law.
- For which no charge would have been made in the absence of this coverage.
- For dental work, except as provided under Dental Care for Accidental Injury.
- Expenses submitted more than 18 months after the date of service are not covered.
- Expenses incurred outside of Canada will not be eligible for reimbursement.

No amount will be paid for any charge incurred that results from or is contributed by:

- War, whether declared or not.
- Insurrection, rebellion or participation in a riot or civil commotion.
- Purposely self-inflicted injury.
- The commission or, attempt to commit, an assault or a criminal offence.

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SPECIAL MEDICAL / HOSPITAL COVERAGE WHILE IN CANADA

This Plan provides **you and your eligible dependents**, under the age of 70, with coverage for many services rendered in Canada while you wait for your provincial health plan's coverage to become effective.

ELIGIBILITY

To be eligible for this benefit **the member** must be:

- A non-Canadian Citizen and a Member of Local 183 who is working for a contributing employer.
- Not covered under a provincial health plan in Canada.
- In the process of obtaining proper documentation to become a legal resident in Canada.
- Your dependents will be eligible for coverage if you satisfy the above eligible requirements for this benefit.

If you are seeking landed immigrant status and have not yet been approved and you have met the above requirements, you may be eligible for coverage under one of the following circumstances:

- During the first 3 months of being a sponsored landed immigrant.
- Prior to obtaining conventional refugee status.
- Prior to approval of business class, skilled worker, in Canada sponsorship and similar landed immigrant applications.

BENEFITS

If you have met the eligibility requirements, **you and your eligible dependents** may be eligible for the following benefits:

- Medical coverage for expenses in Canada up to a maximum of \$25,000 per occurrence.
- Up to a lifetime maximum of \$250,000 per individual.
- Reimbursement of reasonable and customary hospital charges or convalescent hospital charges, including room and board up to the ward level of accommodation.

Expenses incurred for the following:

- Blood plasma, whole blood and oxygen.

- X-rays and laboratory examinations which are required for diagnostic purposes.
- Artificial limbs, eyes or other prosthetic appliances.
- Casts, splints, crutches, trusses, braces (except dental braces), one pair of orthopedic shoes per policy year, if part of a brace, and wheelchairs.
- Expenses for physician or surgeon fees incurred in Canada, which means the reasonable and customary fees for medical care and treatment or surgical procedure performed by a legally qualified physician or surgeon.
- Expenses of an annual health examination, upon completion of 180 days eligibility in any one calendar year.
- Out-patient services provided by a Hospital.
- Expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of \$2,000 as the result of any one accident.

PERIOD OF COVERAGE

You and your eligible dependents are covered under this plan while in Canada.

DEFINITIONS

- **“HOSPITAL or CONVALESCENT HOSPITAL”** means a legally constituted institution which is licensed as a hospital (if hospital licensing is required where the institution is situated), which is open at all times and is operated for the care and treatment of sick and injured persons as in-patients, which has a staff of one or more licensed physicians available at all times, which continuously provides 24 hour nursing by graduate registered nurses, which provides organized facilities for diagnostic and major surgery, and which is not primarily a clinic, rest home, convalescent home, nursing home or home for the aged, health spa or similar establishment.
- **“INJURY”** means bodily injury which is sustained as a direct result of an unintended and unanticipated accident, occurring in Canada, that is external to the body and that occurs while your coverage under this Policy is in force, which causes a loss covered by the Policy which you are in Canada.
- **“SICKNESS”** means the onset of sickness or disease requiring medical treatment, care or advice while you or your eligible dependents are in Canada which causes a loss covered by this Policy.
- **“ACTIVELY AT WORK”** means actually at work on a full-time basis at your place of employment during your stay in Canada.

EXCLUSIONS AND LIMITATIONS

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- Any charges other than those listed above.
- Cosmetic surgery or treatment, unless such surgery or treatment is for accidental injuries incurred while this policy is in effect.
- Charges levied by a physician for time spent traveling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known prior to your or your eligible insured dependents' arrival in Canada.
- A sickness or injury that, at the time of arrival in Canada, might reasonably be expected to require you or your eligible insured dependents to undergo treatment, surgery or hospitalization.
- Suicide or any attempt at suicide while sane or insane.
- Intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, while you or your eligible insured dependents are sane or insane.
- Dental surgery or cosmetic surgery unless such surgery is a result of a covered injury.
- Emotional or mental disorders unless you or your eligible insured dependents are confined in a Hospital.
- Cost of prescription and non-prescription drugs and medicines.
- Fees for services of a licensed chiropractor, physiotherapist or massage therapist.
- If you are eligible for Ontario Health Plan (OHIP) then your dependents are not eligible for this plan.

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DENTAL CARE

You or your eligible dependents may incur reasonable and customary charges for services and supplies provided by or under the supervision of a licensed, certified or registered oral surgeon or dentist within Canada. Eligible services are those that are recommended as necessary by a physician or dentist. Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of his/her license.

Members may choose to either have their dental care provided by the Insured Dental Plan or by enrolling in the LiUNA Local 183 Dental Clinic. LiUNA Local 183 Dental Clinic Members and their eligible dependents must use the Dental Clinic for their Dental Care needs. Members and eligible dependents enrolled in the LiUNA Local 183 Dental Clinic that incur services outside of the LiUNA Local 183 Dental Clinic, while enrolled in the Clinic, will **not** be eligible for reimbursement.

The following chart provides an illustration of the dental coverage provided under the Plan.

Summary of Dental Care Benefits		
Dental Clinic / Insured Plan	<ul style="list-style-type: none"> • Calendar Year Maximum • Dental Fee Guide Reimbursement • Diagnostics: exams, x-rays • Endodontics: root canals • Periodontics: root planing and surgery • Preventative: polishing, scaling, fluoride • Dentures: Partial • Dentures: Complete • Crowns / Bridgework / Implants • Restorative: fillings, crowns • Surgical: extractions, oral surgery • Orthodontics: (dependent children 18 years of age or younger) 	<ul style="list-style-type: none"> • \$3,000 per person / year • 2014 O.D.A. • 100% • 100% • 100% • 100% • 80% • 100% • 100% • 100% • 100% • 60% • (max of \$2,500 per lifetime)

BENEFITS

The total benefits payable are subject to the following maximums:

		<u>Calendar Year Maximum (per individual)</u>
Dental Clinic / Insured Plan	-	\$3,000 per Calendar Year
		<u>Lifetime Maximum (Dependent Children Only – 18 years of age or younger)</u>
Orthodontics	-	\$2,500 Lifetime Maximum

PERCENTAGE PAYABLE

This is the percentage of covered charges that are paid. Covered Charges are charges up to the amount shown in the Fee Guide for needed Dental Care, services or supplies, while you are covered for either a disease or injury that is non-occupational.

DENTAL FEE GUIDE

Payments under the **Insured Dental Plan** will be based on the **2014 Ontario Dental Fee Guide**.

ROUTINE DENTAL CARE SERVICES

You and your eligible dependents are covered for charges up to the benefit maximum as follows:

- Oral examinations, prophylaxis (light scaling and polishing of teeth) and bite-wing X-rays, up to once every 6 months.
- Scaling, root planing or occlusal equilibration (limited to 8 units per calendar year for all procedures combined).
- Fluoride treatment for the maintenance of sound natural teeth (dependent children age 16 or younger).
- Dental X-rays (full mouth series of X-rays or Panoramic X-ray once every 24 months).
- Complete exams covered once in every 24 months.
- Fillings, including porcelain fillings on all teeth and surfaces.
- Oral surgery and extractions for the removal of teeth, including the excision of impacted wisdom teeth.
- Anesthesia and its administration when made necessary due to a dental procedure.
- Space maintainers and pre-fabricated full coverage restorations for primary teeth.
- Repair, relining or rebasing of dentures.
- Repair or re-cementing of crowns, inlays, onlays or bridges.
- Periodontal treatment for disease of the bone and gums of the mouth, including tissue grafts, bone grafts and occlusal guards, but not athletic guards.
- Endodontic treatment, including initial root canal therapy and pulp conservation and root resection.
- Root canal once per lifetime per tooth.
- Scaling and cleaning of teeth may be done by a licensed dental hygienist.
- Fee for the root canal has been reduced by ½ of the fee paid for pulpectomy.

MAJOR RESTORATIVE SERVICES

You and your eligible dependents are covered for charges up to the benefit maximum as follows:

DENTURES

- First installation, including adjustments, of partial, permanent or complete temporary or permanent removable dentures to replace 1 or more natural teeth extracted while you are covered if you are covered for less than 12 consecutive months.
- Denture adjustments that occur more than 3 months after installation.
- Replacement of an existing partial or full removable denture, if it was installed at least 5 years before and cannot be made serviceable or is a temporary full denture which replaces one or more natural teeth extracted while the person is covered if the person has been covered for less than 12 months, and for which replacement by a permanent denture is required and takes place within 1 year from the date the temporary denture was installed. The cost of a temporary denture will be deducted from the cost of a permanent denture.
- Addition of teeth to an existing partial denture, if required to replace 1 or more natural teeth extracted while the person is covered.
- Installation, adjustment, repair, relining or rebasing of dentures may be done by a dentist, denture therapist, technician or mechanic, who is registered and practicing within the scope of his/her license.
- Denture Relines/Rebases are covered once every 24 months per arch.
- Denture repairs/adjustments are not eligible within 3 months of the date the denture was inserted.
- Cost of denture may apply towards Initial Bridge when missing 3 or more teeth within the same arch.

CROWNS, INLAYS, ONLAYS

- Inlays, onlays, gold fillings and crowns.
- First installation of inlays or onlays, and crowns are covered when a natural tooth has extensive loss.
- Replacement of an existing inlays, onlays, and crown, but only if it was installed at least 5 years before and cannot be made serviceable.

BRIDGEWORK

- First installation of a fixed bridge is covered when 2 or less natural teeth have been extracted while insured under the LiUNA Local 183 Members' Benefit Fund.
- Replacement of an existing bridge, but only if it was installed at least 5 years before and cannot be made serviceable.

IMPLANTS

- First installation of an implant is covered if the natural tooth (teeth) have been extracted while insured under the LiUNA Local 183 Members' Benefit Fund.
- The cost of a bridge will be applied towards the implant treatment, when missing 2 teeth or less.
- The cost of a denture will be applied towards the implant treatment, when missing 3 teeth or more.
- Replacement of an existing implant crown, but only if it was installed at least 5 years before and cannot be made serviceable.
- Implant claims are reimbursed in two portions of the approved amount. 50% is reimbursed when the surgical stage is completed, and the remaining 50% will be paid when restorative crown is placed.
- Implants up to a maximum of \$3,000 per calendar year, per individual inclusive of all other dental care services (Routine Dental Care Services and Major Restorative Services).

ORTHODONTICS

Your dependent children 18 years of age or younger are covered for charges as follows:

- Orthodontic treatments are reimbursed at 60% of the total submission, up to an overall maximum of \$2,500 per lifetime.
- An estimate must be submitted prior to any incurred orthodontic treatments.
- Initial treatment cannot exceed 35% of the total cost of orthodontic treatment.
- Treatment must commence prior to the dependent reaching 19 years of age.
- Services will only be eligible if rendered in Canada.
- Reimbursement of orthodontic benefits will only be made if the Member is in benefit at the time the service is rendered.
- Diagnostic procedures, initial fee, monthly, and quarterly fees will be reimbursed as services are rendered.
- Orthodontic reimbursements are limited to a monthly fee, therefore, no lump sums will be reimbursed. Should you choose to pay your orthodontist the entire treatment fee up front, you will only be reimbursed for the services as they are actually rendered. Prepayments are not reimbursable under this plan.

ALTERNATE BENEFITS CLAUSE

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

PREDETERMINATION OF BENEFITS

If charges for a planned Course of Treatment by a licensed dentist in Canada will exceed \$300, proposed details and x-rays should be submitted to the Administrative Agent for pre-approval.

Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

Course of Treatment means one or more services rendered by one or more dentist for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Dental care or appliances that are deemed to be for cosmetic purposes.
- Replacement of tooth structure lost due to incisal wear.
- Fillings are limited to once every 12 months per tooth, per surface.
- Expenses submitted more than 18 months after the date of service are not covered.
- Perio-Splinting is not eligible unless performed in conjunction with periodontal surgery.
- Crowns, Abutments and Pontics on molar teeth will be limited to the cost of metal appliance.
- Fees associated with travel, completion of claim forms and or missed appointment fees.
- Services that are not performed by a licensed dentist.
- Services incurred outside of Canada.
- Dental care covered under a medical plan provided by an Employer or Government.
- Space maintainers and pre-fabricated full coverage restorations for permanent teeth.
- Oral hygiene instruction or nutritional counseling.
- Protective athletic appliances.

- A full mouth reconstruction for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.
- Replacement of a lost or stolen prosthesis.
- Prosthesis, including crowns and bridgework, and the fitting there of which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this benefit is discontinued or more than 90 days after termination of coverage for any other reason.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE

Each Canadian Province and Territory provides a Medicare Plan with comprehensive benefits for hospital confinement, the service of medical physicians and other health practitioners, ambulance services, etc.

When you are outside your province of residence or Canada and require these services, your Provincial Medicare Plan will usually make a payment towards your expenses but that payment is usually limited to the amount that would have been paid for the same service in the Province in which you reside.

This benefit provides extensive coverage for many services rendered outside of Canada. It would be important to note that such expenses are covered provided that they were unexpected and of an emergency nature. This benefit does not provide benefits for medical treatment if the purpose of your trip is to obtain medical treatment.

ELIGIBILITY

To be eligible for this benefit, **you and your eligible dependents** must be:

- Under the age of 80.

PERIOD OF COVERAGE

You and your eligible dependents are covered while outside of your province of residence or Canada for such reasons as business or vacation up to a maximum of 90 consecutive days per trip.

Travel medical insurance covers member and eligible dependents for trips of up to 90 consecutive days. Travelers must return home for at least one day before being eligible for a new set of 90 consecutive days for another trip.

BENEFIT MAXIMUMS

When injuries or sickness result in a claim, benefits will not exceed a lifetime maximum of \$5,000,000 for persons under age 70 for the actual expenses incurred outside of Province that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical plan in Canada. Persons age 70 to 74 are subject to a maximum of \$1,000,000 lifetime maximum and persons age 75 to 80 are subject to a maximum of \$500,000 lifetime maximum.

BENEFITS

If you have met the eligibility requirements, you and your eligible dependents may be eligible for the following benefits:

	<u>Benefit Maximums</u>
• Hospital, Medical and Therapeutic Services	\$5,000,000
• Hospital Confinement	\$5,000,000
• Emergency Evacuation Benefit	\$ 500,000
• Repatriation Benefit	\$ 15,000
• Emergency Dental Treatment	\$ 500
• Identification Benefit	\$ 5,000
• Auto Return Benefit	\$ 4,000
• Family Transportation Benefit	\$ 15,000
• Return Transportation for Travelling Companion	\$ 5,000
• Return and Escort of Dependent Children Under Age	\$ 5,000
• Trip Interruption Benefit	Airfare \$ 500
	<i>Hotel and Meal Expenses (5 day max) \$ 1,500</i>
	<i>Combined Maximum \$ 2,000</i>

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Injuries received while the insured person is participating in any maneuvers or training exercises of the armed forces.
- Pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder.
- Sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury.
- Dental surgery or cosmetic surgery unless such surgery is a result of a covered injury.
- Treatment or services that contravene any government hospital or medical care plan in Canada.
- Sickness or injury due to participation in professional sports.
- Anticipated medical treatment required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure.
- Emotional or mental disorders unless the insured person is hospitalized.
- Expenses incurred on an elective (non-emergency) basis.
- Loss or injury as a result of suicide or any attempted threat or self-inflicted injuries, while sane or insane.

- An act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority.
- Any services or supplies provided by an insured person.
- Any treatment or surgery not required for the immediate relief of acute pain or suffering.
- Any treatment or surgery, which reasonably could be delayed until the insured person returns to Ontario; or anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the insured person prior to departure.

GENERAL INFORMATION

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IN AN EMERGENCY, HERE'S WHAT TO DO:

You or someone acting on your behalf should call World Travel Protection (WTP) immediately, before you get medical assistance in the event of a serious medical emergency. If you can't call right away, contact WTP as soon as you are able to do so. Their operators are backed by a team of emergency care professional physicians and nurses who work closely with the physician looking after you and, if necessary, your family or company physician, to help insure that you receive the medical care you need.

NOTE: If you contact WTP right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

Telephone the World Travel Protection (WTP) at the numbers listed below:

- Canada & U. S. A. - **1-877-490-7228**
- Elsewhere (Collect Call) - **647-258-7274**

An operator will ask you the following:

- Your name, location and the details of your emergency
- Your AIG Policy No: **BSC 9020978**

EMERGENCY OUT OF PROVINCE MEDICAL WALLET CARD

Emergency Out of Province Medical Coverage Wallet Cards to carry while traveling, are available online at www.183membersbenefits.ca or from the Administrative Agent.

BEREAVEMENT PAY

If you suffer the loss of an eligible family member, **you** may be eligible to receive Bereavement Pay from the Plan, for attending funeral or religious services, upon proof of loss of time from work and regular earnings.

ELIGIBILITY

To be eligible for this benefit, **you** must:

- Be actively working at the time the bereavement occurs.
- Provide a signed letter from your employer or payroll department (company letterhead) advising of the last day worked, the days you did not work as a result of the bereavement and confirmation that you were employed at the time of death, confirming your absence.
- Provide an original death certificate or statement of death from the funeral home advising of the name and date of death of your family member.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- A maximum benefit of \$250 per day.
- Benefit is payable up to maximum of 3 consecutive business days.
- Benefits are payable from the 1st day of lost earnings as a result of the bereavement provided you were actively working the day immediately preceding the date the bereavement occurred.

ELIGIBLE FAMILY MEMBERS

Bereavement benefits will be payable for the loss of the following family members:

- Spouse
- Child, Son-in-law, Daughter-in-law, Step-Children
- Parent, Parent-in-law, Step-Parent
- Grandparent
- Brother, Brother-in-law
- Sister, Sister-in-law

INCOME TAX

Under current tax law, Bereavement benefit payments are taxable to the member in the calendar year in which it was received. Members who were in receipt of Bereavement benefit payments in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of received in the prior year.

Any Bereavement benefit payments received on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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PARENTAL LEAVE

If **you** are actively at work and wish to spend time with your family immediately following the birth of a newborn, you may be eligible to receive parental leave benefits.

ELIGIBILITY

To be eligible for this benefit, **you** must:

- Be absent from work immediately following the birth of your child up to a maximum of 3 consecutive days.
- Provide a signed letter from your employer or payroll department (company letterhead) advising of the last day worked, the days you did not work as a result of parental leave and confirmation that you were employed at the time of the birth, confirming your absence.
- Provide an original certificate of birth or a temporary health card from the hospital advising of the name and date of birth of your child.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- A maximum benefit of \$250 per day.
- Benefit is payable up to a maximum of 3 consecutive business days.

INCOME TAX

Under current tax law, Parental Leave benefit payments are taxable to the member in the calendar year in which it was received. Members who were in receipt of Parental Leave benefit payments in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of received in the prior year.

Any Parental Leave benefit payments received on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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JURY DUTY BENEFIT

If you suffer a loss of earnings due to an interruption of employment due to Jury Duty, **you** may be eligible to receive Jury Duty benefits.

ELIGIBILITY

To be eligible for this benefit, **you** must:

- Show a loss of time of work and regular earnings due to Jury Duty leave.
- Provide a signed letter from your employer or payroll department (company letterhead) advising of the last day worked, the days you did not work as a result of Jury Duty and confirmation that you were employed at the time of Jury Duty.
- Provide an original letter from the courthouse confirming dates of attendance due to Jury Duty.

BENEFITS

If you have met the eligibility requirements, **you** may be eligible for the following benefits:

- A maximum benefit of \$200 per day.
- Benefits will be payable for a maximum of 100 days.

INCOME TAX

Under current tax law, Jury Duty benefit payments are taxable to the member in the calendar year in which it was received. Members who were in receipt of Jury Duty benefit payments in the previous calendar year will receive a T4A every February from the Administrative Agent that indicates the total amount of received in the prior year.

Any Jury Duty benefit payments received on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

GENERAL INFORMATION

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MEMBER FAMILY ASSISTANCE PLAN

If **you or your eligible dependents** need family assistance during times of stress, the Member Family Assistance Plan provides access to professional confidential counselling services.

Counsellors have specialized expertise, are fluent in different languages and are available to help develop solutions for your problems or concerns.

Counselling is available in person, by phone or online. There is no cost to you. Offices are local and appointments are made quickly, with your convenience in mind. The counselling is intended to be short-term and focused on providing you with the tools and resources to address the cause of your stress.

If you wish to access the Member Family Assistance Plan service, please call Toll Free 1-866-462-8047 or visit online at www.homewoodhealth.com. The Member Family Assistance Program helps you take practical and effective steps to improve your well-being and be the best you can be. Within a supportive, confidential and caring environment you can receive counselling for any challenge including:

- Nutrition
- Lifestyle Changes
- Weight Management
- Smoking Cessation
- Family Care
- Elder Care
- Relationships
- Financial Stress
- Addictions
- Anxiety
- Depression
- Life Transitions
- Grief/Bereavement
- Other Issues

VACATION PAY

Various collective agreements require contributing employers remit vacation pay to the Labourers' Local 183 Members' Vacation Pay Trust Fund at a rate of ten percent (10%) of gross earnings.

Vacation pay is held on behalf of each member and is paid from the Labourers' Local 183 Members' Vacation Pay Trust Fund annually between June 1st and 15th of each year.

Members may request interim payouts throughout the year by completing a Vacation Pay Withdrawal Application and submitting it to the Administrative Agent.

Any discrepancies with your Vacation Pay amount should be accompanied with a Vacation Pay Problem Form along with photocopies of all pay stubs for all work months and submitted or mailed to:

LiUNA Local 183 Trust Administration
205 – 1263 Wilson Avenue
Toronto, ON M3M 3G2

Fax: 416-240-7488
Email: info@183membersbenefits.ca

Forms are available online at www.183membersbenefits.ca or contact the Administrative Agent.

GENERAL PROVISIONS

COORDINATION OF BENEFITS (EXTENDED HEALTH CARE AND DENTAL CARE)

If a person covered under this Plan is also covered under another plan, benefits under all plans are adjusted so as to limit the combined payment to 100% of the total allowable expense.

The manner in which this is done is to determine which plan pays first (and thus determines where to submit the claim first) and which plan(s) pay next.

The plan that does not have a Coordination of Benefits provision pays before the plan that does (most, if not all, plans have such a provision).

The plan that covers the person as:

- Other than a dependent pays before the plan that covers such person as a dependent; or
- A dependent child of the parent, covered as an employee or member, whose birthday occurs first during the calendar year, pays first.

If priority cannot be established in the above manner, the benefits shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Administrative Agent may:

- Subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed; or
- Pay to or recover from any other person, corporation or organization any excess payment, any payment so made will be deemed to be benefits paid and, to the extent of such payment, will fully discharge the Administrative Agent from all liability under this Plan.

Spousal Plan without Coordination of Benefits Provisions

<i>Member</i>	<i>Spouse</i>
For members whose spousal's plans do not have rules on claiming from more than one plan, should, claim first to the spouse's plan then submit unpaid remaining claims to the Members Benefit Fund when treatment is received.	If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Members Benefit Fund.

Spousal Plan with Coordination of Benefits Provisions

Member	Spouse
<p>Members are to claim to the Members Benefit Fund first then submit unpaid remaining claims to their spouse’s plan when treatment is received.</p>	<p>If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Members Benefit Fund.</p>

Dependent Children

Determination of Coverage	What to do?
<p>A dependent child’s primary coverage is determined by the parent/guardian whose birthday comes earlier in the calendar year.</p>	<p>A member living with their child’s other parent should first claim to the primary coverage then submit unpaid remaining claim to the remaining plan.</p>
<p>If you are separated or divorced, claims for each dependent child should be made in the following order:</p> <ol style="list-style-type: none"> 1. To the plan of the parent in custody 2. To the plan of the spouse of the parent in custody 3. To the plan of the parent not having custody 4. To the plan of the spouse of the parent not having custody 	

DEFINITIONS

Allowable expense means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When the plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health or dental care coverage, or student accident insurance.

ONTARIO HEALTH PLAN (OHIP)

The Ontario Health Plan (OHIP) pays most medical and surgical services required by residents of Ontario and their eligible dependents. It also pays for standard ward hospital charges. Regulations for the Ontario Health Plan are made under the Ontario Health Insurance Act and will change from time to time.

Should you have any questions relating to the commencement date or termination procedures of your OHIP coverage, you should contact OHIP directly.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted for each Benefit to the Administrative Agent within:

- 6 months after the date of death for Life Insurance Benefits.
- 6 months after the start of disability for Short Term Disability and Long Term Disability Benefit.
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Health Care and Dental Care benefits.
- Legal action to recover benefits under this plan must begin within 3 years (6 years for Life Insurance) of the date of loss.
- 90 days after the date of loss for Emergency Out of Province, Special Needs Life Insurance, Long Term Care, Permanent and Total Disability Accident Benefit, Hospital Cash and Critical Illness Benefits.

The Administrative Agent shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably be required during the pendency and payment period, if any of such claim.

OVERPAYMENT OF BENEFITS

In the event where the Plan has paid more benefits to a Member than entitled to, the following measures apply:

- The Member will be notified of the overpayment by the Administrative Agent and asked to repay the Plan.
- The Trustees may elect that if the Member has hours banked in their Hour Bank Account, those hours be cancelled up to the number of hours of equivalent monetary value to the amount of overpayment in which they will be notified by the Administrative Agent.
- If the Member doesn't make the repayment within 30 days, the Trustees may decide the overpayment be treated as a lien against any future benefit claimed by the Member and deducted from any future payments paid to the Member.

HOW TO SUBMIT A CLAIM

Claim forms are available online or from the Administrative Agent. Please be sure to complete them fully, attach necessary original paid in full invoices along with any other original documentation where applicable and keep a copy for your records to substantiate your claims, and submit to the following mailing address:

**Local 183 Trust Administration
205 - 1263 Wilson Avenue
Toronto, ON M3M 3G2**

INSURANCE PROVIDERS

The benefits described under this plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the policies may be obtained from the Administrative Agent.

The Group Insurance Benefits described in this booklet are insured as follows:

GREAT WEST LIFE ASSURANCE COMPANY - POLICY NO. 158000

- Member Life Insurance
- Dependant Life Insurance
- Short Term Disability
- Long Term Disability
- Extended Health Care
- Vision Care
- Dental Care

AIG INSURANCE COMPANY OF CANADA

- Long Term Care – Policy No. **SRG 9134041**
- Second Opinion Medical Benefit – CareNav – Policy No. **SRG 9134041**
- Critical Illness – Policy No. **CI 9105655**
- Special Medical/Hospital Coverage while in Canada – Policy No. **SRG 9114253**
- Emergency Out of Province Medical – Policy No. **BSC 9020978**

CHUBB INSURANCE COMPANY OF CANADA

- Special Needs Life Insurance – Policy No. **GL10363501**
- Accidental Death and Dismemberment – Policy No. **ABT10241001**
- Occupational Accidental Death & Dismemberment – Policy No. **AB10357401**
- Permanent Total Disability Accident Benefit – Policy No. **SG10395001**
- Hospital Cash – Policy No. **SG10395001**

CONTACT INFORMATION

If you have any questions regarding your coverage, you should contact:

Local 183 Trust Administration
1263 Wilson Avenue – East Wing
Suite 205
Toronto, Ontario
M3M 3G2

Telephone Directory:

Toll Free	1-888-790-3534
Member Services Department	416-240-7487
Reception	416-240-7480
General Fax	416-240-7488
Website	www.183membersbenefits.ca
General Email	info@183membersbenefits.ca

Additional Phone Numbers:

Ontario Assistive Devices Program (ADP)	1-800-268-6021
Trillium Drug Program	1-800-575-5386
Ontario Drug Benefit (ODB) Program	1-866-811-9893
AIG – Emergency Out of Province Coverage <i>Canada & U.S.A.</i>	1-877-490-7228
<i>Elsewhere (Collect Call)</i>	647-258-7274
Family Assistance Plan	1-866-462-8047
Disability Management Services	1-866-315-6011
CareNav 24/7 Special Assistance Services	1-866-450-6434
Workplace Safety Insurance Board (WSIB)	1-800-387-0750
Employment Insurance (EI)	1-800-206-7218
Canada Pension Plan (CPP)	1-800-277-9914



LiUNA Local 183
Members' Benefit Fund
(Construction Division)

Benefits Booklet



LiUNA! LOCAL 183
Feel the Power