GROUP INSURANCE PLAN

LABOURERS' UNION LOCAL 506 CONSTRUCTION DIVISION

MAY, 2015

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To Each Member:

This booklet has been up-dated effective May 1, 2015 to show all self-insured benefits and those benefits underwritten by The Great-West Life Assurance Company for the protection of you and your family. The Plan was developed by your Trustees with the advice and assistance of professional Insurance Consultants.

We feel that your participation in the Plan will bring greater peace of mind and an increased feeling of security to you and your family.

Sincerely,
YOUR TRUSTEES

GENERAL CONTRACTORS SECTION OF THE TORONTO CONSTRUCTION ASSOCIATION TRUSTEES

Jim Vlahos
Bill O'Riordan
Chris Robinson
Alex De Iulis

LOCAL 506 UNION TRUSTEES

Carmen Principato
Tony Do Vale
Peter Glaze
Luis Pimentel
Roly Bernardini

POLICY

For simplicity, the Plan is described in a general manner in this booklet. The extent of the insurance for each member and dependent is governed at all times by the completed terms of the Master Group Insurance Policy issued by Great-West Life Assurance Company.

ACCESS TO DOCUMENTS

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West Life as evidence of insurability, subject to certain limitations.

LEGAL ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. Limitations Act, 2002 in Ontario, Quebec Civil Code).

APPEALS

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

BENEFIT LIMITATION FOR OVERPAYMENT

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life's right to use other legal means to recover the overpayment.

PROTECTING YOUR PERSONAL INFORMATION

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service

providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

GENERAL INFORMATION

The Group Insurance is administered by a Joint Board of Trustees representing the Labourers' Union Local 506 and employers participating in the Plan. Such employers are called "Contributing Employers" in this booklet.

An account is kept by the Administrator of the Fund for each member which shows hours worked for a Contributing Employer for which contributions have been made for the purchase of group insurance. This account is called an Hour-Bank Account.

Each month 140 hours will be deducted from your Hour-Bank Account. The number of hours in your Hour-Bank Account may never exceed 1680 hours (enough to provide 12 months of coverage even if you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

A member who is not eligible or has no contributions credited to his account during a 12-month period, any hours in this account will be credited to the general reserves of the Fund.

NOTE: The hour bank deduction for E.D.A.C. varies from the above in accordance with the Collective Agreement and the policy set by the Board of Trustees.

EFFECTIVE JANUARY 1, 2011 the hour bank deduction for EDAC is as follows:

Each month 110 hours will be deducted from your Hour Bank Account. The number of hours in your Hour Bank Account may never exceed 1320 hours (enough to provide 12 months of coverage even if you acquire no hours during that period).

SUMMARY OF BENEFITS

ELIGIBILITY: Construction

420 hrs. – 1st day of 2nd month after attaining 420 hours

Maximum:	1,680 hours.
Termination:	less than 140 hours (subject to pay direct option)
Re-instatement:	280 hours if insurance has been discontinued for less than 12months, otherwise 420 hours.

ELIGIBILITY: EDAC

330 hrs. – 1st day of 2nd month after attaining 330 hours

Maximum:	1,320 hours.
Termination:	less than 110 hours (subject to pay direct option)
Re-instatement:	220 hours if insurance has been discontinued for less than 12 months, otherwise 330 hours.

PAY DIRECT:

Fee set by the Trustees. The retail sales tax of 8% will be applied to Pay Direct Fees.

Maximum:	36 consecutive months. Pay Direct is permitted for all coverages except Weekly Disability Income, Long Term Disability Income, Bereavement and Jury Duty Benefits.

LIFE INSURANCE: (on or off the job)

Member - $100,000
Spouse - $10,000
Dependent children - $3,000
Effective July 1, 1994, employer paid premiums for member life insurance are taxable benefits to members.

ACCIDENTAL DEATH & DISMEMBERMENT

$100,000 – Member only on or off the job. All or a percentage of this amount is payable for dismemberment in accordance with the schedule on pages 17, 18, and 19.

WEEKLY SICK PAY:

1st day Accident or Hospitalization, if hospitalized for at least 18 hours or day surgery

8th day Sickness $400 per week effective August 1, 2002 for a maximum of 26 weeks of disability inclusive of Employment Insurance benefits.

Sickness: 1st to 7th day – waiting period

8th to 14th day - $400 for one week

3rd week to 17th week – employment insurance benefits

18th week to 26th week - $400 per week

Accident or Hospitalization:

1st day to 14th day - $400 per week

3rd week to 17th week – employment insurance benefits

18th week to 26th week - $400 per week

LONG TERM DISABILITY BENEFITS

$1,500 a month maximum. Payable after 26 weeks of disability (for injury) and 27 weeks of disability (for disease).

Benefit subject to offsets for certain income received from other sources. Maximum benefit period 5 years, or to age 65, whichever is less.

SUPPLEMENTARY HEALTH BENEFITS:

(Member and Dependents)

Deductible: No deductible

Maximum: **$100,000** lifetime per individual for all eligible expenses except Outside Province

of Residence expenses. **$1,000,000** per disability for Outside Province of Residence Expenses.

DENTAL CARE BENEFITS: 2014 ODA (100%)

(Member and Dependents)

Deductible: No deductible

Maximum: **$2,500** per calendar year
(Jan. 1st to Dec. 31st)

Large Claims: Claims of $300 or more are to be submitted to the Administrator for approval BEFORE the work begins.

Details of coverage and exclusions are frequently not understood. Please carefully read the pages outlining the dental benefits. Also to reduce misunderstanding, **show these pages to your dentist**, as he or she can quickly tell you whether the proposed services are fully, partially or not covered.

ORTHODONTIC TREATMENT

(Program to straighten teeth)

Plan members and dependents up to age 21.

50% co-insurance lifetime maximum **$2,500**

BEREAVEMENT PAY:

Member only, lost earnings up to **$150.00** a day maximum of 3 days to attend or prepare for a funeral of immediate family as defined herein.

JURY DUTY:

Member only. Lost earnings up to a maximum of **$150.00** a day while serving as a juror.

ELIGIBILITY

Who May Be Insured

This Plan is for members of the Labourers' Union Local 506 (Construction Division) who have worked for Contributing Employers.

When You Become Insured Initially

You will become insured for yourself and your eligible dependents on the first day of the second month following your accumulation of **420** hours in your Hour-Bank Account, provided you are actively at work or available for work on the day you would ordinarily become insured.

***Special Note "Eligibility"**

It should be noted that under the "initial eligibility" and "re-instatement" clauses you must be actively at work with a contributing employer on the date your insurance becomes effective or is reinstated.

If you are not "actively at work" on the date your insurance becomes effective, you must be available for work. This is defined as being on the Union's out-of-work list and seeking work.

Should you not meet one of the above requirements, your insurance will only become effective on the date you return to work or your name is placed on the Union's out-of-work list and you are seeking work.

Reinstatement

If your insurance has previously terminated because of insufficient hours in your Hour-Bank Account, you will again become insured on the first day of the second month following a period (not more than 12 consecutive months) in which you accumulate 280 hours (EDAC Division 220 hours) in your account, 280 hours (EDAC Division 220 hours) applies if your coverage has been terminated for less than 12 months; if your coverage has been terminated for 12 months or more, you have to accumulate 420 hours (EDAC Division 330 hours) to become insured again.

If upon termination of your Group life Insurance you converted it in accordance with the section "Conversion Privilege", it will be necessary for you to submit evidence of insurability satisfactory to the Insurer before again becoming insured for Group Life Insurance under this plan.

Termination of Insurance

The insurance for you and your eligible dependents will terminate:

1. The last day of the month in which you have less than **140** hours **(EDAC Division 110 hours)** in your Hour-Bank Account. However, you may arrange to have your insurance, **except Weekly Disability Income, Long Term Disability, Bereavement Pay and Jury Duty** continued for as long as 36 months on a contributory basis.
2. If you enter Military Service.
3. If the Group Policy terminates.
4. If you discontinue any required contributions.
5. If you attain age 65 for Long Term Disability.
6. If you retire for Weekly Disability Income and Long Term Disability coverages.

A dependent's coverage will also terminate when they are no longer an eligible dependent.

Pay Direct Provisions (Plan Members Only)

Before insurance coverage is cancelled because the number of hours in the Plan Member's hour bank has dropped below 140 hours, (EDAC Division 110 hours) the Plan Member will be notified by the Administrator. The Plan Member may then contribute directly, by means of a personal cheque in order to continue their insurance for all benefits EXCEPT WEEKLY DISABILITY INCOME, LONG TERM DISABILITY, BEREAVEMENT PAY AND JURY DUTY. The Plan Member may continue coverage by this "pay-direct" method for a maximum period of 36 months.

The Plan Member must be a member good standing with the Union in order to be allowed to continued their coverage by the pay-direct method. Payment must be received by the Administrator within 30 days of receipt

of out of benefit notification. The cheque should be made payable to the Trustees of the Labourers' Union Local 506 Employee Benefit Trust and mailed to:

Global Benefits
Labourers' Union Local 506
(Construction Division)
Employee Benefit Trust Administrator
88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8

The Plan Member should be sure to print their name and social insurance number on the back of their cheque to ensure that their account is properly credited.

IF THE PLAN MEMBER WISHES TO PAY DIRECTLY, AS PROVIDED FOR ABOVE, IT IS THEIR RESPONSIBILITY TO CONTACT THE ADMINISTRATOR AND MAKE THE NECESSARY PAYMENTS BY THE 15TH OF EACH MONTH. COVERAGE IS TERMINATED IF THE PLAN MEMBER FAILS TO MAKE THE NECESSARY PAYMENTS ON TIME.

Premium Payment in Event of Illness

If while insured under this coverage you are absent from work due to illness, or your are receiving temporary total disability payments of not less than 50% from the Workplace Safety and Insurance Board, premiums for you and your dependents for all coverages except Weekly Disability Income and Long Term Disability Income benefits will be paid from the general reserves of the Trust fund for up to 12 months from the day your illness or disability commences. If, after 12 months, you are still absent from work, coverage will continue for as long as sufficient hours remain in your Hour Bank to cover the monthly withdrawal. You will be required to provide proof to the administrator of your continuing Workplace Safety and Insurance Benefits.

As a plan member, if you are in receipt of disability benefits as a result of an automobile related accident, you would be entitled to the same freezing privileges as any other member on work related or non-work related disability. As such you would receive freezing applied to your hour bank, commencing with the first of the month following the month of disability and continuing until the month the disability benefits is discontinued or for a period of 12 months whichever is the shortest.

Benefit Protection Guarantee

In order to ensure that Plan Members will not suffer a loss of benefit coverage as a result of working for a Contributing Employer who fails to remit contributions to the Plan by the due date in accordance with the terms an conditions of the Collective Agreement, the Trustees of Local Union 506 Construction Division Employee Benefit Trust have now amended the Plan as follows:

Any Plan Member who works for a Contributing Employer who fails to remit contributions to the Plan in a timely manner may receive credit for the hours that they earned and for which no contributions were received by the Administrator provided that:

a) The Plan Member provides to the union a record of employment, pay slips or some other acceptable form of proof of employment which clearly identifies the period of employment and the hours earned.

Upon receipt of proof of employment the Administrator will credit the Plan Member's hour bank with an amount equal to the hours earned to be posted to the month in which the hours were worked, and debit the record of the Contributing Employer with an amount equal to the hours earned which will show as an underpayment.

The Union will be advised of all such underpayment and will immediately pursue collection of all outstanding contribution plus interest from the delinquent employer.

The effective date of this Plan Change is retroactive to January 1, 1996 and in the event that you worked for an employer who failed to make contributions on your behalf between January 1, 1996 and to-date, then you should contact your union immediately at (416) 638-0506.

DEPENDENTS

Eligible Dependents

Your spouse and unmarried children from live birth to 20 years inclusive.

The spouse of a member, which includes:

i) a person married to the member as a result of a valid civil or religious ceremony;
or

ii) a person whose common law relationship with the member has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose, provided the existence of such common law relationship could be established to the satisfaction of the Insurer.

A common law relationship must include continuous cohabitation and public representation of married status.

If the member has been married to more than one person, the term spouse shall mean only the person to whom the member was most recently married, using the above criteria.

Dependent shall not include:

a) a person divorced from the member; or

b) a person cohabiting with the member without public representation of married status.

Children age 21 and over will be considered eligible if in attendance on a full-time basis at an accredited School, College or University, and wholly dependent on you for support and maintenance up to age 25.

Stepchildren, foster children and legally adopted children may be included the same as your own children provided they depend upon you for support and maintenance.

No one will be eligible as a dependent while covered as an employee or while in military service.

Any functionally impaired child incapable of self-support upon attaining age **21** may be continued under dependent insurance while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. To continue a child under this provision, proof of incapacity must be received by the insurer within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

Dependent Coverage

If the Plan Member has sufficient hours in the hour bank to provide for continuing benefit coverage then the member's spouse and dependent children will be covered for benefits following the death of the member for as long as the member has sufficient hours in the hour bank to provide benefits, and shall be guaranteed benefits for a minimum period of no less than 6 months.

Dependent coverage for Plan Members who have elected to continue their benefit coverage by pay direct shall only be entitled to benefits up to the last benefit month for which payment has been received prior to the date of death.

MEMBER LIFE INSURANCE

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

Conversion Privilege

Your Life Insurance continues for 31 days following the termination of your coverage due to insufficient hours in your Hour bank Account. During this 31 day period you may convert the amount of your Life Insurance, to (1) a non-convertible term insurance to age 65, (2) a permanent plan that Great-West Life offers to the public at the time of conversion, or (3) a one-year non-renewable term insurance which may be converted while it is in force to any plan described above without submitting evidence of health. The premium rate will be determined by the Insurance Company from your age and class of risk at the time of conversion.

Waiver of Premium

The premium waiver is provided **only** to disabled plan members who meet the qualification of being totally and permanently disabled from performing any occupation as determined by the insurer. Plan members whose disability prevents them from performing only their own occupation do not qualify for the waiver of premium. Waiver of premium is payable on the Life Benefit **only**, at the principal amount in effect on the date of disability. Premium waiver is not provided on Accidental Death and Dismemberment Benefits. A waiver of premium is payable only for the duration of the disability up to a maximum benefit period of 5 years, or to age 65, whichever is less. Waiver premiums are paid by the Trust.

DEPENDENT LIFE INSURANCE

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you.

Conversion Privilege

Your Dependent Life Insurance continues for 31 days following your death or your termination of coverage due to insufficient hours in your Hour Bank Account.

During this 31 day period your spouse's amount of Dependent Life Insurance may be converted to (1) a non-convertible term insurance to age 65, (2) a permanent plan that Great-West Life offers to the public at the time of conversion, or (3) a one-year non-renewable term insurance which may be converted while it is in force to any plan described above without submitting evidence of health. The premium rate will be determined by the Insurance Company from your spouse's age and class of risk at the time of conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT

Member Accidental Death Benefit

In the event of your accidental death within 365 days of an accident and upon receipt of due proof of loss satisfactory to the Insurer, your beneficiary will receive the full amount of benefit $100,000. This benefit is paid in addition to the Life Insurance benefit.

Accidental death is defined as death resulting from a bodily injury caused by an accident on or off the job.

Member Dismemberment Benefit $100,000

If a member suffers any of the losses specified below, the Insurer will pay the amount of insurance specified for that loss. The loss must result from a bodily injury caused by an accident on or off the job. The Insurer requires due proof on both accidental death claims and dismemberment claims that:

1. the injury occurred while the member was insured under this coverage;
2. the loss occurred within 365 days after the injury;
3. the loss resulted directly and solely from the injury and independently of all other causes.

When injury results in any of the following losses within 365 days after the date of the accident, the Insurer will pay:

SCHEDULE OF BENEFITS

Both Hands . . . . . .The Principal Sum

Both Feet . . . . . .The Principal Sum

Entire Sight of Both Eyes . . . . . .The Principal Sum

One Hand and One Foot . . . . . .The Principal Sum

One Hand and . . . . . .The Principal Sum
Entire Sight of One Eye

One Foot and . . . . . .The Principal Sum
Entire Sight of One Eye

Speech and Hearing . . . . . .The Principal Sum

One Arm . . . . . .3/4 The Principal Sum

One Leg . . . . . .3/4 The Principal Sum

One Hand . . . . . .2/3 The Principal Sum

One Foot . . . . . .2/3 The Principal Sum

Entire Sight of One Eye . . . . . .2/3 The Principal Sum

Speech or Hearing (both ears) .2/3 The Principal Sum

Hearing (one ear) . . . . . .1/3 The Principal Sum

Four Toes of One Foot . . . . . .1/4 The Principal Sum

Thumb only of One Hand . . . .1/4 The Principal Sum

One, Two or Three Fingers . . .1/6 The Principal Sum

Loss of use of:

Both Legs ..... 2 x The Principal Sum

Both Arms and Both Legs.....2 x The Principal Sum

Both Arms .....2 x The Principal Sum

One Arm and One Leg . . . . . .The Principal Sum

Both Hands . . . . . .The Principal Sum

One Arm .....3/4 The Principal Sum

One Leg .....3/4 The Principal Sum

One Hand.....2/3 The Principal Sum

One Foot.....2/3 The Principal Sum

Thumb and Index Finger.....1/3 The Principal Sum of Either Hand or at least Four Fingers of One Hand

Principal Sum means the amount of insurance indicated in the Summary of Benefits.

Loss as used above with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb means the complete loss of the entire phalanx of the thumb; as used with reference to finger means the complete loss of two entire phalanges of the finger; as used with reference to toe means the complete loss of one entire phalanx of the big toe and all phalanges of the other toes; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

Loss as used above with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

Loss as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

Loss as used above with reference to loss of use means the total and irrecoverable loss of use provided the loss is continuous for twelve consecutive months and such loss of use is determined to be permanent at the end of the period.

Indemnity provided under this section for all losses sustained by any one member as the result of one accident shall not exceed the following:

(a) The Principal Sum for all losses except quadriplegia, paraplegia and hemiplegia for members under age 65.

(b) Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after

the date of the accident with respect to quadriplegia, paraplegia and hemiplegia for members under age 65.

Exclusions:

This plan does not cover any loss, fatal or non-fatal, caused or contributed to by:

1. self-destruction or self-inflicted injury, whether the member be sane or insane; or;
2. declared or undeclared war or any act thereof;
3. riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as provided in the part entitled "AIRCRAFT COVERAGE";
4. a period of hospitalization which is less than five days with respect to the "HOSPITAL INDEMNITY" benefit;
5. committing, attempting, or provoking, an assault or criminal offense.

YOUR ACCIDENTAL DEATH AND DISMEMBERMENT PLAN ALSO INCLUDES THE FOLLOWING BENEFITS. THE FOLLOWING BENEFITS ARE BRIEF DESCRIPTIONS, PLEASE CONTACT YOUR PLAN ADMINISTRATOR FOR COMPLETE DETAILS AND LIMITATIONS.

Aggregate Limit

$5,000,000 per accident for all insured members.

Aircraft Coverage

Coverage while riding as passenger but not as a pilot, operator or member of the crew.

Exposure and Disappearance

Loss due to unavoidable exposure to the elements. Loss of life resulting from bodily injury caused by an accident at the time of a disappearance, sinking or wrecking.

Repatriation Benefit

The Insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased member to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, subject to a maximum of $10,000.

Occupational Training Benefit

In the event of your accidental death, the Insurer will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of $10,000.

Rehabilitation Benefit

In the event you sustain an accidental injury which results in a loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and customary expenses incurred for such training subject to a maximum of $10,000 for any one accident.

Family Transportation Benefit

In the event you sustain an accidental injury and are confined in a hospital located more than 150 kilometers from your normal place of residence, the Insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the confined member, subject to a maximum of $1,000.

"Immediate family" means a person at least eighteen years of age who is the spouse, son, daughter, father,

mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat Belt Benefit

In the event you sustain an accidental injury payable under this benefit, the amount of Principal Sum will be increased by 10% if, at the time of the accident, you were:

1. wearing a properly fastened seat belt; and
2. driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a physician, at the time of the accident. Intoxication and being under the influence of drugs is as defined by the local jurisdiction where the accident occurred.

Hospital Indemnity

A daily benefit (1/30th of 1% of your Principal Sum, maximum of $2,500 per month) will be payable if you are confined in a hospital and under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per injury.

Education Benefit

In the event of your accidental death, the Insurer will pay the Education Benefit stated below for each of your dependent children who are enrolled as full-time students in an institution for higher learning within 365 days following date of death of the member.

The Education Benefit is equal to the reasonable and customary expenses actually incurred, subject to the lesser of 5% of your Principal Sum or $5,000, for each year the dependent child described above continues his education on a full-time basis in an institution for higher learning, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

"Institution for higher learning" includes any university, college, CEGEP or trade school.

WEEKLY DISABILITY INCOME

If you become totally disabled while insured and unable to work as a result of a non-occupational accident or disease, you will be paid at the rate of $400.00 for each week of work that you miss. Benefits will begin on the dates described in a) and b) below, subject to the fulfillment of the coverage provisions.

a) In the case of an accident, your benefits will start from the first day that you miss work, after you have been treated by your doctor (MD).

b) In the case of sickness, your benefits will start from the later of, the eighth day after the date confirmed by your doctor (MD) as the beginning of your disability, or the date you are first seen by your doctor (MD). However if the member is hospitalized for at least 18 hours due to illness, benefits will commence from the date of hospitalization. If the member undergoes day surgery, benefits will commence on the date of their surgery, if earlier than the eighth day.

   "Day-Surgery" shall mean procedures which require an incision or laser procedure which would otherwise be performed as a qualifying surgical procedure. Outpatient testing procedures, including scopes which do not require an incision, are not covered under hospitalization for day-surgery.

Benefits will continue for a maximum of 14 days from the date of disability. If you are then eligible for Disability benefits from Employment Insurance, the plan will stop payment and your disability benefits will continue for a maximum of 15 weeks from the E.I. Upon the expiration of Disability benefits from the E.I., the plan will immediately begin the payment up to a maximum of 9 additional weeks. In this case, your total period of protection from both the E.I. and the plan is 26 weeks for any single period of disability.

Alternatively, if you are not eligible for weekly disability benefits from E.I., your benefits will continue from the plan and will be payable for a maximum of 26 weeks.

Note: Be sure to apply for Employment Insurance Disability benefits as soon as you become disabled. If you do not qualify for these benefits, please contact the Administration Office immediately.

If following a period of disability you return to active work for at least two weeks, a recurrence of this disability will be considered a new period of disability.

Weekly Sick Benefit - **$400.00** a week.
Offsets to Benefits - None.

If you have received Weekly Disability Income benefits under this plan which advances a claim against a third party, and the claim arises out of the incident which caused or contributed to the disability for which benefits were paid, and you recover monies from the third party (by way of judgement or settlement), then such monies will be applied first to reimburse the Insurer for all benefits received by you. At the Insurer's request, you will execute such documents as are required by the Insurer to acknowledge the obligation to reimburse and to assign monies recovered by you to the Insurer up to an amount equal to the total amount of Weekly Disability Income benefits received by you to the date of such judgement or settlement.

Exclusions

Benefits are not payable:

- for disabilities arising from:
- auto-related accidents;
- work-related accidents;
- intentionally self-inflicted injuries;
- voluntary participation in a war, riot, or insurrection;

- during a period of disability in which the member is imprisoned in a penal institution or confined in a hospital, or similar institution as a result of criminal proceedings;
- during a leave of absence including maternity leave;
- for the portion of a period of disability during which you are not under treatment by a physician.

MEMBER LONG TERM DISABILITY BENEFITS

This benefit is equal to $1,500 per month, subject to the 85% All Source Maximum described under Offsets.

The qualifying disability period is 182 consecutive days for disability due to injury (26 consecutive weeks) and 189 consecutive days for disability due to disease (27 consecutive weeks), prior to age 65, or the duration of the benefit period provided under Weekly Disability, whichever is greater.

No-Evidence Limit: Evidence of insurability will not be required.

In the event you become totally disabled for the required period of time known as the Qualifying Disability Period and you are under the continual treatment of a legally qualified physician, you will receive a monthly income benefit.

Qualifying Disability Period:

- 26 consecutive weeks (for injury) and 27 consecutive weeks (for disease).

Monthly Benefit: $1,500

Maximum Disability Period:

- 5 years or to age 65, whichever is less.

Benefits will not be payable beyond age 65, unless you satisfy the Qualifying Disability Period while age 64, in which case benefits will be payable for a maximum of 12 months.

Total Disability

You are considered totally disabled, during the first 24 months in which you receive benefits, if you are unable to perform any and every duty of your occupation. After this period you are considered totally disabled if you are unable to perform any and every duty of any occupation or employment for which you are reasonably qualified by training, education or experience.

Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full-time employment for a period of 6 consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

Offsets

The monthly benefit shall be reduced by payments received from the Labourers' Pension Fund of Central and Eastern Canada shall be limited to 50% of the amount of the pension received up to a maximum reduction of $500.00 per month.

All Source Maximum:

If the reduced monthly benefit described above under Offsets:

i) plus any income or benefits described as a), b), and c) above;

ii) plus any Canada Pension Plan or Quebec Pension Plan family benefits;

iii) plus any payments on account of your disability from any Workplace Safety and Insurance law or similar law;

If a member is receiving any income or benefit payable under any government plan or program or any Workers' Compensation law or similar law for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the gross monthly benefit by that amount.

is in excess of 85% of your "net" earnings at the date disability commenced, the monthly benefit will be further reduced by the amount of such excess.

Exclusions and Limitations

Benefits are not payable for the following:

1. for any portion of a period of disability unless you are receiving ongoing supervision/ treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;
2. for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
3. for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
4. disabilities resulting from self-inflicted injuries or attempted suicide;

5. disabilities as a result of participation in a war, riot, insurrection or criminal offense;
6. for the portion of a period of disability during which you are
   a) imprisoned in a penal institution; or
   b) confined in a hospital, or similar institution, as a result of criminal proceedings;
7. any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet;
8. a disability resulting from an accident which occurs while the member is operating a motor vehicle and the blood contains more than 80 milligrams of alcohol in 100 milliliters of blood (0.08%);
9. or any disabilities resulting from any motor vehicle accident occurring within the provinces of Ontario or Quebec;

Subrogation

In the event of any payment under this coverage, the Insurer shall be subrogated to all of your rights of recovery therefore against any person or organization and you shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. You shall do nothing to prejudice such rights.

Rehabilitative Employment

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would take into account the nature and limitations of your disability. Further details on this aspect will be provided in the event that you become disabled.

Termination – attainment of age 65 or retires.

Time Limitation

A claim for disability income benefits must be submitted within 6 months of the end of the qualifying disability period.

CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS

Effective **January 1, 1996** no benefits will be paid for any claims arising as a result of an Automobile Related Accident which occurs on or after **January 1, 1996**.

Notwithstanding any other provisions of the Plan, claims for benefits arising out of an automobile accident shall be governed by the following.

Certain benefits may be available to Plan Members of the Plan who suffer an impairment as a result of an automobile accident through the "no fault" scheme established by the Province of Ontario. The Labourers' Union Local 506 (Construction Division) excludes those benefits to the extent that a Plan Member is eligible to receive them. The Plan Member will not be entitled to receive benefits under the Plan to the extent he is eligible to receive the "no fault" benefits. This is the case even where the Plan Member is not in receipt of the "no fault" benefits if the Plan Member fails to diligently make application and pursue the "no fault" benefits.

Notwithstanding any other provision of this Plan, no benefits are payable under the Plan to a Plan Member where the Plan Member has incurred an impairment as a result of an automobile accident to the extent the Plan Member is eligible for "no fault" benefits. A Plan Member who incurs an impairment as a result of an automobile accident will be entitled to benefits under the Plan to the extent that:

1. They are not available as "no fault" benefits;

2. There are exclusions in the "no fault" Plan which would exclude or exempt coverage under the "no fault" benefits but are not so exempt by this Plan;

3. The "no fault" benefits are of a limited duration and the benefits available under the Plan are of a greater duration; or

4. The benefits would otherwise be available to the Plan Member under the terms of the Plan.

An individual will **NOT** be entitled to benefits under the Plan if he:

a) Fails to diligently apply for and provide all necessary information to become entitled to "no fault" benefits; or

b) Fails to provide further information and to maintain qualification for the "no fault" benefits.

A Plan Member shall also be disentitled to benefits under the Plan if the Plan Member accepts a settlement respecting the "no fault" benefits to which he or she would otherwise have been entitled. The Plan Members shall be disentitled to benefits under the Plan to the extent that the settlement constitutes a compromise of or waiver of entitlement to "no fault" benefits otherwise available to the Plan Member.

Where a Plan Member makes a claim for benefits under the Plan and has been in receipt of "no fault" benefits, the Plan Member may be required to provide an accounting of the benefits as received under the "no fault" Plan. In addition, a Plan Member who has not indicated receipt of "no fault" benefits may be required to provide evidence that the loss for which a claim is being made does not arise out of an automobile accident.

The benefits under the Plan affected by these provisions will depend on the "no fault" benefits available from time to time. At the date of the writing

of this provision, those benefits include but are not necessarily limited to the following:

1. Short and long term disability benefits;
2. Supplementary health benefits including:
    - prescription drugs
    - vision care
    - ambulance service
    - private duty nursing
    - dental accidents
    - orthopaedic supplies
    - hearing aids
    - physiotherapy and occupational therapy
    - artificial and assistive devices
    - physiological services

The exclusions and limitations described in this section which are applicable to a Plan Member are also applicable to a dependent who makes a claim under the Plan.

SUPPLEMENTARY HEALTH BENEFITS

Member and Dependent Coverage

In the event that you incur in a calendar year any of the Eligible Expenses listed below, you will be paid **100%** of such expenses up to the lifetime Maximum.

Cash Deductible – Zero

Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependents is limited to the Lifetime Maximum Benefit specified in the Summary of Benefits.

On January 1 of each year benefits that were payable prior to that date and not previously reinstated shall be restored subject to the following:

1. the maximum amount restored for each person in a year shall be the lesser of:

   i) $10,000 or

   ii) the amount needed to restore the maximum to $100,000

2. restoration shall not apply to retired members, members age 65 or over, or to any year beginning after termination of insurance during any period of extended benefits.

If benefits which have not been automatically restored for a member or any dependent, in accordance with the preceding paragraph, exceed, in the aggregate, $10,000, the Lifetime Maximum Benefit applicable to such member or dependent may be reinstated, if evidence of insurability satisfactory to the Insurer is submitted to it. The Lifetime Maximum Benefit applicable on the date of approval of such evidence by the Insurer at its Head Office shall be reinstated on that date if he is eligible under this coverage on that date, provided in the case of a member, that he is then actively at or registered for work; otherwise reinstatement shall be effective on the first date thereafter on which he is actively at or registered for work; in the class of members eligible for insurance under this coverage.

Eligible Expenses

The following is a list of eligible expenses.

Hospital Expenses in Canada

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital.

Prescription Drug Expenses

Any medically necessary drug or medicine available **only by prescription** and dispensed by a licensed pharmacist. **Items that can be obtained without a**

prescription are not covered by this plan and claims for such items will be rejected by the Administrator.

No benefit shall be payable for:

1. vitamins, supplements or diet foods;
2. food including infant foods and salt and sugar substitutes;
3. any single purchase of drugs which would not reasonably be used within 90 days of purchase.

Ontario Drug Benefit Program

Dispensing fees and deductibles that would regularly be eligible for benefit coverage will continue to be eligible for benefit coverage for those people over age 65 who are obliged to make the payments when in receipt of drugs dispensed through the Ontario Drug Benefit Program.

Outside Province of Residence Expenses

If, while traveling outside Province of Residence, hospitalization or medical treatment is required due to emergency and non-elective reasons, the following expenses are covered: "subject to a maximum eligible expense of $1,000,000 for expenses incurred due to any one cause or related causes."

1. reasonable and customary hospital charges in excess of any provincial government plan allowance for each day of such hospital confinement;
2. reasonable and customary charges in excess of any government plan allowance for the services of a physician;
3. reasonable and customary charges in excess of any provincial government allowance for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Extended Health Expenses

1. Charges for the services of a licensed speech therapist who is not a member of the family, to restore speech loss or correct an impairment due to a) congenital defect for which corrective surgery has been performed, or b) an accident or sickness except a functional nervous disorder up to a maximum of $500 per calendar year;

2. Charges for the services of an osteopath and podiatrist up to a maximum eligible expense of $300 in excess of the provincial plan beginning with the first visit per specialty for any calendar year for each individual;

3. Charges for the services of a qualified acupuncturist up to a maximum of $25 for each treatment up to $300 per calendar year;

4. Charges for the services of a chiropractor up to a maximum eligible expense of $35 per visit up to a maximum of $500 per calendar year;

5. Charges for the services of a physiotherapist, who is not a member of the family, when not covered by a provincial government plan up to $60 per visit up to a maximum of $1,500 per calendar year;

6. Charges for the services of a psychologist up to a maximum of $300 per calendar year;

7. Charges for the services of a psychoanalyst up to a calendar year maximum of $300.

8. Charges for the services of a massage therapist up to a maximum of 50% for each treatment up to $300 per calendar year. Doctor's referral required once every calendar year.

9. Charges for the services of a registered nurse (R.N.), which are rendered in the patient's home, provided such nurse is not a resident in your home or a relative of your family. These charges

will be considered eligible expenses only if recommended by a physician and only if it is medically necessary. You should apply for a pre-care assessment before home nursing begins;

10. Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer;

11. Charges for rental (or, at the Insurer's option, purchase) of braces, crutches and purchase of prostheses;

12. Charges for professional ambulance service other than airline, to the nearest hospital qualified to provide the necessary treatment;

    Emergency transportation by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation is subject to a maximum eligible expense equal to the economy airfare for the insured, and, if medically required, a medical attendant who is neither a resident in the member's home nor a relative of the member or the member's spouse.

13. Charges for necessary dental treatment required as the result of an accidental injury by external means to sound natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be a covered medical expense;

14. Charges for orthopedic shoes and special foot appliances which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment. Charges for orthopedic shoes,

including repairs, are limited to a maximum benefit of $250 every 12 consecutive months; charges for orthotics are limited to a maximum benefit of $400 every 12 consecutive months.

15. Charges for laboratory tests and x-rays not covered by any provincial government plan;

16. Charges for hearing aids, subject to a maximum eligible expense of one hearing aid up to a maximum of $400 per person in any period of 24 consecutive months;

17. Charges for vaccinations and immunizations;

18. For diabetics the cost of needles, syringes and/or chemical diagnostic aids. A blood glucose monitoring machine is covered to a maximum of $50 per person per lifetime.

19. Expenses required after surgery for breast prosthesis $350 every 24 months, surgical brassiere 2 per calendar year.

20. Expenses for fertility drugs to a lifetime maximum of $5,000 effective January 1, 2008.

21. Expenses for smoking cessation products are limited to $400 per person per lifetime.

22. Benefits for synvisc are limited to a maximum of 3 treatments (including 3 injections per treatment) in a 12-month period.

23. Benefits are payable for physician services provided in Canada for the completion of claim forms or other medical assessment forms required for claims adjudication purposes. The maximum amount payable is $100 for any one disability.

24. Wigs for cancer patients undergoing chemotherapy is $500 every year.

25. Surgical hose – 2 pairs per calendar year.

26. Tens machine - $400 lifetime maximum.

Vision Care Expenses

Charges for vision care as follows: These limitations shall not apply in the event of an accidental injury to the natural eye.

1. Eye examinations performed by a qualified optometrist or ophthalmologist;
2. Eyeglasses or contact lenses to a maximum expense of $300 per calendar year per person.
3. Laser eye surgery up to $1,000 lifetime maximum.

Exclusions

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment;
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices;
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions;
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances;
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada;
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case

of certain maintenance drugs, a 100-day supply will be covered;

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital;
- Non-injectable allergy extracts;
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason;

Limitations

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

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

- Services or supplies that do not represent reasonable treatment;
- Services or supplies associated with: recreation or sports rather than with other daily living activities;
- the diagnosis or treatment of infertility, other than drugs contraception, other than oral contraceptives;
- Extra medical supplies that are spares or alternates;
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province;
- Expenses arising from war, insurrection, or voluntary participation in a riot;
- Chronic care.

The foregoing list of eligible expenses shall not include any of the following:

1. Charges which are considered an insured service of any provincial government plan;
2. Charges for general health examinations;
3. Charges for surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
4. Charges for a surgical procedure by a physician other than as provided under outside Province of Residence expenses;
5. Charges not specified in the list of eligible expenses;
6. Charges which are from an occupational injury or sickness covered by any Workplace Safety and Insurance law or similar legislation;
7. Charges for dental work where a third party is responsible for payment of such charges;
8. Charges for transport or travel, other than as provided under eligible expenses;
9. Charges which are furnished without the recommendation or approval of a licensed physician;
10. Charges which are not medically necessary to the care and treatment of any existing injury, disease or pregnancy;
11. Charges which would not normally have been incurred but for the presence of this insurance or for which the member is not legally obligated to pay;
12. Charges which the Insurer is not permitted by law to cover;

13. Charges incurred for any loss caused by or contributed to by any motor vehicle accident occurring in the provinces of Ontario or Quebec.

14. Charges for convalescent hospital.

DENTAL EXPENSE BENEFIT

Member and Dependent Coverage

As the wording of this dental coverage is technically oriented you are strongly urged to take this booklet with you when you visit your dentist.

In the event that you incur in a calendar year any of the eligible expenses listed below, you will be paid **100%** of the eligible expenses up to a limit of the appropriate fee in the 2014 Ontario Dental Association fee guide (General Practitioner).

NOTE: Specialist fees charged in excess of the 2014 Ontario Dental Association fee guide for general practitioners are not an eligible expense.

Cash Deductible – Zero

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Summary of Benefits, which is presently $2,500 per calendar year (January 1st to December 31st) for the member and each eligible dependent.

Extension of Benefits

No benefits for Eligible Expenses will be paid after the termination of the Master Policy or after your insurance under this coverage ceases except to complete the installation of dentures within 30 days of the termination of coverage provided the impression was taken prior to termination.

Dental Claim Form Required

No payment will be made unless a Dental Claim Form, satisfactory to the Insurer, is submitted to the Administrator.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, The Manufacturers Life Insurance Company reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, the Administrator will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your Plan Administrator, including pre-treatment x-rays if the proposed treatment involves crowns or bridgework.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the 2014 Fee Guide for General Practitioners of the Dental Association. Further details may be found in the Master Policy.

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

   (a) oral examinations: standard oral examination limited to once every 6 months, complete oral exam and diagnosis is covered only once every 2 years;

   (b) x-rays: complete series or equivalent once every 2 years;

   (c) study casts: once per year;

2. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures.

3. **Preventive Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

   (a) scaling and polishing (prophylaxis) once every 6 months, topical fluoride;

   (b) passive space maintainers, those that do not move the teeth, for dependent children only.

4. **Basic Restorative Dentistry:** The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings excluding white fillings on molar teeth) or stainless steel crowns. In addition, sedative dressings are covered.

5. **Extractions:** Removal of teeth.

6. **Endodontics:** Emergency endodontic procedures and root canal therapy.

7. **Periodontics:**

   (a) Adjunctive Services as follows: Scaling, Root planning, Acute infections, Occlusal Adjustment, Provisional splinting;

   (b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;

   (c) Special Periodontal Appliances.

8. **Oral Surgery:** Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post operative care.

9. **Repairs, Relining and Rebasing of Dentures:** Repair or relining and rebasing of dentures (once every 3 years), including addition of new teeth,

but not including the cost of dentures, their replacement or duplication.

10. **Removable Prosthetic Devices:** The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming insured.

    Initial installation of partial or full dentures is not covered except if:

    (a) The initial installation is more than 12 consecutive months after the plan member became insured under this coverage.

    Replacement of existing dentures is not covered except if:

    (a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan or;

    (b) The replacement is more than 12 consecutive months after the individual became insured under this coverage, and the existing dentures are at least 5 years old and no longer serviceable.

    Temporary denture is covered under the plan but must be replaced with permanent denture within 12 months.

    Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is **not covered**.

11. **Extensive Restorative Dentistry:** Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual

costs of such a restoration. Such procedures are subject to the pre-existing condition limitations on teeth fractured prior to becoming insured.

12. **Fixed Prosthetic Devices:** The initial installation of fixed prosthetic devices subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming insured.

    The initial installation of fixed prosthetic devices is not covered except if:

    (a) The initial installation is more than 12 consecutive months after the plan member became insured under this coverage.

    Recementing and replacement of the facing or veneer of the fixed prosthetic device.

    The replacement of existing fixed prosthetic devices is not covered except if:

    (a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan or;

    (b) The replacement is more than 12 consecutive months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

    (c) Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants are covered only up to the amount that would have been paid for the best alternative treatment i.e. bridgework.

ORTHODONTICS

(Program to Straighten Teeth)

(Plan member and dependents up to age 21)

This benefit applies to orthodontic treatment for members and dependents who are covered for Dental Insurance. The maximum lifetime benefit is $2,500, which is available to each covered member or dependent.

The Plan pays 50% up to $5,000 of eligible charges to a lifetime maximum of $2,500, e.g.

Eligible Charges	**Plan Pays**
$1,500	$750
$2,000	$1,000
$3,000	$1,500
$5,000	$2,500 maximum

If a plan member or dependent attains maximum age while in receipt of orthodontic treatment for a plan which commenced prior to their attaining maximum age, the payment of benefits will continue until the treatment plan has been completed.

Eligible charges are those made to you for an Orthodontic procedure that is in an "Orthodontic Treatment Plan" that prior to the treatment has been reviewed by the Administrator and returned to you showing estimated benefits.

The claim will be paid in equal installments beginning when the orthodontic appliances are first inserted, and monthly or quarterly thereafter for the estimated duration of the treatment plan, as long as the patient remains covered and continues to receive the treatment.

In any event the following charges are not eligible:

1. Charges for a procedure for which an active appliance was installed before the patient was covered;

2. A charge incurred while the patient's coverage isn't in effect. However, if benefits are being paid at termination of coverage, they will be continued for charges incurred within 90 days of termination and will be considered as incurred prior to termination.

ORTHODONTICS

Treatment Plan Provisions

A Treatment Plan is a written report prepared by the dentist showing the recommended treatment program and the estimated cost. You are required to submit a Treatment Plan to the Administrator prior to the commencement of treatment in all cases where the estimated cost is $300 or more. This enables the Administrator to determine in advance what the Plan's share of the cost of treatment is and thus allow you to know the extent of your share of the cost.

Exclusions and Limitations

Payments will not be made for any dental procedure required due to any injury or disease for which the member or dependent was advised to receive treatment, or for which treatment began before the effective date for that dental procedure. Payments will not be made for any dental procedure required due to teeth extracted, missing or fractured before the effective date for that procedure.

1. Services or supplies that are primarily for cosmetic dentistry (veneers, recontouring existing crowns and staining porcelain);
2. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
3. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
4. Any miscellaneous charges such as counseling or instruction, travel, broken appointments, communication costs of completion of forms;

5. Any charge resulting from any intentionally self-inflicted injury;

6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover;

7. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;

8. Any hospital charges for board and room and related services and supplies;

9. Any dental examinations required by a third party;

10. Services or supplies in connection with any procedure excluded as an eligible expense;

11. Services or supplies in connection with Orthodontics (the straightening of teeth by braces) except for plan members and dependents under age 21;

12. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease.

13. Duplicate X-Ray;

14. Custom flouride appliance, any oral hygiene instruction and nutritional counselling;

15. Temporomandibular joint disorders, vertical dimension correction or myofacial pain.

BEREAVEMENT PAY

In the event of a death in the member's immediate family, an eligible member shall be entitled to Bereavement Pay for lost time from work up to a maximum of 3 days (excluding week-ends) for each day that the member is absent from work for the purposes of attending or arranging the funeral.

Immediate family shall be defined as the member's **Spouse, Son, Daughter, Mother, Father, Brother, Sister, Grandfather, Grandmother, Mother-in-law, Father-in-law**.

Immediate family shall include legal, common-law and adoptive relationships.

The maximum benefit payable shall be $150.00 a day for each day that the member is absent from work, up to 3 days.

No payment shall be made for lost time following the date of the funeral unless the member is required to travel for the purpose of attending the funeral.

Bereavement Pay for lost time on Saturday or Sunday shall only be paid if the member was scheduled to work on such day and this requirement is verified by the member's employer.

To be eligible for benefit a member must have been in benefit at the date of the death.

Claim forms may be obtained from the Union office or the Administrator and must be completed by the member and his/her employer.

JURY DUTY BENEFIT

Eligible Members who are called to perform Jury Duty shall be entitled to be paid for lost earnings up to a maximum of $150.00 a day less any fee received from the Court for any day that the Member incurs lost earnings while serving as a Juror.

Claim Forms should be obtained from the Union Office and completed by both the Member and his/her Employer.

Completed Claim Forms should be sent to the Administrator.

Bereavement Pay and Jury Duty benefits are self-insured benefits, provided by the Employee Trust Fund and are not underwritten by the insurance carrier.

LABOURERS' UNION LOCAL 506 RETIREE BENEFIT

Life Insurance

Member:	$12,000.00
Spouse/child:	$5,000.00

Supplementary Health Benefits:

Member and Dependents Coverage

Deductible:	No deductible
Maximum:	$100,000 lifetime per individual for all eligible expenses.
Percentage:	100% for all eligible expenses
Dental Care Benefits:	2014 ODA (100% Basic and dentures/90% bridgework and crowns)
Deductible:	No deductible
Maximum:	$2,000 per calendar year per person
Maximum Lifetime:	$10,000 per person
Reinstatement:	$10,000 per person
Orthodontic Treatment:	Nil

SUPPLEMENTARY HEALTH BENEFITS

Member and Dependents Coverage

In the event that you incur in a calendar year any of the Eligible Expenses listed below, you will be paid 100% of such expenses up to the lifetime Maximum.

Cash Deductible – Zero

Eligible Expenses

The following is a list of eligible expenses:

Hospital Expenses in Canada

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital.

Prescription Drug Expenses

Any medically necessary drug or medicine **available only by prescription** and dispensed by a licensed pharmacist. **Items that can be obtained without a prescription are not covered by this plan and claims for such items will be rejected by the Administrator**.

No benefit shall be payable for:

1. vitamins, supplements or diet foods;
2. food including infant foods and salt and sugar substitutes;
3. any single purchase of drugs which would not reasonably be used within 90 days of purchase.

Extended Health Expenses

1. Charges for the services of a licensed speech therapist who is not a member of the family, to restore speech loss or correct an impairment due to a) congenital defect for which corrective surgery has been performed, or b) an accident or sickness except a functional nervous disorder up to a maximum of $300 per individual per calendar year;
2. Charges for the services of an osteopath, or a qualified acupuncturist up to a maximum eligible expense of $300 per specialty for any calendar year for each individual;
3. Charges for the services of a chiropractor or a podiatrist up to a maximum eligible expense of

$300 per specialty per calendar year per person, in excess of the OHIP limits beginning with the first visit;

4. Charges for the services of a physiotherapist, who is not a member of the family, when not covered by a provincial government plan up to a maximum of $300 per individual per calendar year;

5. Charges for the services of a registered nurse (R.N.), which are rendered in the patient's home, provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if it is medically necessary up to a maximum of $5,000 per individual per calendar year;

6. Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer;

7. Charges for the rental (or, at the Insurer's option, purchase) of braces, crutches and purchase of prostheses;

8. Charges for professional ambulance service, other than airline, to the nearest hospital qualified to provide the necessary treatment;

   Emergency transportation by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation is subject to a maximum eligible expense equal to the economy airfare for the insured, and, if medically required, a medical attendant who is neither a resident in the member's home nor a relative of the member or the member's spouse.

9. Charges for necessary dental treatment required as the result of an accidental injury by external

means to sound natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be a covered medical expense;

10. Charges for orthopedic shoes and special foot appliances which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment. Charges for orthopedic shoes, including repairs, are limited to a maximum benefit of $250 every 12 consecutive months; charges for orthotics are limited to a maximum benefit of $400 every 12 consecutive months.

11. Charges for laboratory tests and x-rays not covered by any provincial government plan;

12. Charges for hearing aids, including batteries and repair, subject to a maximum eligible expense of $500 every 36 months;

13. Charges for vaccinations and immunizations;

14. For diabetics the cost of needles, syringes, and/or chemical diagnostic aids. A blood-glucose monitoring machine is covered to a maximum of $50 per person per lifetime;

15. Expenses required after surgery for breast prostheses - $350 every 24 months;

16. Smoking cessation: Expenses for smoking cessation products are limited to $400 per person per lifetime.

17. Benefits for synvisc are limited to a maximum of 3 treatments (3 injections per treatment) in a 12-month period;

18. Surgical brassiere 2 per calendar year;

19. Wigs for cancer patients undergoing chemotherapy is $500 every year;
20. TENS machine $400 lifetime maximum;
21. Surgical hose 2 pairs per calendar year;
22. Charges for the purchase of a medical protection travel plan, will be reimbursed for premium paid up to $400 per calendar year per family.

Vision Care Expenses

Charges for eyeglasses or contact lenses up to a maximum of $300.00 every 24 consecutive months.

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

1. Charges for convalescent hospital;
2. Charges for outside Province of residence expenses;
3. Charges which are considered an insured service of any provincial government plan;
4. Charges for general health examinations;
5. Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
6. Charges for a surgical procedure by a physician;
7. Charges not specified in the list of eligible expenses;
8. Charges which are from an occupational injury or sickness covered by any Workplace Safety and Insurance law or similar legislation;
9. Charges for dental work where a third party is responsible for payment of such charges;
10. Charges for transport or travel, other than as provided under eligible expenses;

11. Charges which are furnished without the recommendation or approval of a licensed physician;

12. Charges which are not medically necessary to the care and treatment of any existing injury disease or pregnancy;

13. Charges which would not normally have been incurred but for the presence of this insurance or for which the member is not legally obligated to pay;

14. Charges which the Insurer is not permitted by law to cover;

15. Charges incurred for any loss caused by or contributed to by any motor vehicle accident occurring in the provinces of Ontario or Quebec.

DENTAL EXPENSE BENEFIT

Member and Dependent Spouse Coverage

In the event that you incur in a calendar year any of the Eligible Expenses listed below, you will be paid **100%** of the Eligible Expenses for basic work and 90% for bridgework up to a limit of the appropriate fee in the 2014 Ontario Dental Association fee guide (General Practitioner).

Cash Deductible – Zero

Maximum Benefit

The total benefits payable are subject to the maximum specified in the Summary of Benefits, which is presently $2,000 per calendar year (January 1st to December 31st) for the member and dependent spouse.

Extension of Benefits

No benefits for Eligible Expenses will be paid after the termination of the Master Policy or after your insurance under this coverage ceases except to

complete the installation of dentures within 30 days of the termination of coverage provided the impression was taken prior to termination.

Dental Claim Form Required

No payment will be made unless a Dental Claim Form, satisfactory to the Insurer, is submitted to the Administrator.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, The Manufacturers Life Insurance Company reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, the Administrator will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your Plan Administrator, including pre-treatment x-rays if the proposed treatment involves crowns or bridgework.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the appropriate fee in the 2014 Ontario Dental Association fee guide (General Practitioner). Further details may be found in the Master Policy.

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

    a) oral examinations: standard oral examination limited to once every 6 months, complete oral exam and diagnosis is covered only once every 2 years;

    b) x-rays: complete series or equivalent once every 2 years;

c) study casts: once per year;

2. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures.

3. **Preventive Therapy:** Procedures intended to eliminate or reduce the need for further dental treatment subject to the following limitation:

   a) Scaling and polishing (prophylaxis) once every 6 months, topical fluoride.

   b) Pertaining to passive space maintainers as outlined under the Active Members benefit.

4. **Basic Restorative Dentistry:**
   The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings excluding white fillings on molar teeth). In addition, sedative dressing are covered.

5. **Extractions:** Removal of teeth.

6. **Endodontics:** Emergency endodontic procedures and root canal therapy.

7. **Periodontics:**

   a) Adjunctive Services as follows: Scaling, Root Planning, Acute infections, Occlusal Adjustment, Provisional Splinting;

   b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;

   c) Special Periodontal Appliances.

8. **Oral Surgery:** Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post operative care.

9. **Repairs, Relining, and Rebasing of Dentures:** Repair or relining and rebasing of dentures (once every 3 years), including

addition of new teeth, but not including the cost of dentures, their replacement or duplication.

10. **Removable Prosthetic Devices:** The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming insured.

    Initial installation of partial or full dentures is not covered except if:

    a) The initial installation is more than 12 consecutive months after the plan member became insured under this coverage.

    Replacement of existing dentures is not covered except if:

    a) The replacement is required because of extraction, loss or fracture of one of more sound natural teeth after the individual became insured under this plan or;

    b) The replacement is more than 12 consecutive months after the individual became insured under this coverage, and the existing dentures are at least 5 years old and no longer serviceable.

11. **Extensive Restorative Dentistry:** Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. Such procedures are subject to the pre-existing condition limitations n teeth fractured prior to becoming insured.

    Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is **not covered**.

Extensive Restorative Dentistry: Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. Such procedures are subject to the pre-existing condition limitations on teeth fractured prior to becoming insured.

12. **Fixed Prosthetic Devices:**
The initial installation of fixed prosthetic devices subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming insured.

The initial installation of fixed prosthetic devices is not covered except if:

a) The initial installation is more than 12 consecutive months after the plan member became insured under this coverage.

Recementing and replacement of the facing or veneer of the fixed prosthetic device.

The replacement of existing fixed prosthetic devices is not covered except if:

(a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan or;

(b) The replacement is more than 12 consecutive months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

Treatment Plan Provisions

A Treatment Plan is a written report prepared by the dentist showing the recommended treatment program

and the estimated cost. You are required to submit a Treatment Plan to the Administrator prior to the commencement of treatment in all cases where the estimated cost is $300 or more. This enables the Administrator to determine in advance what the Plan's share of the cost of treatment is and thus allow you to know the extent of your share of the cost.

Exclusions and Limitations

Payments will not be made for any dental procedure required due to any injury or disease for which the member or dependent was advised to receive treatment, or for which treatment began before the effective date for that dental procedure. Payments will not be made for any dental procedure required due to teeth extracted, missing or fractured before the effective date for that procedure.

1. Services or supplies that are primarily for cosmetic dentistry;
2. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
3. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
4. Any miscellaneous charges such as counseling or instruction, travel, broken appointments, communication costs of completion of forms;
5. Any charge resulting from any intentionally self-inflicted injury;
6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover;
7. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;
8. Any hospital charges for board and room and related services and supplies;

9. Any dental examinations required by a third party;
10. Services or supplies in connection with any procedure excluded as an eligible expenses;
11. Services or supplies for implantology;
12. Services or supplies in connection with Orthodontics;
13. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease.

BEST DOCTORS

Available for Active & Retired Members

How to Contact Best Doctors

Simply call 1-877-419-BEST (2378) and you will be connected to one of the Member Advocates - a Registered Nurse – who will help you get started. The Member Advocate will take care of all the details for you to begin the Best Doctors Check-up to ensure you have the right diagnosis and the right treatment plan.

Best Doctors was founded in 1989 by Harvard Medical School professors. It opened its Canadian Office in 1998.

The services include the interconsultation – provides an in-depth review of a member's medical files to confirm diagnosis and treatment.

- Best Doctors 360° - helps members navigate the healthcare system to take control of their own healthcare
- FindBestDoc – locate a specialist if a member does not have one
- FindBestCare – access to hospital and doctor discounts if out-of-country care is necessary. Out-of-country costs are the responsibility of the Plan Member.

To be eligible for this service you must be a member in good standing with Labourers' Union Local 506 and covered for benefits under Labourers' Union Local 506 (Construction Division) Employee Benefit Trust Fund. This benefit is provided through a partnership between Best Doctors and Great-West Life.

EMPLOYEE ASSISTANCE PROGRAM

Available for Active & Retired Members. Effective January 1, 2014 the Plan of Benefits is to provide an employee Assistance Program providing the following coverage for Eligible Active Plan Members and their dependents. This program is provided by Great-West Life and Schepell.fgi.

Contact Program

- Assessment counseling, case management and referral services
- Work-life support and resources
- Online services
- Trauma response service
- Employer/manager support services

Schepell.fgi. provides the services to the Plan Members on a strictly Confidential basis. The contact number for assistance is: toll free 1 800 387-4765 or online resources at www.shepellfgi.com

GENERAL PROVISIONS

Enrollment

The Insurer has allowed a 30 day open enrollment at the inception of the Plan with no medical evidence required following which anyone wishing to become insured with the exception of new retirees would be required to submit evidence of insurability as approved by the insurer. New retirees and their spouse may

become covered without proof of insurability provided that they enroll within 30 days of retirement. Should they not enroll within the 30 day period, then proof of insurability would be required.

Effective July 1, 1996, upon retirement a pensioner who is in benefit at the date of retirement will be allowed to continue in benefit for as long as their hour bank has sufficient contributed hours to provide benefit coverage **(except for Weekly Disability and Long Term Disability benefits)**.

Once a retiree's hour bank has been exhausted they must elect either to:

a) Join the Plan of Benefits for Retirees within 30 days or;

b) Continue benefit coverage on a Pay Direct basis up to the maximum period provided for in the Construction Plan.

A retired Plan Member who elected to continue benefit coverage in the Construction Plan will not be allowed to join the Retiree Plan once their pay direct privileges have been exhausted.

Continuing coverage in the Retirees Benefit Plan is mandatory and in the event that the Plan Member allows their coverage to terminate due to non payments, the Plan Member would not be allowed to reinstate coverage.

Surviving Spouse of Retiree

Surviving spouse may continue coverage under the pay direct privilege for medical and dental benefits, provided the member was covered under the Health and Dental plan at the time of death and until such time as they remarry.

Quarterly payments are payable and due in advance on April 1st, July 1st, October 1st and January 1st of each year.

In order for the Benefit Plan to continue, the Insurer requires a minimum of 75% participation of the Members in the Local 506 Retiree Club. Establishment of the insured Plan of Benefits in no way obligates the Labourers' Local 506 or the Trustees to continue to provide benefits and the Labourers' Local 506 and/or the Trustees reserve the right to modify and/or terminate the Plan of Benefits.

GOLD CARD MEMBERS

The Trust will provide complimentary coverage for Gold Card Members with 50 continuous years of service provided they were covered for the benefit month of January 2014. Complimentary coverage for a dependent spouse will continue following the death of a Plan member.

Retiree Plan members who elect to return to work: Once you have exhausted your dollar bank and pay direct option in the Active Plan of Benefits and you go on to the Retiree Plan, you are not permitted to re-join the Active Plan of Benefits.

How To Claim

Guidelines for health or dental claims

These general guidelines can help you understand some of your responsibilities when submitting claims for health care providers (such as dentists, pharmacists, hospitals, opticals and medical supply companies) and practitioners (such as chiropractors, massage therapists, chiropodists and physiotherapists). Following these principles will help avoid misunderstandings and delays in claim reimbursement.

- **Never sign a blank claim form** before or after visiting a health care provider. Sign only one completed claim form at a time. A claim form should always be complete before you sign it. When signing, check to make sure the date and patient's name are correct, the amount billed is the amount you paid, and the service billed is the treatment, product or service you received.

Your signature is our assurance that the patient received the services appearing on the claim form.

- **Never submit a claim prior to receiving the medical treatment, service or product.**
- **Review claim acknowledgement statements for claims** that your health care provider submits directly to Global Benefits. You should always receive a record or statement of your claim details from your health care provider, even if the payment was made automatically.
- **Never give anyone your policy numbers** or other information about your benefits plan, especially if they offer you cash or some other incentive. Keep this information confidential and in a safe place.
- **Make sure you understand the treatments** being recommended for you and your family. Ask if they would recommend the same product or service if you didn't have coverage.
- **Keep records of appointments, treatments and dates** so you have a personal medical history that you can refer to.
- **Know what your benefits are and how your benefits plan works,** what is covered, what is not and the limits so you can make informed choices and avoid misunderstandings.
- **Protection of your benefits plan is important.** Please be aware that Global Benefits monitors all claims that plan members, their dependants and service providers submit. If you receive an audit inquiry from Global Benefits or the insurer it is important that you respond promptly.

1. Obtain a claim form from the Administrator or your Local Union Office. For dental claims, be sure to get a claim form before you go to the dentist.

2. Carefully complete the claim form using a separate form for each member of the family.
3. Where applicable, have your dentist or physician complete the portion of the form required to be completed by them.
4. Attach any receipts to the claim form.
5. The completed form should be sent to the Administrator:

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8
(416) 635-6000

Time Limitations
A claim for disability income benefits (excluding retirees and pay directs) must be submitted within 6 months of the end of the qualifying disability period.

Claims for other benefits must be submitted within 12 months of the date incurred.

OHIP Coverage

The Ontario Health Insurance Plan pays for most medical and surgical services required by residents of Ontario and their eligible dependents. OHIP also pays for standard ward hospital charges.

As regulations for OHIP are made under the Ontario Health Insurance Act and will change from time to time, it is suggested that descriptive folders obtainable from OHIP district offices be read in conjunction with this booklet. This is particularly important with respect to the definition of "dependents" under OHIP, and the provision for continuing OHIP when such persons are no longer "dependents".

OHIP Claims

All OHIP claims should be made directly to OHIP. They should not be sent to the Administrator of this plan.

GROUP LEGAL PLAN

Labourers' International Union of North America Local 506

TABLE OF CONTENTS

PLAN INTRODUCTION LETTER

To All Eligible Plan Members:

The Board of Trustees are pleased to provide you with a description of the Group Legal Benefits provided by the Labourers' International Union of North America Local 506 for legal claims incurred on or after January 1st, 2014. Claims incurred prior to this date will be adjudicated based on the text in the previous plan booklet.

The booklet provides a complete description of the legal benefits to which you and your eligible dependents are entitled, the rules governing the eligibility for the benefits and the procedures that you should follow when making a claim.

Be sure to read this booklet carefully so you will be acquainted with the various legal benefit provisions. This Group Legal Program is designed to provide legal assistance to you and your family. It is important that you understand the provisions of the Plan. **The Plan will not cover all of your legal expenses** and will only cover those legal services provided for in this booklet. The final determination of any claim, question or problem that may arise will be governed by the Trust Agreement and the Current Schedule of Benefits which have been approved by the Board of Trustees. These documents are available for examination at the Fund Office.

NOTE: Group Legal claim forms may be obtained from the Administrator or the Union Office. This form must be completed in its entirety by the Plan Member and submitted to the Administrator along with an **ITEMIZED STATEMENT OF ACCOUNT** on legal letterhead setting out the dates of service, a description of the services provided and a breakdown of the legal fees payable excluding disbursements and taxes from the law firm.

All claims must be submitted within 24 months of the date of service or the date of offence for Highway Traffic Act claims.

Services provided by licensed Paralegals in possession of P1 licences are covered for the following:

Litigation in Small Claims Court (a lawyer is required for Civil litigation matters in the Superior Court of Justice)

Traffic and other offences heard in Provincial Offences Court

Eg: Municipal by-laws
Blind Persons Rights Act
Environmental Protection Act

Minor criminal charges under the Criminal Code heard in the Ontario Court of Justice (as long as the maximum term of imprisonment for the offence is not more than six months)

Financial Services Commission of Ontario

Hearings before tribunals

Immigration and Refugee Board (IRB) hearing

Should you have any questions regarding your benefits, do not hesitate to contact the Administrator or the Union Office where a member of the staff will be pleased to assist you.

Sincerely,

Your Board of Trustees

ELIGIBILITY

Active Plan Members of the Labourers' International Union of North America Local 506 who are employed by contributing employers and on whose behalf contributions to the Group Legal Benefit Plan have been received and who are currently eligible for benefit coverage under the Labourers' International Union of North America Local 506 Health & Welfare Benefit Plan shall be entitled to benefit coverage in the Group Legal Plan. Active Plan Members and their eligible

dependents shall continue to be eligible for legal benefits as long as they remain eligible for benefits in the Labourers' International Union of North America Local 506 Health & Welfare Benefit Plan.

Group Legal Benefit coverage is provided for Plan Members who elect to continue benefit coverage by paying direct.

Group Legal Benefit coverage is provided for all Retirees who are eligible in the Labourers' Union Local 506 Retiree Benefit Plan and who are paying direct to maintain their benefits.

Group Legal Benefit coverage is provided for Plan Members whose Health and Welfare benefits are extended by freezing.

All claims are subject to the rules applicable to the Plan of Benefits. Please see page 87.

Termination of Coverage

Group Legal Benefits will terminate on the same date that the Plan Member ceases to be eligible for benefits in the Health & Welfare Benefit Plan. Legal services that commence following this date will be ineligible for coverage.

Claims Procedure

All eligible Plan Members are entitled to use any Lawyer of their own choice to provide legal services. The Plan Member should obtain a Group Legal claim form from the Administrator or the Union Office. This form must be completed in its entirety by the Plan Member and submitted to the Administrator along with an **ITEMIZED STATEMENT OF ACCOUNT** on legal letterhead setting out the dates of service, a description of the services provided and a breakdown of the legal fees payable excluding disbursements and taxes from the law firm.

The schedule of fees set out in this booklet are the maximum amounts payable by the Plan for the services described herein. It is recommended that the Plan Member show the booklet to the Lawyer or licensed Paralegal providing the services in order for them to be familiar with the maximum amounts payable by the Fund.

NOTE: The Fund will pay for legal services only. All additional charges beyond the maximum payable by the Plan or for non-legal services, disbursements, taxes, administration or filing fees are the responsibility of the Plan Member. For those services which are provided by the Plan on an hourly basis, the Board of Trustees have established an hourly rate of reimbursement of $150 per hour for claims incurred on or after September 1st, 2010.

Group Legal benefits are a taxable benefit and Plan Members will receive a T4A for contributions made to the Labourer's International Union of North America Local 506 Group Legal Trust Fund on their behalf.

All claims should be sent to:

GLOBAL BENEFITS
Attention: The Defenders Group
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8

Along with a completed Group Legal claim form and an Itemized Statement of Account on legal letterhead setting out the dates of service, a description of the services provided and a breakdown of the legal fees payable excluding disbursements and taxes from the law firm.

All Group Legal claims must be submitted within 24 months of the date of service or the date of offence for Highway Traffic Act claims.

Changes and/or Discontinuation of the Plan

It is our hope to continue to provide the best benefits affordable. However, because of the ever-changing economic environment, the benefits provided in this booklet cannot be guaranteed for the future. In order to protect the Fund, the Trustees have the right to amend, delete, add or modify the Plan's benefits, as they apply to all current and future members, including the right to add, delete or suspend benefits, monetary or otherwise, as circumstances may warrant.

SCHEDULE OF BENEFITS

The following is a schedule of benefits for claims for legal services incurred on or after January 1st, 2014 that are covered by the Group Legal Plan and the maximum amounts payable for each service.

Unless otherwise specified, all Plan maximums are based on a calendar year. The maximum amount set out in this schedule is the maximum amount payable for each service, notwithstanding the fact that certain proceedings may take in excess of one calendar year to complete.

"A" - REAL ESTATE

A Plan Member and the dependent Spouse shall be provided with legal assistance in connection with the purchase or sale of a family dwelling which is the **Plan Member's principal residence**, and which shall be used by the Plan Member's family as a dwelling place; the purchase of a lot on which to build a family dwelling (provided a building permit is issued within l year) and the purchase or sale of a vacation property. Also covered under the Plan insofar as they relate to the Plan Member's principal family residence is the arrangement of new or renewal of mortgage. **The Plan Member and the dependent Spouse shall not be entitled to assistance in connection with a**

commercial or income producing property. Maximums include 1 purchase, 1 sale, 1 mortgage incidental to purchase or 1 new or renewal of mortgage, 1 transfer of title and 2 discharges of mortgages in any 12 month period. Benefits relating to the purchase, sale, transfer of title, new or renewal of mortgage, mortgage incidental to purchase or discharge of mortgage on a vacation or recreational property are limited to a **lifetime maximum of 1 per Plan Member.**

Codes		Maximum Amount
A1	Purchase Family Dwelling	$450
A2	Sale Family Dwelling	$450
A3	Purchase Lot for Family Dwelling	$450
A4	Purchase/Sale Vacation Property	$450
A5	Transfer of Title	$250
A6	Mortgage New or Renewal	$300
A7	Mortgage Incidental to Purchase	$200
A8	Discharge of Mortgage	$150

NOTE: Plan Members claiming for the purchase and/or sale of a principal family residence must complete and sign the real estate affidavit on the reverse of the claim form. The maximum block fee of $450 payable for A1 Purchase Family Dwelling or A2 Sale Family Dwelling are inclusive of the required Transfers of Title on the property. Code A6 Mortgage New or Renewal is only payable for mortgages unrelated to a purchase. Mortgage services provided by a financial institution must identify the amount of the legal fee included in the administration fee in order for the Plan Member to be reimbursed. In case the required information is not provided, a formula will be used to determine the legal portion of the fees charged in order to reimburse the Plan Member. Survivorship applications will be paid under Code A5 Transfer of Title and allowed up to a maximum amount of $250. Title insurance, title examining counsel fees, property valuations and appraisals are not covered under this Plan of Benefits.

"B" - DIVORCE AND DOMESTIC PROCEEDINGS

A Plan Member and the dependent Spouse shall be entitled to representation in connection with any matrimonial or divorce proceedings. Representation of the Plan Member and the dependent Spouse shall include the preparation of a separation agreement, filing a petition of divorce or separation and all other acts necessary for terminating the relationship, establishing the custody of the children and effecting an equitable distribution of property. If proceedings are non-contested the Spouse of the Plan Member will be encouraged to seek the advice and consultation of independent counsel. Mediation is not a covered service under this Plan of Benefits.

Cheques for legal services provided to a Plan Member's dependent Spouse will be mailed directly to the dependent Spouse or the dependent Spouse's Lawyer as requested for the following matters:

Divorce Spouse
Property and Custody Support Spouse
Separation Agreement Spouse

Please ensure that the Spouse's mailing address and phone number are submitted.

Codes		Maximum Amount
B1	Divorce Member	$600
B2	Divorce Spouse	$600
B3	Property and Custody Support Member	$600
B4	Property and Custody Support Spouse	$600
B5	Separation Agreement Member	$600
B6	Separation Agreement Spouse	$600
B7	Modification of Separation Agreement	$300
B8	Adoption (Private)	$500

B9	Guardianship	$400
B10	Change of Name	$250
B11	Birth Certificate Assistance	$200
B12	Post or Pre-Nuptial Agreement	$500

NOTE: The Lawyer must clearly specify the matter and provide a description of services. The block fees set out herein are payable only for services provided and are not accumulative. If your Lawyer prepares a separation agreement you would only be entitled to a maximum of $600. You would not be entitled to claim for property and custody support notwithstanding the fact that issues of property and custody support are set out in the separation agreement. If a request is submitted for reimbursement pertaining to a consultation in connection with a family matter, please ensure that the Statement of Account clearly indicates the date of service and the fee charged.

The maximum amounts set out in this section are the maximum amounts payable for each service notwithstanding the fact that certain proceedings may take in excess of one calendar year to complete.

"C" - PREVENTIVE LAW

Plan Members and their eligible dependents shall be entitled to receive legal advice by telephone or direct office consultation on any problem that the Plan Member believes to be of a legal nature.

Codes		Maximum Amount
C1	Preventive Law	$300

"D" - NON-COMPLEX LEGAL DOCUMENTS

Legal documents which are not deemed to be excessively complex will be prepared for Plan Members and their eligible dependents.

Codes		Maximum Amount
D1	Power of Attorney - Personal Care	$ 50
D10	Power of Attorney - Property	$ 50
D2	Deeds	$100
D3	Simple Contracts	$200
D4	Tenant Leases (Residential)	$150
D5	Notarized Affidavits or Documents	$ 25
D6	Other Legal Documents	$200

"E" - WILLS

A Plan Member and the dependent Spouse shall be entitled to have prepared what is commonly regarded as a Simple Will (this does not include the creation of any trust or other estate). A Plan Member and the dependent Spouse shall be entitled to the periodic review and amendment of all testamentary instruments, including the preparation of revised Wills and Codicils not to exceed one revision in any 12 consecutive months. Probation of a Will is not a covered service under this Plan of Benefits.

Codes		Maximum Amount
E1	Simple Will Member	$100
E2	Simple Will Spouse	$100
E3	Revised Will or Codicil Member	$ 75
E4	Revised Will or Codicil Spouse	$ 75

"F" - LANDLORD AND TENANT MATTERS

A Plan Member as Lessee shall be represented in connection with any claims or controversies arising out of a lessor-lessee relationship in respect of their dwelling. **Proceedings in which the Plan Member or their eligible dependents is the landlord will not be a covered benefit under this Plan of Benefits.**

Codes		Maximum Amount
F1	Leases/Tenancy	$500

"G" - CONSUMER AND PERSONAL PROPERTY LAW

Plan Members and their eligible dependents shall be entitled to legal representation in connection with any claim against a manufacturer, distributor or retailer for defects in any merchandise, article or service or in a recovery on any warranty given in connection with the sale of merchandise, article or service, where such claim is in excess of $100. The Plan shall not be obliged to litigate under code H2 on any claim unless the dollar value exceeds $300.

Codes		Maximum Amount
G1	Contracts/Warranty	$400
G2	Consumer Protection Act	$400
G3	Bankruptcy (Personal)	$500
G4	Garnishment of Wages	$300
G5	Tax Advice	$250
G6	Liens (Personal)	$250
G7	Small Claims Court	$500

NOTE: The fees of a Trustee in Bankruptcy are covered up to the maximum allowed by the Plan for personal bankruptcy i.e. voluntary petition and not

involving any business. When requesting reimbursement for a bankruptcy, the Bankrupt must be discharged prior to submitting the claim. A Form 13-Trustee's Statement of Receipts and Disbursements must be submitted in order to be reimbursed for the Trustee's fees. Consumer Proposals are not a covered service under this Plan of Benefits.

While tax advice is covered, preparation of tax returns are excluded from coverage under this Plan of Benefits.

"H" - CIVIL LITIGATION DEFENDANT

Plan Members and their eligible dependents shall be represented in connection with any civil action or civil administrative proceeding in which the Plan Member or dependent is named as a defendant or respondent provided that such representation shall not exceed twenty (20) hours in a calendar year. The Plan shall be under no duty to provide legal representation to a Plan Member or eligible dependents where representation is provided for under statutory programs.

Plan Members shall be required to pay any disbursements in connection with such defensive litigation including the costs of discovery, witness fees, etc.

"H" - CIVIL LITIGATION PLAINTIFF (PLAN MEMBER ONLY)

Only the Plan Member shall be represented in connection with the filing of a civil or administrative action for and on behalf of the Plan Member in connection with any material injury to person or property for the deprivation or injury of any constitutionally or statutorily guaranteed right, any right conferred at common law or for the adjustment of any grievance both recognizable and actionable in either law or equity.

No representation shall be available under this item for any action that is either non-meritorious, calculated to be vexatious only, of a non-material or of a non-consequential nature or would be contrary to public policy.

In the event that any damages are recovered or some form of monetary claim effected, the first $4,000 excluding damages for property replacement and/or medical expenses of any such recovery shall be free of any assessment by the Plan for legal costs expended on the Plan Member's behalf. If the monetary settlement is in excess of the $4,000, the Plan Member is not entitled to reimbursement under the Plan of Benefits. The Plan shall be entitled to recover any legal costs expended on behalf of the Plan Member from costs awarded by the court and from any monetary settlement in excess of $4,000. Please see the exclusions to the Plan on page 87.

Codes		Maximum Amount
H1	Defendant Representation	20 Hours @ $150/hr
H2	Plaintiff Representation	20 Hours @ $150/hr

NOTE: The maximum amounts set out in this section are the maximum amounts payable for each service notwithstanding the fact that certain proceedings may take in excess of one calendar year to complete.

"J" - GOVERNMENT PROGRAMS AND ASSISTANCE

A Plan Member and the dependent Spouse shall be entitled to legal representation on behalf of themselves or their eligible dependents in any matter requiring legal assistance arising out of disputes or appeals with Social Assistance or Employment Insurance.

A Plan Member and the dependent Spouse shall be entitled to legal representation in matters of immigration into or out of Canada on behalf of himself

or his dependents, or on behalf of any other relative who the Plan Member and/or his spouse has directly sponsored into Canada. Services provided by Immigration Consultants are not covered. Licensed Paralegals can only represent a Plan Member for matters relating to an Immigration and Refugee Board (IRB) hearing.

Codes		Maximum Amount
J1	Social Assistance	$150
J2	Employment Insurance Commission	$150
J3	Immigration Member	$600
J4	Immigration Spouse	$600

NOTE: The maximum amounts set out in this section are the maximum amounts payable for each service notwithstanding the fact that certain proceedings may take in excess of one calendar year to complete.

"K" - INSURANCE RELATED MATTERS

Plan Members and their eligible dependents shall be represented in connection with any claim against the insurer **(except for benefits provided by the Labourers' International Union of North America Local 506 Benefit Trusts or benefits provided by a contributing employer to this Group Legal Benefit Plan)** by reason of failure to provide or pay the benefits as contracted for or to render advice in the interpretation of any policy provision.

In the event it is necessary to litigate any claim against an insurance carrier, the conditions set forth in item "H" hereinbefore shall apply.

Codes		Maximum Amount
K1	Accident and Health	$300
K2	Life and Annuity	$300

K3	Fire and Homeowners	$300
K4	Casualty	$300
K5	Automobile Liability	$300
K6	Marine	$300
K7	Other	$300

"L" - AUTOMOBILE RELATED MATTERS

Plan Members and their eligible dependents shall be represented in connection with the following automobile related events:

Actions relating to the suspension/revocation of driver's licence

Damage and personal injury

Uninsured Motorist

Litigation under this item is subject to the limitations set forth in Item "H".

Codes		Maximum Amount
L1	Civil Actions (Re: Auto Accident)	$500
L2	Damage and Personal Injury	$500
L3	Uninsured Motorist	$400

"M" - CRIMINAL MATTERS (LIMITED)

Plan Members and their eligible dependents shall be entitled to limited legal representation when charged under Provincial or Federal Statutes of the following:

Summary Conviction Matters

Indictable and Hybrid Offences

Impaired Driving/Driving over (0.8 mg)

Representation for driving while impaired or driving over 0.8 mg is limited to 1 charge in any calendar year and a lifetime maximum of 2 charges.

The Plan will only pay up to the M1 maximum block fee for representation on all charges arising out of a single incident. **A copy of the Highway Traffic Act ticket or summons must accompany all claims for Highway Traffic Act matters.** The Plan Member must be eligible for benefit coverage on the date of the offence. Parking violations and fines are excluded from coverage under this Plan of Benefits.

Codes		Maximum Amount
M1	Highway Traffic Act	$300
M2	Provincial Offences Act or Offences under Municipal Bylaws	$500
M3	Criminal Code of Canada	$700
M4	Criminal Pardons	$600

NOTE: Plan Members and their eligible dependents shall be entitled to legal or administrative costs for services provided for the processing of an application to remove a criminal record and complete an application for pardon. Local police checks, fingerprinting, Federal Government fees and U.S. waivers are not covered under this Plan of Benefits.

In the event that several charges are laid arising out of a single incident pertaining to criminal matters, the Plan will only allow reimbursement up to the Plan maximum. In the event that several charges are laid on a single occasion but arising out of seperate incidents pertaining to criminal matters, the Plan will only allow reimbursement up to the Plan maximum.

If a request for reimbursement pertaining to a consultation in connection with a criminal matter is submitted, please ensure that the Statement of Account clearly indicates the date of service and the fee charged.

The maximum amount set out in this section is the maximum amount payable for each service, notwithstanding the fact that certain proceedings may take in excess of one calendar year to complete.

"N" - APPEALS

Plan Members and their eligible dependents shall be entitled to legal representation on appeals. The Plan shall pay a maximum of 50% of the legal fees up to $1,000 on an appeal. Appeals are limited to one appeal only on any decision of the Court or any conviction arising out of the same incident or charge.

Codes		Maximum Amount
N1	Appeals	50% up to $1,000

MAXIMUM REPRESENTATION

The maximum representation that a Plan Member shall receive inclusive of their eligible dependents shall not exceed 30 hours of legal service in a calendar year or $4,500.

EXCLUSIONS

The following services are excluded from coverage under the Plan:

1. Disbursements, court costs, filing fees, land transfer taxes, administration fees, registration fees, including mortgage registration fees, property valuations, appraisals and tax.
2. Title searches, survey fees, title insurance and title examining counsel fees.
3. Fines and penalties, whether civil or criminal.

4. Any judgement for damages, including judicially awarded costs.

5. Any proceedings or dispute involving an Employer or their officers, agents, representatives or employees.

6. Any proceedings or dispute involving the Union, its officers, agents, representatives or employees.

7. Any proceedings arising under the Ontario Labour Relations Act or any other statute that relates to labour relations or terms and conditions of employment, including but not limited to W.S.I.B., Employment Insurance, the Occupational Health and Safety Act or the Ontario Human Rights Code in matters involving an Employer.

8. Any dispute involving the Plan, the Plan of Benefits or any other Plan or Trust Fund provided by a Contributing Employer to this Plan of Benefits or Labourers' International Union of North America Local 506 Benefit Trusts.

9. Matters involving election to any public office.

10. Non-personal legal services (e.g. any business related matters).

11. Any controversy between a Plan Member and any of his dependents apart from divorce, separation or annulment. Mediation is excluded from coverage.

12. No service shall be provided that will violate Public or Statutory Law.

13. Any case in which defense or other legal representation is provided through insurance or other indemnification.

14. Action instituted prior to becoming a Plan Member or civil actions requested to file arising out of pre-existing conditions. Exceptions may be waived by the Board of Trustees.

15. Class actions or interventions or amicus curiae filings in any suit or controversy among other parties not involving the immediate and direct interest of a Plan Member.

16. Any case in which defense or other legal representation is provided through any government agency, which will represent a Plan Member without charge.

17. Any representation required by reason of any acts committed or acts which a Plan Member omitted to perform giving rise to tort, negligence, or criminal claims, or charges, which acts of omission occurred prior to a Plan Member joining the Plan.

18. Court appearance in connection with small claims involving an amount less than $100 and civil litigation involving an amount less than $300. Costs of discovery and witness fees.

19. Services rendered by a licenced Paralegal except for services rendered with respect to those listed on page 73.

20. Services rendered by immigration consultants.

21. Probation of a will.

22. Preparation of tax returns.

23. Parking violations and fines.

24. Stale dated claims that were incurred over 24 months prior to their submission.

INTERPRETATION — The Trustees shall be exclusively responsible for the interpretation and application of this Plan, the determination of all questions pertaining to eligibility and entitlement to benefit.

PLAN RULES

Definitions:

"Benefits" means payment of a monetary sum to or on behalf of a Plan Member for legal fees incurred by the Plan Member or eligible dependents in obtaining Legal Services for matters covered by the Plan.

"Covered Individual" means a Plan Member, his or her spouse and eligible dependents.

"Dependents" means any person with the following relationship to the Plan Member:

(l) Plan Member's Spouse in respect of whom the contributions are being made for coverage under the Plan.

(2) Plan Member's unmarried children (including adopted and/or step children) under 21 years of age who are wholly dependent on the Plan Member for support.

(3) Plan Member's unmarried children (including adopted and/or step children) up to age 25, who are full time students at a University or similar educational institution and depend wholly on the Plan Member for support.

"Legal Services" means representation or advice from a qualified legal practitioner with respect to those matters listed in the Schedule of Benefits.

"Plan Member" means a member of the **Labourers' International Union of North America Local 506** who is employed by a Contributing Employer and who is eligible to receive benefits under the Plan.

"Plan" means the **Labourers' International Union of North America Local 506 Group Legal Benefit Plan.**

"Spouse" means an individual who:

(l) is married to the Plan Member through an ecclesiastical or civil ceremony.

(2) although not legally married to the Plan Member, cohabits with him/her for at least one year in a spousal relationship recognized as such in the community in which he/she resides.

"Trust Agreement" means the Agreement between the Employers and the Union pursuant to which the Trust Fund was established.

"Trust Fund" means the **Labourers' International Union of North America Local 506 Group Legal Benefit Trust** established pursuant to the Trust Agreement.

Capitalized terms used in this Legal Benefit Plan but not defined above shall have the meanings given to those terms in the Trust Agreement.

LAW SOCIETY REFERRAL SERVICE

The Law Society Referral Service connects residents of Ontario looking for legal assistance with a lawyer or paralegal within their community, who will provide up to a 30 minute free consultation to help determine their rights and options. The service will also help to find a legal professional to meet a specific requirement, such as speaking a certain language.

To access the service:

Visit: https://lsrs.lsuc.on.ca

Call: 1-855-947-5255 or 416-947-5255 (GTA)

Notes

ADMINISTRATOR,
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GROUP INSURANCE BENEFITS
UNDERWRITTEN BY

THE GREAT-WEST LIFE ASSURANCE COMPANY

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