GROUP BENEFIT PLAN

LABOURERS' UNION LOCAL 506 INDUSTRIAL DIVISION

OCTOBER 1, 2015

The Weekly Disability Income Benefit, Supplementary Health Care and Dental Care benefits described in this booklet are integrated with benefits for which the Trustees are liable. The Great-West Life Assurance Company is liable for such benefits to the extent they are not paid by the Trust Fund and are covered under the terms of the group contract. Great-West Life, however, will administer all benefit payments.

POLICIES AND CERTIFICATES

This booklet describes the principal features of the Group Plan. The complete terms of the Group Insurance Plan are set forth in the Group Insurance Policies issued by Great-West Life Assurance Company. These Policies are the governing documents in any question of interpretation.

Your Group Policy Number is 164022 for Life Insurance, Accidental Death and Dismemberment Insurance, and Long Term Disability Benefits, Weekly Disability Benefits, Supplementary Health Care Benefits and Dental Care. Your Certificate Number by consent is your own identification number.

This booklet is for your general information only and is not the insurance policy. In the pages which follow, you will find a brief description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim. The final determination, however, of any claim question or problem which may arise will be governed by the Trust Agreement and the Insurance Policy issued by Great-West Life Assurance Company. These documents are available for examination at the Fund Office.

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

To All Eligible Members:

This revised booklet has been published to give you an up-to-date description of the benefits provided by the Fund, as of October 1, 2015.

The booklet provides a description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits, and the procedures that should be followed when making a claim.

The Trustees are very pleased with the progress of the Fund, and the comprehensive protection now offered to you and your eligible dependents.

Be sure to read this booklet carefully so you will be acquainted with all the various benefit provisions. Should you have any questions regarding your benefits, do not hesitate to contact the Administrator where a member of the staff will be pleased to assist you.

Sincerely,

BOARD OF TRUSTEES

Carmen Principato
Nick Repole
Roly Bernardini
Tony Do Vale
Jack Eustaquio

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

TABLE OF CONTENTS

SUMMARY OF BENEFITS

FOR MEMBERS:

LIFE INSURANCE	$100,000
ACCIDENTAL DEATH AND DISMEMBERMENT	$100,000

WEEKLY DISABILITY BENEFIT

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

8th day Sickness

$400 per week for a maximum of 52 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 52nd 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 52nd week - $400 per week

LONG TERM DISABILITY BENEFIT

Waiting Period – 52 weeks

$1,500 per month payable after 52 weeks of disability for up to five years, but not beyond the attainment of age 65 or 12 months if the waiting period is completed after the member attains age 64, but before the attainment of age 65.

FOR DEPENDENTS:

LIFE INSURANCE

Spouse	$10,000
Each child 14 days to age 21, 25 if attending school (full-time)	$3,000
Each child from live birth but under 14 days	$250

FOR MEMBERS AND DEPENDENTS:

Supplementary Health Insurance
100% of covered expenses are payable up to an overall benefit maximum of $15,000 per calendar year. Includes cost of prescription drugs and vision care, etc. Out-of-Hospital Nursing Benefit has a separate maximum of $10,000 per calendar year. (See the Supplementary Health Section of this booklet for details.)

Out of Province Emergency Care has a separate maximum of $1,000,000 for any one cause.

Semi-private Hospitalization
(This benefit is self insured by the Trust Fund)

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

Dental Care
The Dental Care benefit pays 100% routine care, dentures and crowns and bridgework (laboratory charges are limited to 60%) of the Ontario Dental Association's 2014 Schedule of Fees. The maximum benefit for all Dental Care expenses for any one family member every calendar year is $2,000.

Orthodontic Treatment
(Program to Straighten Teeth)

Is payable at 50% co-insurance of the Ontario Dental Association's 2014 Schedule of Fees and has a benefit maximum per lifetime of $2,500 for each plan member, spouse or dependent child up to age 21.

Claims of $500 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 read the Dental Section of this booklet. Also to reduce misunderstanding, show these pages to your dentist, as he can quickly tell you whether the services he proposes are fully, partially or not covered. **You should ask your dentist if there will be any additional charges for work NOT COVERED by this plan.**

ELIGIBILITY

When Do You and Your Dependents Become Eligible for Insurance?

To become eligible for benefits, you must meet all four of the following qualifications:

1) You must be in good standing with the Union.
2) You must complete an enrolment card (which may be obtained from your local Union Office, your Union Steward or the Administrator).
3) You must have enough hours to your credit in your "Hour-Bank" account.
4) You must be insured under a Provincial Health Insurance Plan.

Eligible Dependents

Dependent means a spouse or unmarried child from live birth but under 21 years of age (25, if regularly attending full-time school) and solely dependent upon the member for support.

Spouse means a husband or wife by virtue of a religious or civil marriage ceremony; except that, a person living with the member will be deemed to be the member's spouse, if such person:

- is publicly represented as the member's spouse; and
- has been living with the member for a period of at least 1 continuous year.

Child means:

- a natural or legally adopted child; or
- a step-child or other child who is dependent upon the member for support and lives with the member in a regular parent-child relationship.

NOTE:

Eligible Dependents must be insured under a Provincial Health Insurance Plan.

What about a change of status?

It is essential that you complete an enrolment card (available from the local Union Office, your Union Steward or the Administrator) and forward it to the Administrator in the event of any of the following changes:

1) Change of address

2) Change from member without dependents to member with dependents (get married)

3) Change from member with dependents to member without dependents

4) Birth or adoption of a child

5) Change of beneficiary for your life insurance.

NOTE:
New dependents should be reported to the Administrator within 31 days or an evidence of health form indicating evidence of good health satisfactory to the Insurance Company will be required for that dependent before insurance coverage may begin.

"Hour-Bank System"
The hour-bank system is used by the Administrator to keep track of the contributions made by an employer on behalf of each member. For each hour you work for an employer who participates in this program, a contribution is made by that employer to the Labourers' Union Local 506 Employee Benefit Trust.

Initial Eligibility
You and your dependents become eligible for coverage on the first day of the second month after you have accumulated 150 bank hours, if you are available for work on that date.

Example: If your hour-bank accumulates 150 hours in it by January 17th, you and your dependents will be eligible for all benefits on the following March 1st.

Continuation of Coverage
For each month you are covered for benefits, 150 hours will be withdrawn from your hour-bank to pay for this coverage. If you are unable to work because of illness or accident and are receiving a disability income benefit from the benefit plan or from Workplace Safety and Insurance Board of Ontario (WSIB), your hour-bank will be frozen and the premiums to continue benefits for you and your dependents will be covered for a period of up to 12 months.

Termination of Coverage
Your insurance will terminate on the first day of the month following the date on which you have less than a total of 150 hours in your hour-bank account.

Example: If the hours in your bank drop below 150 in January, you and your dependents will go out of benefit the following February 1st.

Reinstatement of Coverage
If your insurance has terminated due to insufficient hours in your hour-bank account, you shall again be eligible for benefits on the first day of the second month following the date on which you accumulate 150 hours in your hour-bank account.

Example: If, after dropping below 150 hours in January, as in the last example, you work during the next month, February, so that 150 hours or more are in your hour-bank account, you and your dependents will again be fully covered on the following April 1st.

Maximum Balance in "Hour-Bank"
The maximum balance in a member's "Hour-Bank" account is 450 hours.

Continuation of Health Care and Dental Care Benefits for Incapacitated Children
Health Care and Dental Care Benefits will continue beyond the date an unmarried child attains the limiting age for insurance, provided proof is submitted to Great-West Life within 31 days after such date that such child:

- is incapable of self-sustaining employment by reason of functional impairment;
- became so incapacitated prior to attainment of the limiting age; and
- is chiefly dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to Great-West Life, as required, but not more often than yearly.

Continuation of Health Care and Dental Care Benefits After Your Death
Your dependents who are insured under this plan at the time of your death will continue to be insured while premium payments for such insurance are continued, but not beyond the earliest of:

- the date such dependents cease to be eligible;
- the date your spouse remarries (children will continue to be insured);

- the end of the 12-month period after the date of your death; or
- the date insurance for your dependents terminates for any reason.

Upon your death, benefits are payable to your spouse, if living, or to your child (or legal guardian).

Pay Direct Provisions

Before insurance coverage is cancelled because the number of hours in your hour-bank account has dropped below 150 hours, you will be notified by the Administrator. You may then contribute directly, by means of your personal cheque in order to continue your insurance. You may continue coverage (excluding disability benefits) by this "pay-direct" method if your bank account has dropped below 150 hours, and you may pay direct for a maximum period of 36 continuous months.

You must be a member in good standing with the Union in order to be allowed to continue your coverage by the pay-direct method. The cheque should be made payable to the Trustees of the Labourers' Union Local 506 Employee Benefit Trust and mailed to the Administrator:

Global Benefits
Labourers' Union Local 506
(Industrial Division) Benefit Plan
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8

Be sure to print your name and social insurance number on the back of your cheque to ensure that your account is properly credited.

IF YOU WISH TO PAY DIRECTLY, AS PROVIDED FOR ABOVE, IT IS YOUR RESPONSIBILITY TO CONTACT THE ADMINISTRATOR AND MAKE THE NECESSARY PAYMENTS BY THE 15TH OF EACH MONTH. COVERAGE IS TERMINATED IF YOU FAIL TO MAKE THE NECESSARY PAYMENTS ON TIME.

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 and conditions of the Collective Agreement, the Trustees of Labourers' Local Union

506 Industrial 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 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 contributions plus interest from the delinquent employer.

The effective date of this Plan Change is retroactive to January 1, 1998 and in the event that you worked for an employer who failed to make contributions on your behalf between January 1, 1998 and to-date, then you should contact your union immediately at (416) 638-0506.

LIFE INSURANCE FOR MEMBERS

The Life Insurance amount of $100,000 is payable in the event of your death from any cause at any time or place while you are insured. (This means whether you are at work or whether you are not at work). Payment will be made to your beneficiary(ies), if living, otherwise to your estate. You may change your beneficiary whenever you wish by means of completing a new enrolment card and forwarding it to the Administrator.

Disability Provision

If you become totally and permanently disabled while insured and before age 65, your life insurance coverage will remain in force as long as you remain so disabled, subject to the following requirements.

1) you must be totally disabled for at least 6 months, and
2) medical evidence must show that you are totally and permanently disabled, and
3) written notice and proof of your disability must be given to the Insurance Company within 24 months after you cease active work. From then on you must submit proof satisfactory to the Insurance Company, as required, that you are so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, you are, and will continue to be, unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

Conversion Option

If your Member Life Insurance terminates because your employment or class membership terminates or because you no longer qualify for coverage under the Disability Provision, then on or before your 65th birthday, you may convert up to 100% of the terminated amount, less any amount of group life insurance for which you may become eligible within 31 days of the date of the termination.

Note: The conversion option does not apply to reduction of life insurance or termination of insurance which become effective at specified ages or upon your retirement.

The individual policy may be:

- a permanent plan that Great-West Life offers to the public at the time of conversion;

- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

In no event may the converted policy exceed $200,000, nor may it include disability or other added benefits.

You must apply in writing and pay the first premium to Great-West Life within 31 days of the date your insurance terminates. The premium rates will be based on your age and class of risk at the time of conversion. No medical examination or health questionnaire will be required.

Extension of benefit

If you die within 31 days of the date your Member Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this plan even if you did not apply for conversion.

DEPENDENT LIFE INSURANCE

In the even of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you if living, otherwise to your estate. The amount of the insurance is $10,000 for your spouse, $3,000 for each dependent child 14 days of age to age 21 (25 if attending school on a full-time basis) and $250 for each child from live birth but under 14 days old.

Disability Provision
If your Life Insurance is being continued under the Disability Provision, Dependent Life Insurance will also continue.

Conversion Option
If Dependent Life Insurance for your spouse terminates because your employment or class membership terminates or because of your death, then on or before your spouse's 65th birthday, your spouse may convert up to 100% of the terminated amount, less any amount of group life insurance for which your spouse may become eligible within 31 days of the date of the termination.

Note: The conversion option does not apply to reduction of life insurance or termination of insurance which become effective at specified ages or upon your retirement.

The individual policy may be:

- a permanent plan that Great-West Life offers to the public at the time of conversion;
- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

In no event may the converted policy exceed $200,000, nor may it include disability or other added benefits.

You or your spouse must apply in writing and pay the first premium to Great-West Life within 31 days of the date your spouse's insurance terminates. The premium rates will be based on your spouse's age and class of risk at the time of conversion. No medical examination or health questionnaire will be required.

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

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

For Loss of:

Life . . . . . .The Principal Sum
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 Entire Sight of One Eye .The Principal Sum
One Foot and Entire Sight of One Eye .The Principal Sum
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 or loss of use of:

Both Legs . . . . . .Two Times The Principal Sum
Both Arms and Both Legs . .Two Times The Principal Sum
Both Arms . . . . . .Two Times 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
At least Four Fingers of One Hand .1/3 The Principal Sum

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;

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 offence.

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 for at least 5 days 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 FOR MEMBERS

If you become 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 1 through 4.

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 (M.D.).

b) In the case of sickness, your benefits will start from the later of the eighth day after the date confirmed by your doctor (M.D.) as the beginning of your disability, or the date you are first seen by your doctor (M.D.). However benefits will be paid from the first day of hospitalization if you are hospitalized for at least 18 hours prior to the eighth day.

Benefits will continue for a maximum of 14 days from the date of disability. If you are then eligible for Accident and Sickness benefits from Employment Insurance, the plan will stop payment and your disability benefits will continue for a maximum of 15 weeks from E.I. Upon the expiration of Accident and Sickness benefits from E.I., the plan will immediately begin payment up to a maximum of 35 additional weeks. In this case, your total period of protection from both E.I. and the plan is 52 weeks for any single period of disability.

Alternatively, if you are not eligible for weekly Accident and Sickness benefits from E.I., your benefits will continue from the plan and will be payable for a maximum of 52 weeks.

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

Coverage Provisions

1) Disability must commence while you are covered by the benefit plan.

2) You must be under the continuing care of a licensed doctor (M.D.) but it is not necessary to be confined to your home to collect benefits.

3) Only those days on which you are not performing work for compensation or profit are counted as days of disability.

4) After collecting disability benefits, you can re-qualify for a new 52-week benefit period provided:

   a. The cause of the second disability is not related to the first one and the latest disability absence occurs after return to active work for at least one full day, or

   b. You have worked full time for at least two consecutive weeks since the first disability ended, for disabilities that are, related or of the same cause.

No benefit will be paid for:

1) Any disability or charge that results from or is contributed by claims arising as a result of an Automobile Accident;

2) Any day you do any kind of work for pay or profit;

3) The period you are entitled to pregnancy leave of absence by statute, contract or employer agreement. This plan will, however, pay benefits for the post-natal recovery period of maternity leave in accordance with Great-West Life's claim practices.

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

1) War, whether declared or not;

2) Insurrection, rebellion or participation in a riot or civil commotion;

3) Purposely self-inflicted injury; or

4) Your commission of or attempt to commit, an assault or a criminal offence.

Great-West Life may require you to report for a medical examination as often as is reasonable by a licensed doctor (M.D.) of their choice. Failure to report for a medical examination may result in termination of your benefit payments.

Extension of Benefit

If you are disabled on the date your insurance terminates, you will be entitled to the same benefit as though your insurance had not terminated.

How to Make a Claim for the Disability Income Benefits and Long Term Disability

1) Obtain a claim form from the Administrator or your local Union Office.
2) Obtain a claim for Employment Insurance sick benefits.
3) Be sure and complete both forms.
4) Have the claim form for disability income benefits completed by your physician.
5) Subsequent proof of claim shall be submitted promptly by or on behalf of the member at such intervals as the Insurance Company may require. All such proof of claim shall be signed by a licensed doctor (M.D.).
6) Forward the form to the Administrator.

   Global Benefits
   Labourers' Union Local 506
   (Industrial Division) Benefit Plan
   88 St. Regis Crescent South
   Toronto, Ontario
   M3J 1Y8

7) File your E.I. sick claim at the same time you file the claim with the Fund Administrator.

LONG TERM DISABILITY

If you become totally disabled while insured as a result of sickness or accidental injury and are under the care of a licensed physician or surgeon and residing in Canada, unless prior approval to the contrary is obtained from Great-West Life, you will receive a monthly indemnity in the amount of $1,500.00 for up to 5 years. To be eligible for benefits, you must have been seen by, and treated by, a licensed doctor (M.D.) within 31 days of the date you became Totally Disabled. This indemnity is payable after you have completed the qualifying period, which is the first 52 weeks of a period of Total Disability, but not beyond the attainment of age 65. However, should the waiting period be completed after the attainment of age 64, but before the attainment of age 65, the benefit shall be payable for 12 months or until the end of the disability, if earlier.

Total Disability

The expression "total disability" as employed herein shall mean, during the waiting period and for the next 24 months of disability, a state of disability resulting from sickness or accidental injury that wholly prevents you from performing the essential duties of your occupation (type of work, not just your own job).

Thereafter, it shall mean a state of disability that wholly prevents you from engaging in any remunerative employment for which you are, or may reasonably become fitted by education, training or experience.

The availability of employment will not be considered in the assessment of your disability.

Successive Disabilities

Any 2 periods of total disability that are:

a. due to the same or related cause; and

b. separated by return to active full-time work for less than 6 months (2 weeks during the Waiting Period);

will be deemed to be 1 period of Total Disability with only the initial Waiting Period applying, provided the first period begins while you are covered under this benefit.

Offsets

The monthly benefit shall be reduced by payments received from the Labourers' Pension Fund of Central and Eastern

Canada and 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:

1) plus any income or benefits described above;
2) plus any Canada Pension Plan or Quebec Pension Plan family benefits;
3) 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;

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

Rehabilitation
If you recover enough from your disability to be able to work full-time or part-time at any job under a rehabilitation program approved in writing by Great-West Life, you will still be deemed to be Totally Disabled and your benefit will only be reduced by the greater of:

- 50% of the income you receive from such rehabilitative work; or
- the amount needed to keep your disability benefit income plus your rehabilitative income at the same level as your pre-disability earnings.

If you refuse to participate in a rehabilitation program recommended by Great-West Life, your benefit payments will be terminated.

Third Party Liability
If you receive benefit payments under this plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle Great-West Life to be reimbursed for any amount(s), including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to Great-West Life of any judgement or settlement of claim against a third party, further benefit payments under this plan will terminate until Great-West Life has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgement or settlement for loss of future income, no further benefit will be paid under this plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Limitations

No benefit will be paid for the period you are entitled to pregnancy leave of absence by statute, contract or employer arrangement.

No benefit will be paid for any disability (or charge) that results from or is contributed to by claims arising as a result of an automobile accident.

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

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury;
- your commission of, or attempt to commit, an assault or criminal offence; or
- chronic alcoholism, or use of narcotics, barbiturates or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated.

Benefit payments may be terminated if you:

- fail to provide proof of ongoing disability when requested to do so;
- are not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist;
- refuse or fail to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Third Party Liability provision; or

- fail to report for a medical examination, as often as may reasonably be required, by a licensed doctor (M.D.) of Great-West Life's choice.

Waiver of Premium
No premium is required for this Benefit during a period for which you are entitled to receive benefit payments.

Extension of Benefit
If you are Totally Disabled on the date your insurance terminates, you will be entitled to the same benefit as though your insurance had not terminated.

CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS

Effective March 1, 2000, no benefits will be paid for any claims arising as a result of an Automobile Related Accident.

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 Industrial 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 the 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 INSURANCE FOR MEMBERS AND DEPENDENTS

You and your eligible dependents will be reimbursed for out of pocket health costs for the types described below as covered expenses, and incurred anywhere in the world while insured. In all instances, the expense must be reasonable and medically necessary.

Maximum Benefit

The maximum amount payable for supplementary health insurance benefits (excluding Out-of-Hospital Nursing) for any one insured person is $15,000 in any calendar year. The Out-of-Hospital Nursing Benefit Maximum is $10,000 per calendar year. The Out-of-Country Emergency Care maximum is $1,000,000 per one cause.

Covered Expenses

Covered expenses are charges which are required to be paid for the following services and supplies related to the treatment of non-occupational injuries, diseases, pregnancy and for vision care.

a) Drugs and medicines (including oral contraceptives) and vaccines obtainable only upon a licensed doctor (M.D.) or licensed dentist's prescription (or other professionals authorized by Provincial Legislation to prescribe drugs), and dispensed by a registered Pharmacist or Licensed Doctor (M.D.) legally authorized to dispense such drugs.

   Items that can be obtained without a prescription are not covered by this plan and claims for such items will be rejected.

   Erectile dysfunction medications (including Viagra) are not covered under the plan.

   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.

b) Ambulance

   Charges in excess of the amount payable under the insured person's Provincial Health Plan for emergency

transportation within the continental limits of the U.S.A. and Canada:

- by professional licensed ambulance service (other than air ambulance) to transport the insured person to and from a hospital; or
- by regularly scheduled airline or railroad or by air ambulance from the city or town or location in which the insured person becomes disabled to and from the nearest hospital qualified to provide special treatment for the injury or sickness, except that in any calendar year only charges incurred for the first trip to and the first trip from a hospital on account of any one accident or sickness are included.

c) Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse.

You should apply for a pre-care assessment before home nursing begins.

d) Out of Province Emergency Treatment as follows:

Charges incurred while traveling or vacationing outside the insured person's home Province provided part of the charge is payable under the insured person's Provincial Health Plan, that are:

- hospital charges for:
- room and board in excess of the ward rate under the insured person's Provincial Health Plan up to the average semi-private rate plus user fees; and
- other inpatient and outpatient medical services; and
- reasonable and customary charges for the area in which they are incurred, that are in excess of the amount payable under the insured person's Provincial Health Plan for:
- a licensed doctor (M.D.);
- professional license ambulance service, including air or rail ambulance service, to transport the insured person back to a hospital within his home Province,

provided prior approval is obtained from Great-West Life; and

- medical supplies provided during hospital confinement;
- medical supplies provided out of hospital if they would have been covered in Canada;
- drugs.

e) Durable Medical Equipment and Supplies

Charges for supplies and the rental of or, at Great-West Life's option, the purchase of durable medical equipment of the type and model adequate for the insured person's medical needs based on the nature and severity of the disability, such as, but not limited to:

- hospital beds, wheelchairs, canes, crutches, walkers and trusses;
- braces for back, neck, arm or leg and non-dental prostheses such as artificial limbs and eyes; including replacement if required because of a change in physical condition;
- respiratory equipment, including oxygen;
- kidney dialysis equipment;
- splints, casts, catheters, and hypodermic needles;

but excluding personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to:

- heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

Before incurring any major expenses you should submit details to determine what extent benefits are payable. In any event, a letter will be required from a licensed doctor (M.D.) describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

f) Vision Care

Charges for prescription glasses or contact lenses up to a maximum of $300.00 per calendar year. No amount will be paid for safety or sunglasses, anti-reflective coatings, or for tints other than No. 1 or No. 2.

Laser eye surgery up to a lifetime maximum of $1,000.

The cost of one eye examination including refractions is covered once every 2 years.

g) Hearing Aids

The cost for the purchase of hearing aids, excluding batteries, when provided by a certified, clinical audiologist, subject to a maximum amount of $300.00 per period of five (5) consecutive years per insured person.

h) Health Practitioners

Charges including x-ray charges, for a practitioner who is registered and legally practicing within the scope of his license as:

- a chiropractor - $35 per visit up to a calendar year maximum of $500;
- an osteopath or podiatrist up to a calendar year maximum of $300, per type of practitioner;
- a physiotherapist - $60 per visit up to a calendar year maximum of $500, when treatment is prescribed by a licensed doctor (M.D.) as to duration and type;
- an acupuncturist - $25 per visit up to a calendar year maximum of $300;
- a psychologist/social worker up to a calendar year maximum of $300 when treatment is prescribed by a licensed doctor (M.D.) as to duration and type; or
- a psychoanalyst who is a licensed doctor (M.D.) if the covered person is not hospitalized (Quebec residents only), up to a calendar year maximum of $300;
- a speech therapist up to a calendar year maximum of $300, when treatment is prescribed by a licensed doctor (M.D.) as to duration and type.

No amounts will be paid for any visits for which any amount is payable under the insured person's Provincial Health Plan, unless permitted by law.

i) Foot Care

Charges for orthopedic shoes (including repairs) up to a calendar year maximum of $250 per covered person and arch supports, molds or orthotic devices up to a calendar year maximum of $250 per covered person which have been specially designed and molded for the covered person and are required to correct a diagnosed physical

impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- a description of the physical findings from the clinical examinations;
- a brief description of the abnormal walking pattern associated with the diagnosis; and
- confirmation that the product has been custom-made.

Your orthopedic shoes and arch supports, molds or orthotic devices must be prescribed on an annual basis. For information on eligible prescribing and dispensing providers, please contact your Benefits Administrator for a copy of the plan member information sheet provided by Great-West Life.

j) Dental Care For Accidental Injury

Charges for dental care by a licensed dentist for the prompt repair of sound natural teeth when required for a non-occupational accidental injury, external to the mouth, that occurs while the person is insured.

k) Diagnostic Laboratory and X-Ray Expenses

l) 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;

m) Charges for diabetics, the cost of needles, syringes and chemical diagnostic aids. A blood glucose monitoring machine is covered to a maximum of $50 per person per lifetime;

n) Breast prosthesis to a maximum of $350 every 2 years;

o) Surgical brassiere, 2 per calendar year;

p) Surgical hose, 2 pairs per calendar year;

q) Wigs for cancer patients undergoing chemotherapy is $500 every year;

r) Tens Machine $400 lifetime maximum;

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

t) Expenses for smoking cessation products are limited to $125 per person per lifetime maximum;

u) Expenses for fertility drugs are limited to $2,500 per lifetime maximum;

v) Charges for Intra-uterine Devices (IUD's);

w) Colostomy, ilestomy supplies, catherters and supplies are covered.

Extension of Benefits
If an insured person is Totally Disabled on the date insurance under these Benefits terminates, entitlement to benefits will be the same as though such insurance had not terminated, for as long as such person remains continuously so disabled, but not beyond the earliest of:

- the date such person becomes insured under any other group-type plan providing similar coverage; or
- 3 months.

Definitions
Note: applicable to Semi-Private Hospitalization – This Benefit is self insured by the Trust Fund.

To be recognized as a hospital for insurance purposes, an institution must keep patients regularly overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of licensed doctors (M.D.), must have regular 24 hour, nursing service by registered graduate nurses and is approved as a hospital for payment of the ward rate under the Provincial Health Plan. Unless they fully meet this definition institutions such as clinics, nursing homes, and places for rest, the aged, drug addicts or alcoholics do not qualify as hospitals.

Limitations
No amount will be paid for any disability (or charge) that results from or is contributed to by claims arising as a result of an automobile accident.

No amount will be paid for care services or supplies:

- for drugs, sera or injectible drugs when administered in a hospital setting whether administered on an in-patient or out-patient basis, except as provided under Out-of Province;
- if the payment is prohibited by law;

- that a covered person may obtain as a benefit under any governmental plan or law;
- for which no charge would have been made in the absence of this coverage;
- for dental work, except as provided under Dental Care for Accidental Injury;
- for erectile dysfunction medications (including Viagra), effective April 9, 1999.

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

- Atomizers, appliances, prosthetic devices, 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.

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

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury; or
- the insured person' commission of, or attempt to commit, an assault or a criminal offence.

How to Make a Claim for your Covered Expenses under the Supplementary Health Insurance:

1) Obtain a claim form from the Administrator or your Local Union Office or Union Steward.
2) Carefully complete the claim form.
3) Complete the "claim for Reimbursement of the Covered Expenses" portion of the claim form.
4) List all expenditures incurred, using a separate form for each member of the family.
5) Attach all receipts to the claim form.
6) Forward all forms and receipts to:

    Global Benefits
    Labourers' Union Local 506
    (Industrial Division) Benefit Plan
    88 St. Regis Crescent South
    Toronto, Ontario
    M3J 1Y8
    Telephone: (416) 635-6000

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents and your dependent's physician can access this service if the physician has made a diagnosis of a serious physical illness or condition for which there is objective evidence, or if the covered person or his or her physician suspects that the person has this condition. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll free.
- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.
- If it is appropriate, the member advocate may arrange for an in-depth review of the covered person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of

the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the covered person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet his or her specific medical needs. Expenses incurred for travel and treatment are not covered by this service.
- If the covered person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.
- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Note: These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

EMPLOYEE ASSISTANCE PROGRAM

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 Shepell.fgi.

CONTACT PROGRAM

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

Shepell.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* 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*

DENTAL COVERAGE FOR MEMBERS AND DEPENDENTS

You and your eligible dependents will be reimbursed for out of pocket dental costs of the types described below under "covered expenses".

You are strongly urged to show this Booklet to your dentist. The technical terms used to identify the covered dental services may be unfamiliar to you, but your dentist will be able to answer your questions about them. He will also be interested in knowing what benefits this plan covers. In addition, some dentists may charge higher amounts for their services than this plan allows. Benefits will only be paid according to the 2014 Ontario Dental Association Fee Guide for General Dental Practitioners.

Before going to the dentist, get a claim form from the Administrator or the local Union Office.

Predetermination of Benefits
Treatment Plan

On some occasions, the dental care you require will be complex in nature and costly in expense. In such cases, no doubt your dentist will have discussed with you the treatment he plans and the sort of fees that will be involved. In order that you will know in advance, the financial assistance you will receive from this plan, a special "Pre-Determination of Benefits Service" has been adopted. Since it is the purpose of

the plan to pay the least expensive, professionally adequate method of treatment, and since frequently the more complex forms of dentistry offer more than one choice of treatment plan, the plan requires that you give advance notification when the dentist's fee for a proposed plan of treatment exceeds $500.

Please follow these steps

1) Obtain a copy of the dentist's treatment plan or have the dentist complete the plan's Dental Claim form clearly indicating that the services are proposed and not completed. Either of these statements will give the Administrator the necessary information for pre-determination.
2) Forward this information to the Administrator.
3) The Administrator will tell you what the plan will pay if the dentist completes the treatment prescribed in his treatment plan, and if you are insured when the services are rendered.

This extra service is for your benefit, so that you will know in advance what you will have to pay from your own pocket and budget for it. If you don't take advantage of it you may find you have received dental services, the cost of which is in excess of what the plan covers. Any such excess cost will come out of your own pocket.

Covered Expenses
Up to $2,000.00 in benefit payments will be made during each calendar year for each eligible insured family member. Expenses will be reimbursed at 100%. Payments for the following expenses will be based on the usual reasonable and customary fee charged by the dentist up to a limit of the appropriate fee in the 2014 Ontario Dental Association Fee Guide for General Dental Practitioners.

Expenses reimbursed at 100%

- oral exams, including the cleaning of teeth, but not more than once every 6 months; complete exams only once every 12 months;
- scaling and root planing (limited to 10 units per calendar year for all procedures combined);
- occlusal equilibration (limited to 8 units per calendar year);

- topical applications of sodium or stannous fluoride twice every 12 months (under age 17 only);
- dental x-rays (Bite-wings up to four every 12 months, full mouth once each 24 months);
- extractions;
- oral surgery, including excision of impacted wisdom teeth;
- fillings (including white fillings);
- anaesthetics administered in conjunction with oral surgery or other covered dental services;
- space maintainers and prefabricated full coverage restoration for primary teeth;
- injections of antibiotic drugs by the attending dentist;
- periodontic treatment for disease of the bone and gums of the mouth, including tissue grafts and occlusal guards, but not athletic guards;
- occlusal guards in connection with periodontal treatment or bruxism;
- endodontic treatment, including root canal therapy;
- inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth extracted while the individual is covered or after being covered under the plan for 1 year;
- initial installation of partial permanent or full temporary or permanent removable dentures to replace one or more natural teeth extracted while the individual is covered or after being covered under the plan for 1 year;
- pit and fissure sealants (one application per tooth per lifetime for covered dependent children);
- replacement of an existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial denture to replace extracted natural teeth, but only if evidence satisfactory to the Insurance Company is presented that:

  a) the replacement or addition of teeth is required to replace one or more natural teeth extracted after the

existing denture was installed and while the individual is covered; or after being covered under the plan for 1 year;

b) if the existing denture or bridgework was paid for by the plan, it must have been installed at least 5 years prior to its replacement and that the existing denture or bridgework cannot be made serviceable and after being covered under the plan for 1 year (waiting period is waived if replacement of denture is required because of breakage);

c) the existing denture is an immediate temporary denture replacing one or more natural teeth extracted while the individual is insured, or after being covered under the plan for 1 year, and replacement by a permanent denture is required and takes place within one year from the date of installation of the temporary denture.

- repair, resurfacing or recementing of crowns, inlays, onlays or bridges;
- relining of full or partial dentures and rebasing of dentures once every 24 months;
- one denture adjustment or repair every 24 consecutive months.

Treatment in the case of each dental expense, must have been made by a licensed dentist, except that cleaning and scaling of teeth may be performed by a licensed dental hygienist, and installation, adjustment, repair, relining or rebasing of full dentures, may be done by a denture therapist, denturist, technician or mechanic if he is legally qualified and licensed.

Charges for such care, services and supplies will be deemed to be Covered Charges up to the lesser of the amount shown in the Practitioner's tariff of the Province where the charges are incurred or the Fee Guide for dentists.

Reasonable and customary charges by an anaesthetist for the administration of a general anaesthetic in connection with a covered dental procedure will be deemed to be Covered Charges.

Alternative Services

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

Dental Implants: 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 least expensive alternative treatment (i.e. bridgework).

Orthodontics
(Program to Straighten Teeth)

Covered charges

- diagnostic procedures including models;
- therapy and appliances; and
- correction of malocclusion.

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

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

If a member up to 21 years or dependent spouse or child 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 is not in effect. However, if benefits are being paid at termination of coverage, they will be continued for charges incurred during the rest of the monthly installment period in progress.

Exclusions

- orthodontic treatment or correction of malocclusion (teeth straightening) except for dependent children, spouse and members up to age 21;
- any dental procedure which is included under any other medical plan provided by an employer or government;
- the initial installation of dentures and bridgework (including crowns and inlays forming the abutments), when such charges are incurred for the replacement of teeth, all of which were extracted when the individual was not insured;
- prostheses, including crowns and bridgework, and the fitting thereof which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this benefit is discontinued or more than 31 days after termination of coverage for any other reason;
- replacement of a lost or stolen prosthetic device;
- personalization or characterization of dentures;
- services and supplies that are partially or wholly cosmetic in nature;
- supplies which were first prescribed or recommended prior to the date on which the individual would otherwise become insured hereunder for the reimbursement in respect of such supplies;
- charges for completion of claim forms;
- charges for Oral Hygiene instructions, nutritional counseling or protective athletic appliances;
- charges for appointments broken without notice;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- space maintainers and prefabricated full coverage restorations on permanent teeth;
- charges that would not have been made if there was no benefit plan; or
- charges for a consultation.

Limitations
No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances;
- The following periodontal services – subgingival periodontal irrigation, charges for post surgical treatment;
- The following oral surgery services – implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for implantology, remodeling and recontouring oral tissues will be covered under Major Coverage;
- Hypnosis or acupuncture;
- Veneers, recontouring existing crowns, and staining porcelain;
- Services or supplies that do not represent reasonable treatment;
- Congenital defects or developmental malformations in people 19 years of age or over;
- Expenses arising from war, insurrection, or voluntary participation in a riot.

How to make a Claim for your covered expenses under the Dental Benefit:

1) Obtain a claim form from the Administrator or your local Union Office
2) Carefully read the instructions on the front of the claim form
3) Your dentist must complete Part 1 of the claim form and you must complete Parts 2 and 3.
4) You or your dentist should send the completed form to:

   Global Benefits
   Labourers' Union Local 506
   (Industrial Division) Benefit Plan
   88 St. Regis Crescent South
   Toronto, Ontario
   M3J 1Y8
   Telephone: (416) 635-6000

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

MEMBER AND DEPENDENT OHIP
(ONTARIO HEALTH INSURANCE PLAN)

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

COORDINATION OF BENEFITS
(HEALTH CARE AND DENTAL CARE BENEFITS ONLY)

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

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

The plan that does not have a coordination of benefits provision pays before the plan that does (most, if not all, Insurance Company plans have such a provision).

The plan that covers the person as:

- other than a dependent pays before the plan that covers such person as a dependent; or

- a dependent child of the parent, covered as an employee or member, whose birthday occurs first during the calendar year, pays first.

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

To implement this provision, Great-West Life may:

- subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed; or
- pay to or recover from any other person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge Great-West Life from all liability under this plan.

Allowable expense means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

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

Proof of Loss

Written proof stating the occurrence, character and extent of loss must be submitted for each benefit to Manulife Financial within:

- 6 months after the date of death under the Death Provision for Life Insurance Benefit;
- 24 months after the date the employee ceases active work because of Total and Permanent Disability under the Disability Provision for Life Insurance Benefit;
- 6 months after the date of the loss for Accidental Death and Dismemberment Benefits;

- 6 months after the end of the Waiting Period for the Employee Long Term Disability Benefit; and to Global Benefits within:
- 6 months after the start of Disability for the Employee Weekly Disability Benefit;
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Health Care and Dental Care Benefits.

Legal action to recover benefits under this plan must begin within 2 years (6 years for Life Insurance) of the date of loss.

Great-West Life shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the tendency and payment period, if any, of such claim.

CHANGE OR DISCONTINUANCE OF THE PLAN

The Plan is financed by contributions from employers under collective agreements with the Union. The Board of Trustees has established the plan and the eligibility rules.

Any person who wishes to appeal any action by the plan's Administrator must notify the Trustees of the benefit plan by a letter, addressed to Labourers' Union Local 506's Headquarters in Toronto, Ontario. If necessary, such person may be given an opportunity to appear before the Trustees. The decisions of the plan's Trustees are final and conclusive and binding on all persons.

The Trustees necessarily reserve the right to change or discontinue the plan if future circumstances should require such change or discontinuance.

This booklet is intended to give you a general explanation of the insured benefits but it should be understood that the master insurance contracts are the governing documents in any question of interpretation.

For Information about your Eligibility for Coverage, Claims or Benefits:

Call or write:

Global Benefits
Labourers' Union Local 506
(Industrial Division) Benefit Plan
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8

Telephone: (416) 635-6000

Mailing Instructions:

When writing the Administrator, please enclose the following information:

(a) Your name as listed on your employer's payroll

(b) Your home address

(c) Your social insurance number

(d) Your telephone number

(e) The name of your local union

(f) Your date of birth

The benefits described under this plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the contract(s) or copies of those provisions may be obtained from your Plan Administrator.

**ADMINISTRATOR,
CONSULTANTS AND ACTUARIES**

88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8

Telephone: (416) 635-6000

THE
Great-West Life
ASSURANCE COMPANY

**GROUP INSURANCE BENEFITS
UNDERWRITTEN BY**

**THE GREAT-WEST LIFE
ASSURANCE COMPANY**

591G 707