LiUNA!
LOCAL 3000
HEALTHCARE • INDUSTRIAL • PROFESSIONAL

OCTOBER
2020

LiUNA LOCAL 3000
HEALTH AND WELLNESS TRUST FUND
Member Benefit Booklet

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INTRODUCTORY PLAN

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

OCTOBER 2020

WELCOME

This booklet describes the conditions of eligibility, coverage and claims procedures under the LiUNA Local 3000 Health and Wellness Trust 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 dependents. 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 dependents of the LiUNA Local 3000 Health and Wellness Trust 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 dependents 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. 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 dependents 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 dependents.

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

CHANGE OF YOUR DEPENDENT 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 some time 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 3000.
- of a Bargaining Unit represented by LiUNA Local 3000.
- who work for a Contributing Employer and where the Collective Agreement makes provisions for contributions to the Health and Wellness Trust Fund.

INITIAL BENEFIT COVERAGE

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

- On the 1st day of the month following the date your employer has made the required contributions as outlined by the Board of Trustees.
- Coverage continues automatically for each month provided your employer remits the required contribution on your behalf.

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 Health and Wellness Trust Fund on the following basis:

- Monthly payments in the amount equal to the cost of the required contribution.
- You have the option to make self-payments for a maximum of 6 consecutive months provided you remain a Member in Good Standing with LiUNA Local 3000.
- You are entitled to the same benefits you enjoyed while you were employed with the exception of Short-Term Disability 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 3000 must be maintained and in a current status.

The cheque should be made payable to "LiUNA Local 3000 Health and Wellness Trust Fund" and mailed to:

LiUNAcare Local 3000
c/o Benefit Plan Administrators Limited
300 - 90 Burnhamthorpe Road West
Mississauga, ON L5B 3C3

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 dollar banks 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 of Ontario. Members must report their WSIB claim number and submit Proof of Acceptance of their claim by WSIB to the Administrator as soon as possible. Members have one (1) year from the date of the accident to report their WSIB claim to the Administrator and are to continue to remain a member in Good Standing with LiUNA Local 3000.

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 required contribution in your account 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 3000.
- Upon your attainment of age 65 with respect to Short Term Disability Benefits; age 70 for Accidental Death & Dismemberment, Hospital Cash, and Critical Illness Benefits; age 75 for Life Insurance and Dependent Life Insurance Benefits; age 85 for Emergency Out of Province Benefits.
- Coverage for your dependents will terminate on the date such dependents cease to be eligible.
- 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 Health and Wellness Trust Fund, you will be covered by the Plan:

- On the first day of the month following the receipt of your employers contribution.

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, 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 Benefit payments which are also reported on the T4A form received.

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 of your surviving spouse's death.
- The date coverage for your dependents terminates as per the definition of dependent or for any other reason.

- The end of the 12-month period after the date of your death with respect to your spouse and dependents.
- 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.

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.
- Became 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.

DEPENDENT 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.

DEPENDENT 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 coverages. The booklet provides further details.

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
LIFE INSURANCE (page 19)	**Benefit Maximum:** • Member - $50,000 • Spouse - $10,000 • Dependent Child - $4,000	✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 75 ✓ Contact the Administrative Agent for details on eligibility for this benefit
ACCIDENTAL DEATH & DISMEMBERMENT (page 21)	**Benefit Maximum:** • Member - $25,000 • Spouse - $7,500 • Dependent Child - $1,000	✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 70 ✓ Contact the Administrative Agent for details on eligibility for this benefit
SHORT TERM DISABILITY (page 24)	**Weekly Benefit Maximum**: • 66 2/3% of your weekly earnings to a maximum of $400 per week. **Benefits are payable from:** • 1st day accident or hospitalization of a minimum of 18 hours • 8th day illness / disease / sickness **Benefit Duration**: • Maximum of 26 weeks or to the attainment of age 65 **Integration**: • 15 Week Employment Insurance Sickness Benefits	✓ Members Only ✓ Coverage terminates at the attainment of age 65 ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
CRITICAL ILLNESS (page 27)	**Benefit Maximum:** • Member - $10,000	✓ Members Only ✓ Coverage terminates at the attainment age 70 ✓ Contact the Administrative Agent for details on eligibility for this benefit ✓
HOSPITAL CASH BENEFIT (page 30)	**Daily Benefit Maximum:** • Maximum of $50 per day. **Benefits are payable after:** • 3 consecutive days of hospitalization **Benefit Duration:** • Maximum of 120 consecutive days	✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 70 ✓ Contact the Administrative Agent for details on eligibility for this benefit
EXTENDED HEALTH CARE BENEFITS (page 32)	Any dollar amount shown as a "limit" in this summary refers to a maximum eligible charge, and not a maximum benefit **Lifetime Maximum:** • $1,000,000 each insured family member **Prescription Drugs:** • Member Advantage Card • 100% Reimbursement • Opioids - $5,000 Lifetime Maximum • Medical Cannabis - $1,000 per calendar year up to $5,000 Lifetime Maximum.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 32)	**Coinsurance Levels:** • 50% Orthopedic Shoes and Compression Surgical Stockings • 100% Other Covered Charges **Paramedical Services Limits**: • Physiotherapist*, Chiropractor, Podiatrist/Chiropodist, Occupational Therapist, Acupuncture, Osteopath, Naturopath and Massage Therapy* up to a maximum of $50 per visit up to a maximum benefit of $750 per calendar year combined. • Clinical Psychologist/Psychotherapist up to $50 per visit up to a maximum of $750 per calendar year. • Speech Therapist* to a maximum of $100 per visit up to 10 visits per calendar year. * *MD Referral Required* **Medical Services and Supplies:** • Orthopedic Shoes: 1 pair reimbursed 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: $1,500 every 24 months for one set (including replacement, repairs and batteries). • Nursing Services: $5,000 lifetime maximum. • Ambulance services: outpatient services.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 32)	• Vision Care: Maximum benefit of $300 once every 24 months for one (1) set of eyeglasses (lenses/frames combined) or contact lenses in lieu of eyeglasses. • Eye Exams: One time to a maximum of $80 once within the same 24 months. • 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. • Limb braces, crutches, prosthesis services, wheelchair, hospital bed, or oxygen equipment.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
DENTAL CARE BENEFITS (page 41)	**Co-Insurance Levels:** **Plan Member:** • Routine Care - 80% • Dentures - 50% • Crowns and Bridgework – 50% **Calendar Year Maximums:** • $1,500 per individual **Dental Ontario Dental Association (ODA) Fee Guide:** • 2018 ODA Fee Guide	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EMERGENCY OUT-OF-PROVINCE MEDICAL (page 46)	**Benefit Maximum**: • $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 84 **Trip Duration:** • Under age 80 – Trips are limited to a maximum of 90 consecutive days • Age 80 to 84 – Trips are limited to a maximum of 60 consecutive days	✓ Members and eligible dependents ✓ Coverage terminates at the attainment of age 85 ✓ Contact the Administrative Agent for details on eligibility for this benefit
EXPEDIATED HEALTHCARE (page 49)	**Benefit**: • Immediate access to diagnostic scans such as MRI & CT Scans and specialist consultations	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
mHEALTH MENTAL HEALTHCARE (page 50)	**Benefit**: • Confidential Online Platform for virtual real-time Cognitive Behavioral Therapy (CBT) sessions with a psychologist. • Sessions up to 12 weeks from home via computer or handheld device. • Access to educational materials. • Assessments can be shared confidentiality & securely with primary care physicians or counsellors.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
vCARE VIRTUAL HEALTHCARE (page 51)	**Benefit**: • Confidential Online Platform for virtual 24/7 non-emergency personalized medical support through the mobile application. • Instant access to connect with healthcare provider for primary health questions & concerns. • Fill and refill prescriptions. • Initiate specialist referrals and lab requisitions. • Unlimited virtual consultations via text or chat. • Updates sent securely and confidentiality to primary care physicians with consent.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
HEALTHCARE NAVIGATION (page 52)	**Benefit**: • Health coaching platform with nurse navigator to aid navigating current healthcare system for serious and chronic diseases. • Single point of contact throughout the diagnosis, treatment, and rehabilitation process.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
CANCER ASSISTANCE (page 53)	**Benefit**: • Specialized cancer care for immediate access to highly trained oncologists and experienced oncology nurses who work with patients and family to ensure right treatment is received.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
MYCONSULT SECOND OPINION MEDICAL (page 54)	**Benefit**: • Online secured web platform to a medical second opinion program from the expertise of top Cleveland Clinic global specialists for prolonged or chronic illnesses without the time and expense of travel.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
HEALTH COACHING (page 55)	**Benefit**: • Confidential one-on-one telephone access to dedicated professional for coaching support. • Health goals include diabetes, heart health and mindful eating. • Nutritional Assessments available.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
SELF HELP WORKS (page 55)	**Benefit**: • Online training program with video-based workshops to help with: ▪ smoking cessation ▪ weight loss ▪ alcohol consumption ▪ exercise motivation ▪ stress relief ▪ diabetes ▪ sleep restoration and more.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit
VIRTUAL HOME DELIVERY PHARMACY (page 55)	**Benefit**: • Convenience of home delivery for prescription medications sorted into daily packets to ensure correct daily dosage and auto renewing or prescriptions.	✓ Members and eligible dependents ✓ Contact the Administrative Agent for details on eligibility for this benefit

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	$ 50,000
Dependents - Spouse - Children	 $ 10,000 $ 4,000

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.

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.

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 Up to ($)	Spouse Up to ($)	Child Up to ($)
Life (Principal Sum)	25,000	7,500	1,000
Both Hands or Both Feet	25,000	7,500	4,000
Entire Sight of Both Eyes	25,000	7,500	4,000
One Hand and One Foot	25,000	7,500	4,000
One Hand and Entire Sight of One Eye	25,000	7,500	1,000
One Foot and Entire Sight of One Eye	25,000	7,500	1,000
Speech and Hearing in Both Ears	25,000	7,500	4,000
One Arm or One Leg	18,750	5,625	2,000
One Hand or One Foot	18,750	5,625	750
Entire Sight of One Eye	18,750	5,625	750
One Entire Finger of Either Hand	4,166	1,250	166
Speech or Hearing in Both Ears	18,750	5,625	2,000
Thumb and Index Finger of Same Hand	8,333	2,500	333
Four Fingers of the Same Hand	8,333	2,500	333
Hearing in One Ear	8,333	2,500	333
All Toes of the Same Foot	6,250	1,875	250
Thumb of Either Hand	6,250	1,875	250
Brain Death	25,000	7,500	1,000

FOR LOSS OF USE OF:	Member Up to ($)	Spouse Up to ($)	Child Up to ($)
Both Arms, Both Feet, Both Hands or Both Legs	50,000	15,000	2,000
One Hand or One Foot	18,750	5,625	750
One Arm or One Leg	18,750	5,625	750
Thumb and Index Finger of the Same Hand	8,333	2,500	333

FOR TOTAL PARALYSIS OF:	Member Up to ($)	Spouse Up to ($)	Child Up to ($)
Quadriplegia / Paraplegia / Hemiplegia	75,000	22,500	10,000

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 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 and Vehicle Modification	15,000
Day Care and Special Education	5% of Insured Person's Principal Sum up to 5,000
Parental Care	10% of Insured Person's Principal Sum up to 5,000
Seat Belt Benefit	10% of Insured Person's Principal Sum
Identification / Critical Illness Benefit	10% of Insured Person's Principal Sum
In-Hospital Indemnity	1% of Insured Person's Principal Sum per month
Bereavement	1,000
Cosmetic Disfigurement (Third Degree Burn)	25,000

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 a 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.

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 65, **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 65.
- Short term disability benefit is not offered to all members and is directed by what has been negotiated in your Collective Agreement.

BENEFITS

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

- 66 2/3% of pre disability weekly earnings up to a maximum benefit of $400 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 26 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 26 weeks of benefit payments.

- Benefits are paid to a maximum of 26 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:

- 90 working days before you again become disabled because of the same or a related cause.
- 30 working days 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.

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.

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 from the Administrative Agent 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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CRITICAL ILLNESS

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

ELIGIBILITY

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

- Member under the age of 70.
- Covered at the time of diagnosis and be diagnosed by a licensed physician (M.D.) in Canada.

INSURED CONDITIONS

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

ELIGIBLE CRITICAL ILLNESS CONDITIONS:		
Alzheimer's Disease	Heart Attack	Motor Neuron Disease
Aortic Surgery	Heart Valve Replacement/Repair	Multiple Sclerosis
Aplastic Anemia	Kidney (Renal) Failure	Muscular Dystrophy
Bacterial Meningitis	Life Threatening Cancer	Occupational HIV Infection
Benign Brain Tumor	Non-Life-Threatening Cancer (25%)	Parkinson's Disease
Blindness (Sight)	Loss of Independent Existence	Quadriplegia (Paralysis)
Coma	Loss of Limbs (Two)	Paraplegia (Paralysis)
Coronary Artery Bypass Graft	Loss of Speech	Hemiplegia (Paralysis)
Deafness (Hearing)	Major Organ Failure on Waiting List	Severe Burn
Dementia (Alzheimer's Disease)	Major Organ Transplant	Stroke

BENEFITS

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

- A maximum benefit of $10,000.

MULTIPLE EVENT BENEFIT

If the Insured Member is diagnosed with a Critical Illness for which the Principal Sum has been paid and the Insured Member has thereafter been considered actively at work for at least 90 days and is then diagnosed with another separate Critical Illness; then a Multiple Event Benefit equal to the Principal Sum may be payable if the Critical Illness is listed as an Eligible Second Event Critical Illness. The Multiple Event Benefit Coverage has the possibility of being payable of up to 9 separate claims.

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;
- Any tumor in the presence of any Human Immunodeficiency (HIV);
- Chronic Lymphocytic Leukemia;
- Follicular Thyroid Cancer; or
- Malignant Gastrointestinal Stromal Tumors (GIST).

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 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.

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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 dependents** may be eligible for the following benefits:

- A maximum daily benefit of $50.
- 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 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.

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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.

BENEFITS

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 orthopedic shoes; 50% for surgical stockings (>20 mmHg) or compression stockings excluding elastic stockings.
- 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 maximum life benefit of $5,000.
- Vaccines / Immunizations covered up to a maximum of $250 per calendar year.
- Smoking Cessation coverage for one (1) course treatment up to a maximum of $350 per lifetime.
- You and your eligible spouse will be provided a **Member Advantage Card** that you **must present to your pharmacist** when purchasing your prescription drugs for you and your eligible dependents.

MEMBER ADVANTAGE CARD

Once you satisfy the eligibility requirements, you and your eligible spouse will be provided with a Member Advantage 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 Member Advantage Card does not work at the pharmacy due to incomplete information, please contact the Member Services at **905-247-3040**.
- If you are **not** in benefit at the date of your prescription drug purchase, your Member Advantage Card will not work, and you will be required to purchase the medication directly at the pharmacy.
- Should your Member Advantage 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 Services.
- 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 Member Services at 905-247-3040 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, injectables, fertility, and erectile dysfunction.
- 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 3000 Health and Wellness Trust Fund 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 Benefit 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:

- Physiotherapist, Podiatrist / Chiropodist, Chiropractor, Occupational Therapist, Acupuncture, Osteopath, Naturopath and Massage Therapist up to a maximum charge of $50.00 per visit to a maximum benefit of $750.00 per calendar year combined.
- Clinical Psychologist / Psychotherapist up to a maximum charge of $50.00 per visit to a maximum of $750 per calendar year.
- Speech Therapy up to a maximum charge of $100 per visit up to a maximum of 10 visits per calendar year.
- 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.

MEDICAL CANNABIS

You and your eligible dependents are covered for Medical Cannabis coverage in the province of Ontario as follows:

- Up to a calendar year maximum of $1,000 and a lifetime maximum of $5,000 per insured individual.
- For medical purposes when obtained from a licensed producer pursuant to a medical document issued by an authorized healthcare practitioner and has been assigned a product identification number as defined under the Cannabis Act and Regulations.
- Must be accompanied with a Prior Authorization Approval and purchased through a Licensed Producer.
- For the treatment of one of the six eligible pre-determined conditions:
    - Neuropathic Pain (Chronic)
    - Spasticity
    - Palliative Care
    - Spinal Cord Injury
    - Nausea / Vomiting from Chemotherapy
    - Anorexia

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, 50% up to a maximum reimbursement of $250 per calendar year.
- 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 gain 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 $1,500 every 24 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 benefit of $300 every 24 months includes one (1) set of eyeglasses (lenses and frames combined) or contact lenses in lieu of eyeglasses. Included in the vision care is one (1) eye exam up to a maximum of $80.00 within the same 24 months. Remaining balances cannot be applied to future claims.
- 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 are **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 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.
- Corrective laser eye surgery.
- Any eye exam fees rendered.

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.
- Flash Glucose Monitor & Sensors (FGM) and Continuous Glucose Monitors (CGM) up to Reasonable & Customary expense.
- Intrauterine Devices (IUD's).
- Apnea monitors.
- One (1) external breast prosthesis to a maximum of $500 per breast, once every 24 months.
- Two pairs of surgical brassieres, per calendar year.
- Two pairs of custom graduated compression stockings with a minimum compression factor of 20mmgh or higher, reimbursed up to 50% of their purchase price to an overall maximum benefit of $300 per calendar year.
- Wigs up to a lifetime maximum of $500.
- Sclerotherapy (Vein Injections) is limited to $20.00 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 3000 Health and Wellness Trust 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 3000 Health and Wellness Trust Fund for consideration. For more information on the Ontario Assistive Devices Program (ADP), please call 1-800-268-6021.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- For drugs, sera or injectable drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis.
- Any type of orthotics, whether custom made or not.
- 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 are not 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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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.

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

Summary of Dental Care Benefits	
• **Calendar Year Maximum**	• **$1,500 per person / year**
• **Dental Fee Guide Reimbursement**	• **2018 O.D.A.**
• **Diagnostics : exams, x-rays**	• **80%**
• **Endodontics : root canals**	• **80%**
• **Periodontics : root planing and surgery**	• **80%**
• **Preventative : polishing, scaling, fluoride**	• **80%**
• **Dentures :**	• **50%**
• **Restorative : fillings, crowns**	• **50%**
• **Surgical : extractions, oral surgery**	• **50%**
• **Orthodontics**	• **No Coverage**

BENEFITS

The total benefits payable are subject to the following maximums:

Calendar Year Maximum (per individual)

$1,500 per Calendar Year

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 **Dental Plan** will be based on the **2018 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 per procedure.
- 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 denturist, 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 crown 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 3000 Health and Wellness Trust Fund.

- Replacement of an existing bridge, but only if it was installed at least 5 years before and cannot be made serviceable.

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.
- Orthodontic coverage.
- Implants and/or services and supplies related to implants.
- Fees associated with travel, completion of claim forms and or missed appointment fees.
- Services that are not performed by a licensed dentist.
- Services that are performed 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 85.

PERIOD OF COVERAGE

You and your dependents are covered while outside your province of residence or Canada for such reasons as business or vacation up to a maximum of:

- 90 consecutive days per trip if under age 80
- 60 consecutive days per trip ages 80 to 84

Travel medical insurance covers member and eligible dependents for trips of up to the consecutive days above. Travelers must return home for at least one day before being eligible for a new set of 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 84 are subject to a maximum of $500,000 lifetime maximum.

BENEFITS

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

	Benefit Maximums
• 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*
	Hotel and Meal Expenses (5 day max) *$ 1,500*
	Combined (if includes airfare) *$ 2,000*

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

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.

IN AN EMERGENCY, HERE'S WHAT TO DO:

You or someone on your behalf should call 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 Number

EMERGENCY OUT OF PROVINCE MEDICAL WALLET CARD

Emergency Out of Province Medical Coverage Wallet Cards to carry while traveling, are available from the Administrative Agent.

EXPEDITED HEALTHCARE

If you or your eligible dependents require access to a diagnostic procedure or are referred to a specialist and are placed on a medical waitlist, you and your eligible dependents may be eligible for the QuikCare Platinum as follows.

The QuikCare Platinum program provides expedited access to the Canadian Healthcare system to assist you and your eligible dependents by allowing those who are placed on a medical waitlist, immediate access to diagnostic scans (MRI/CT Scans) and specialist consultations so you can focus on taking care of your wellbeing.

The QuikCare Platinum program was designed for diagnostic scans to be booked and preformed within 72 hours and specialist consultations be booked within weeks and not months so you don't have to spend time worrying if your condition is worsening, being stressed, unable to work and participate in your usual day to day activities which can have a substantial impact to you and your family.

The different types of diagnostic scans and specialists covered available to you and your eligible dependents include the following:

- Magnetic Resonance Imaging (MRI)
- Computed Tomography Scan (CT Scan)
- Ultrasounds
- Orthopedic
- Cardiologist
- Neurologist
- Gastroenterologist
- General Surgeon
- Ear, Nose & Throat (ENT)
- Ophthalmologist
- Urologist
- Rheumatologist
- Neurosurgeon

When your physician recommends a diagnostic procedure or refers you to a specialist, you can contact the QuikCare Platinum 24/7 dedicated toll-free helpline at 1-844-900-8357 to set up your consultation with one of our intake specialists for rapid intervention.

mHEALTH MENTAL HEALTHCARE

If you or your eligible dependents require help to assess any mental health issues you may have and require any type of support, you and your eligible dependents may be eligible for the mHealth virtual mental healthcare as follows.

The mHealth online platform is an easy to access digital platform with educational materials and virtual real-time therapy. Members and eligible dependents have access to mental health forums and libraries with videos and podcasts, support, video therapy, a diagnostic and statistical mental health assessment tool, and a variety of other resources.

Members and eligible dependents get effective psychological treatment that will improve and sustain their overall health by ensuring rapid access to Cognitive Behavioural Therapy (CBT) as a short-term therapy that offers long term benefits. The program offers virtual CBT therapy sessions with a psychologist for a range of psychological conditions in the comfort and privacy of the members' own home for up to12 weeks including but not limited to:

- Anxiety
- Addiction
- Depression
- Stress
- Substance Abuse

This confidential evidence-based treatment alleviates the social stigma associated with mental health care. Should more intensive therapy or psychiatric intervention be needed, escalation can be facilitated.

Members and dependents can download and share results of the assessment tool with their primary care physician or their mental health counsellors, securely and confidentially, from the comfort of home via computer or a handheld device. Register online or contact the Confidential Helpline 24/7 at 1-844-900-8357.

vCARE VIRTUAL HEALTHCARE

If you or your eligible dependents have a non-emergency health question or concern and are unable to visit a walk-in clinic or get an appointment with your family doctor, you and your eligible dependents may be eligible for the vCare Virtual Healthcare as follows.

The vCare online platform provides you and your eligible dependents with 24/7 personalized medical support wherever you are through the mobile application. The virtual care platform is designed to address your healthcare needs via secure text and video chat anywhere at any time.

Members and eligible dependents can connect instantly with a healthcare provider for any primary health questions and concerns, fill and refill prescriptions, specialist referrals, and lab requisitions as outlined below:

- Unlimited virtual consultations via secure text and video chat
- Convenient primary and mental healthcare support
- Fill and refill prescriptions, specialist referrals, and lab requisitions
- Virtual follow-ups with no appointments required
- Health record on the platform with updates sent to your family doctor with your consent

The on-demand virtual healthcare solution avoids visits to the doctor's office, walk-in clinics and emergency rooms for non-emergency issues such as but not limited to:

- Infections, rashes, and skin irritations
- Anxiety and depression
- Stomach and digestive issues
- Cough, cold and flu
- Weight loss counselling, smoking cessation, and more.

The vCare online platform can help with most primary care needs though specific cases will require an in-person medical appointment at the discretion of our healthcare providers. Don't wait until you are sick, active your account now to be ready when the need arises. For emergencies, please call 911 or go to the nearest emergency room.

HEALTHCARE NAVIGATION

If you or your eligible dependents require any sort of health coaching along with assistance navigating the current health care system for serious and chronic diseases, you and your eligible dependents may be eligible for Health Care Navigation as follows.

The Health Care Navigation platform provides you and your eligible dependents with a single point of contact, such as a personal nurse, throughout the diagnoses, treatment, and rehabilitation process. The nurse navigator will provide information about test and treatment options and assist with but not limited to the following:

- Doctor-to-doctor consults with patient.
- In-depth assessments of treatment plans and options proposed by the local treating physician to ensure they are consistent with medical best practice.
- Explanation of options for tests and treatments in each case.
- Facilitate access to diagnostic tests, treatments, and clinical trials.
- Guide patients to alternate treatment locations, when requested or required.
- Ongoing coaching as how to best manage chronic conditions such as diabetes, heart disease and chronic pain to name a few.
- Dramatically improve the overall quality of care, recovery, and outcomes.

The Health Care Navigation platform provide an individualized and personal service based on each individual's situation and is the only service of its kind in Canada. Services are unlimited and are to ensure members and eligible dependents receive the right care, at the right place, at the right time, every step of the way. For more information, please contact Compass Health Care Navigation at 1-866-883-5956 to speak with a nurse navigator.

CANCER ASSISTANCE

If you or your eligible dependents are cancer patients and require navigation through the public health care system, you and your eligible dependents may be eligible for Cancer Assistance as follows.

The Cancer Assistance program provides you and your eligible dependents access to highly trained oncologists and experienced oncology nurses who work with patients and their immediate family to ensure that the right treatment is received. The program provides expert assessment of current cancer treatment approaches along with the following:

- Help reduce the physical and emotional impact of cancer.
- Ensure medical best practices are utilized throughout active treatment.
- Provide expert assessment of current cancer treatment approaches.
- Provide answers to patients' questions and explanation of tests and treatments.
- Empower patients to better understand their diagnosis and treatment options.

The Cancer Assistance program specializes in cancer care. Services are unlimited and are to ensure members and eligible dependents receive the right treatment when needed most. For more information, please contact Cancer Assistance at 1-866-599-2720.

MyCONSULT SECOND OPINION MEDICAL

If you or your eligible dependents suffers from a prolonged or chronic illness and would prefer a detailed second opinion, you and your eligible dependents may be eligible for Cleveland Clinic's MyConsult Online Medical Second Opinion program as follows.

Cleveland Clinic Canada is a global healthcare leader and the MyConsult Online Medical Second Opinion program connects you and your eligible dependents to the expertise of top Cleveland Clinic global specialists without the time and expense of travel.

Through the secure web platform, members and eligible dependents can submit their detailed health information, medical records and diagnostic test results to an assigned nurse navigator who will submit to the Cleveland Clinic. The most appropriate Cleveland Clinic doctor is assigned to the consultation and will review and provide a detailed second opinion to you and your physician to discuss the results and recommended treatments via phone. MyConsult Online Medical Second Opinion helps to:

- Make the most informed decision about your healthcare or that if an eligible dependent.
- Ensure the diagnosis is correct.
- Ensure the treatment plan is optimal for you and your family.
- Receive a comprehensive written report from a Cleveland Clinic expert.
- Learn about new and innovative treatment plans.

The Cleveland Clinic is a global health care leader specializing in heart care. For more information, please contact MyConsult at www.clevelandclinic.ca.

WELLNESS BENEFITS

HEALTH COACHING

Members and eligible dependents can now take back their health with the new Health Coaching program. The Health Coaching program is a confidential program which gives members and eligible dependents telephone access to a dedicated professional who will provide one-on-one coaching support in achieving health goals around diabetes, heart health and mindful eating. To complete your nutritional assessment, sign up for the program online to start achieving all your health goals.

SELF HELP WORKS

Members and eligible dependents can now use a training process that combines the principles of cognitive behavioural therapy with health coaching best practices with the Self Help Works online program. The online Self Help Works program allows for lifestyle goals become reality with video-based workshops to help with smoking cessation, weight loss, alcohol consumption, exercise motivation, stress relief, diabetes management, sleep restoration and more. Sign up online to learn more about these life changing programs to help take back your health.

VIRTUAL HOME DELIVERY PHARMACY

The Virtual Home Delivery Pharmacy was added to the Plan to provide Members and eligible dependents the convenience of home delivery for their prescription medication sorted into daily packets to ensure the correct dose daily, also ensuring auto-renewing of prescriptions, while taking advantage of lower dispensing fees and same day delivery within the Greater Toronto Area. Home delivery pharmacy is available online or by using the app on your device, simply sign up and have access to all your prescription information.

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 <u>without</u> Coordination of Benefits Provisions

Member	*Spouse*
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 Local 3000 Benefit Plan when treatment is received.	If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Local 3000 Benefit Plan.

Spousal Plan with Coordination of Benefits Provisions

Member	*Spouse*
Members are to claim to the Local 3000 Benefit Plan first then submit unpaid remaining claims to their spouse's plan when treatment is received.	If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Local 3000 Benefit Plan.

Dependent Children

Determination of Coverage	*What to do?*
A dependent child's primary coverage is determined by the parent/guardian whose birthday comes earlier in the calendar year.	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.
If you are separated or divorced, claims for each dependent child should be made in the following order: 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 Benefit.
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Extended 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, 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.
- 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 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:

LiUNAcare Local 3000
c/o Benefit Plan Administrators Limited
300 - 90 Burnhamthorpe Road West
Mississauga, ON L5B 3C3

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. 177882

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

AIG INSURANCE COMPANY OF CANADA

- Critical Illness
- Emergency Out of Province Medical

CHUBB INSURANCE COMPANY OF CANADA

- Accidental Death and Dismemberment
- Hospital Cash

CONTACT INFORMATION

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

LiUNAcare Local 3000
c/o Benefit Plan Administrators Limited
300 - 90 Burnhamthorpe Road West
Mississauga, ON L5B 3C3

Telephone Directory:

Member Services	**905-247-3040**
General Fax	**905-275-6462**
Website	**www.liunacare3000.com**
Email	**info@liunacare3000.com**

Additional Phone Numbers:

Ontario Assistive Devices (ADP) Program	**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	
Canada & U.S.A.	**1-877-490-7228**
Elsewhere (Collect Call)	**647-258-7274**
Expedited Healthcare	**1-844-900-8357**
mHealth Mental Healthcare	**1-844-900-8357**
Healthcare Navigation	**1-866-883-5956**
Cancer Assistance	**1-866-599-2720**
MyConsult Second Opinion Medical	**www.clevelandclinic.ca**

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