

LIUNA

LOCAL 1059

BENEFIT PLAN

Designed for you and your family
Construction Benefits

Supplementary
Health

Dental Care
Benefits

Group Legal
Plan



LIUNA LOCAL 1059
BENEFIT TRUST

LIUNA LOCAL 1059 GROUP
LEGAL TRUST

Revised May 1, 2026

LiUNA Local 1059 Optical Centre

(details on page 76)

635 Wilton Grove Road, London ON, N6N 1N7

Mon. 9:00 am to 8:00 pm

Wed. 9:00 am to 8:00 pm

Fri. 9:00 am to 6:00 pm

Tue. 9:00 am to 8:00 pm

Thu. 9:00 am to 8:00 pm

Sat. 9:00 am to 4:00 pm

Sun. Closed

☐ (519) 963-2969 ☐ optical@liuna1059.ca

LiUNA Local 1059 Dental Studio

(details on page 85)

635 Wilton Grove Road, London ON, N6N 1N7

Mon. 9:00 am to 6:00 pm

Wed. 9:00 am to 6:00 pm

Fri. 9:00 am to 4:00 pm

Tue. 9:00 am to 7:00 pm

Thu. 9:00 am to 7:00 pm

Sat. 8:00 am to 4:00 pm

Sun. 9:00 am to 2:00pm (every other Sunday)

☐ (519) 286-1206 ☐ info@1059dental.com ☐ www.1059dental.com

LiUNA Local 1059 Chiropractic, Physiotherapy & Massage Clinic

(details on page 82)

635 Wilton Grove Road, London ON, N6N 1N7

Mon. 10:00 am to 8:00 pm

Wed. 8:00 am to 8:00 pm

Fri. 9:00 am to 4:00 pm

Tue. 8:00 am to 8:00 pm

Thu. 8:00 am to 8:00 pm

Sat. 8:00 am to 1:15 pm

Sun. 9:00 am to 2:30 pm

All hours are subject to change. Clinic closed occasionally on Saturday and Sunday

☐ (519) 286-1310 ☐ info@middlesexspineandSPORTclinic.ca

Green Shield Online Pharmacy

(details on page 69)

Mon - Fri 8:00 am - 7:00pm

☐ 1 (855) 844-2242 ☐ pharmacy.east@greenshield.ca ☐

www.greenshield.ca/Pharmacy

Sign up page: www.greenshield.ca/pharmacy

Members Health

(details on page 70)

24 Hour Service

☐ 1 (800) 484-0152 ☐ info@members-health.com ☐ www.members-health.com

CMHA - Thames Valley Addiction & Mental Health Services

(details on page 69)

Joshua Keene RSSW CPGC Mon - Fri 8:30 am to 4:30 pm

☐ (226) 376-2629 ☐ josh.keene@cmhatv.ca

LiUNA LOCAL 1059

635 Wilton Grove Road
London, Ontario N6N 1N7

☐ (519) 455-8083

Fax (519) 455-0712

☐ admin@liuna1059.ca

☐ liunalocal1059.com



H E A L T H

Plan Administrator

149 Main Street East
Hamilton, Ontario L8N 1G4

☐ (289) 768-3621

Toll-Free 1 (877) 671-0459

Fax (289) 768-3620

☐ customerservice@wahealth.ca

☐ claims@wahealth.ca

☐ www.wahealth.ca

TABLE OF CONTENTS

	PAGE
INTRODUCTION	6
ON THE IMPORTANCE OF BEING REGISTERED	7
SUMMARY OF BENEFITS	8
Local 1059 London	
GENERAL CONDITIONS	9
WHO IS COVERED BY THE PLAN?	9
ELIGIBILITY REQUIREMENTS	10
Initial Eligibility—Member	10
Maintaining Coverage.....	10
Maintaining Coverage by Direct Payments.....	10
Termination of Coverage.....	11
Reinstatement of Eligibility	12
Restrictions	12
DEFINITION OF EMPLOYEE	12
DEPENDENTS	
Who are Eligible Dependents?.....	14
WHAT HAPPENS TO MY COVERAGE IF I BECOME TOTALLY DISABLED AND UNABLE TO WORK?	16
CHANGE OF STATUS	17
COVERAGE MAINTENANCE ON DEATH	17
DETAILS OF BENEFITS	
MEMBER LIFE INSURANCE	
Amount Payable.....	17
Insurance During Total Disability	18
Life Insurance Conversion Benefit.....	19
DEPENDENT LIFE INSURANCE	
Amount Payable.....	20

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT	
Amount Payable.....	22
Additional Benefits.....	25
Critical Illness Benefits.....	46
MEMBER WEEKLY SICK PAY	
Amount Payable.....	64
When Payable	64
Successive Disabilities	65
MEMBER LONG TERM DISABILITY	
Amount Payable.....	66
When Benefits Start	66
How Benefits are Paid	66
Definition of Totally Disabled	66
Successive Disabilities	66
Rehabilitation Feature.....	67
Exclusions.....	67
Offset To Benefits	67
Independent Medical Examinations	68
Addiction & Mental Health Counselling Services ...	68
CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS	
	71
MEMBER AND DEPENDENT SUPPLEMENTARY HEALTH BENEFIT	
General.....	73
Maximum Amount.....	73
Eligible Expenses.....	74
Exclusions.....	83
MEMBER AND DEPENDENT DENTAL BENEFITS	
	85
General.....	86
Maximum Amount.....	86
Calendar Year	86
Eligible Expenses.....	86
Orthodontics.....	88
Treatment Plan Provisions	89
Exclusions.....	90
Bereavement	91
Parental Leave Benefit.....	92

DEFINITIONS FOR THE PURPOSE OF THIS PLAN	93
HOW TO SUBMIT A CLAIM	
General.....	93
Health/Dental.....	96
Member Life/Dependent Life/Member Accidental Death and Dismemberment	97
Member Weekly Sick Pay	97
Member Long Term Disability	97
Filing Deadline.....	99
 INSURANCE COMPANY	 101
GROUP LEGAL PLAN.....	102
PLAN INTRODUCTION LETTER.....	103
ELIGIBILITY	104
CLAIMS PROCEDURES.....	105
SCHEDULE OF BENEFITS	106
“A” Real Estate	107
“B” Divorce and Domestic Proceedings.....	108
“C” Preventive Law	109
“D” Non-Complex Legal Documents.....	109
“E” Wills.....	110
“F” Landlord and Tenant Matters.....	110
“G” Consumer and Personal Property Law	111
“H” Civil Litigation Defendant.....	112
“H” Civil Litigation Plaintiff (Plan Member Only)	112
“J” Government Programs and Assistance	113
“K” Insurance Related Matters	114
“L” Automobile Related Matters	114
“M” Criminal Matters	115
“N” Appeals	116

“O” Jury Duty.....	116
MAXIMUM REPRESENTATION.....	117
EXCLUSIONS.....	117
PLAN RULES - DEFINITIONS.....	119
IMPORTANT INFORMATION FOR SERVICE PROVIDERS	120

LIUNA LOCAL 1059 BENEFIT TRUST

INTRODUCTION

Dear Member:

This booklet describes the conditions of eligibility, coverage and claims procedures under The LIUNA Local 1059 Benefit Trust, which, for description ease, we refer to as the Trust Fund.

The Trust Fund was created on July 1, 2007, for the Members of Labourers International Union of North America, Local 1059 London.

Every effort has been made to ensure that the coverage descriptions, in this booklet, are consistent with the Plan Text and the group insurance policy issued by The Life Insurance Company and with related government legislation. However, this booklet is not, in itself, a legal contract, so it follows the terms of the insurance policy and of the governing legislation.

However, changes to the benefits, either made by the Trustees or as a result of legislative changes, often occur between booklet publications. Thus, this booklet may not reflect coverage at the time a claim is made. Where there is a discrepancy between the benefits described in the booklet and the Plan Text or insurance policy, the provisions of the Plan Text or insurance policy, as the case may be, prevails.

The Trustees hope that the benefit coverages, provided by the Trust Fund, are of real value to you and your eligible dependents. Should you require additional information, please contact the Administrator or your Local Union office.

Sincerely,
The Board of Trustees

Brandon MacKinnon
Jim MacKinnon
Carlo Mastrogiuseppe

Ryan Aarts
Alfonso Balassone
Tyson VanLeeuwen

MEMBERSHIP

In order to be eligible for benefits you must be a member of Local 1059 and maintain your membership in good standing. If you fail to keep up your membership you are not eligible for benefits except in very limited circumstances or as approved by the Trustees.

ON THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete and send a Member Enrolment and Beneficiary Designation Form to the Administrator. On this form you name the beneficiary to whom your Life insurance should be paid.

If you have sent a Member Enrolment Form to the Administrator already and you have no desire to change your beneficiary, it is not necessary for you to complete another form. However, if you would like to change your beneficiary, or have not completed a Member Enrolment and Beneficiary Designation Form, you should ask your Union Office for one of these forms.

Should your dependent status change (i.e. should you marry or acquire new dependents), you must complete a new Member Enrolment and Beneficiary Designation Form on which you may update your current dependent status.

THE ADMINISTRATOR IS:

W.A. Health

149 Main Street East

Hamilton, Ontario L8N 1G4

☐ (289) 768-3621

Toll-Free 1 (877) 671-0459

Fax (289) 768-3620

- ☐ customerservice@wahealth.ca
- ☐ claims@wahealth.ca
- ☐ www.wahealth.ca

SUMMARY OF BENEFITS

Contributions made on behalf of plan members working for employers who have made contributions to the LIUNA Local 1059 Benefit Trust in accordance with the collective agreement will pay fully insured and self-insured benefits.

Member Only:

Life Insurance \$125,000
Reduces to \$25,000 at age 75

Accidental Death and Dismemberment..... \$125,000
Reduces to \$25,000 at age 75

Critical illness Benefit.....\$10,000
Benefit terminates at age 70

Weekly Sick Pay\$600

Benefits are payable from:

1st day accident

8th day sickness

Note: If you are eligible for E.I. disability benefits, or W.S.I.B. benefits, you must apply for them.

Benefit Period: 26 weeks.

Long Term Disability –

A maximum benefit of \$1,300 per month for a maximum period of 2 years, but not beyond age 65.

Waiting period — Accident 182 days
— Sickness 189 days.

Offset:

Reduced by C.P.P. and/or W.S.I.B. benefits. Minimum benefit is \$500 per month.

Dependents Only:

Life Insurance

Spouse..... \$15,000

Unmarried Dependent Children \$15,000

Members and Dependents:

(Spouse and unmarried children from birth) *

* See “Who are Eligible Dependents?”

Supplementary Health Care

Co-insurance 100%

Lifetime Maximum \$100,000 per person

Covered Expenses: For details see **member and dependents supplementary health benefits.**

Dental Benefits

Co-insurance	100%
Annual Maximum	\$2,500

Reimbursement will be based on the Ontario Dental Association's 2024 General Practitioners Fee Guide.

Orthodontics (straightening of teeth) plan members and dependents up to age 21.

Orthodontic treatments are payable at the rate of 75% of the eligible charges up to a lifetime maximum of \$3,000.

For Enhanced Benefits please see LiUNA Local 1059 Dental Studio on page 48.

Covered Expenses: For details see

CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS

No benefits will be paid for any claims arising as a result of Automobile Related Accident with the exception of Life, Dependent Group Life and AD&D claims.

GENERAL CONDITIONS

Who is covered by the Plan?

All eligible Members of The LIUNA Local 1059 Benefit Trust and their eligible dependents are covered for the benefits maintained by their local, under one of the following groups:

- Group 2: (Construction) Full benefit coverage
- Group 25: (Industrial Unit) Full benefit coverage

Contact your Local Union to verify which Group is applicable to the Collective Agreement that you are employed under.

ELIGIBILITY REQUIREMENTS

Initial Eligibility – Member Group 2 only

The Administrator keeps an account for you of the contributions made by your employer on your behalf. This account is called a Dollar Bank account.

You become eligible for the group insurance coverage provided by the Trust Fund on the first day of the second calendar month following the accumulation of earned credits equal to 2 months of normal deductions.

Example, if you have earned enough dollars to cover 2 monthly deductions by the end of July, your group insurance will become effective September 1.

Maintaining Coverage

Your insurance continues automatically provided you have sufficient dollars in your account for the Administrator to deduct the required monthly deduction.

There is no limit on the amount of Fund Credits (dollars) that may be accumulated by you.

Maintaining Coverage by Direct Payments

As mentioned previously, your insurance continues automatically provided you have sufficient dollars to your credit for the Administrator to deduct the required monthly deduction. However, if at the end of any month, you have less than the required deduction to your credit, and you are not eligible for Fund Assistance, you will be advised by the Administrator that you are eligible to make Direct Payments to the Fund. (For details of Fund Assistance see “**WHAT HAPPENS TO MY COVERAGE IF I BECOME TOTALLY DISABLED AND UNABLE TO WORK**”)

Direct Payments may be made for a total of 18 months for Plan Members covered in Group 2 and for a total of 6 months for Plan Members covered in Group 25 (upon layoff only) following the month for which your coverage was last paid by current or accumulated employer contributions or Fund Assistance. You will be required to pay the amount of the monthly deduction that was being charged in the month immediately prior to the month in which your Direct Payment begins. The Administrator will provide you with the amount of the monthly deduction required when they first inform you that you are eligible for Direct Payments. All benefits are maintained under the Direct Payment option (with the exception of the Short Term and the Long-Term Disability benefit). Direct Payments must be made by you when you are first eligible to make these payments. Failure to do so will result in the cancellation of your benefits.

Termination of Coverage for Group 2 only

Your coverage will terminate should:

- i) your Dollar Bank drop below the required deduction, and
- ii) you are not eligible for Fund Assistance as described under **“WHAT HAPPENS TO MY COVERAGE IF I BECOME TOTALLY DISABLED AND UNABLE TO WORK” (as described on page 16)**, or
- iii) you do not choose to maintain your coverage by making Direct Payments, or
- iv) You have made Direct Payment for 18 months.

Should any of the above occur the Administrator will send you a notice, showing the date your group coverage terminated. When your coverage terminates, you may have a small balance in your account i.e. less than one monthly deduction. If no contributions are made for you, within 12 months of the date of termination, any balance in your account will be cancelled.

Reinstatement of Eligibility for Group 2 only

If your coverage under this Plan ceases (see Termination of coverage), it may be reinstated by once again accumulating an amount equal to 2 monthly deductions in your account. Your coverage will then take effect on the 1st day of the second calendar month following this accumulation.

Payment for continuation of coverage must be made payable to The LiUNA Local 1059 Benefit Trust and forwarded to W.A. Health. Payment cannot be made by your employer. Failure to do so may result in coverage termination and return of contributions.

Restrictions

The insurance policy and/or Benefit Trust will not pay any claims that you incur as a result of active service in the army, navy or air force of any country. The “**DE-TAILS OF BENEFITS**” section of the booklet, outlines the coverage provided by the Fund.

DEFINITION OF EMPLOYEE

“Employee” means any of the following persons:

- a. A member of the Union:
 - (i) who is employed under a Collective Agreement within the Union’s bargaining unit;
 - (ii) who is unemployed but who is registered with the Union for referral to work under a Collective Agreement.
 - (iii) who is unable to work due to illness or disability;
 - (iv) who is employed by an Employer who is obligated to, or does make contributions to the Trust to the same extent and in the same manner as the employer would be obligated to make such contributions if it were doing so under a Collective Agreement;

- (v) who is employed outside of the Union's bargaining unit of a Collective Agreement but on whose behalf the Employer is making contributions to the Trust;
- (vi) who is permitted by the terms of the Benefit Plan to make Contributions to the Trust;
- (vii) on whose behalf Contributions are made to the Trust, pursuant to Article 1.07 (d) herein;
- (viii) on whose behalf Contributions are made to the Trust by the Union or an entity associated with the Union where the member is employed by the Union or an entity associated with the Union;

and

- b. A person who is not a member of the Union:
 - (i) who is employed by the Union or an entity associated with the Union;
 - (ii) who is employed by an Employer or Association and in respect of whom the employer of such person makes Contributions to the Trust in such manner and amount as the Trustees by resolution determine;
 - (iii) is an apprentice registered with the Union;
or
 - (iv) is a probationary employee working under a Collective Agreement.

and

- c. A former member of the Union:
 - (i) who has retired from and permanently ceased employment in the construction industry and who was a member of the Union at the time the former member

- retired from and permanently ceased employment in the construction industry; or
- (ii) who is suspended for a period of less than one year solely for non-payment of dues and who is not in violation of any other provision of the Union's constitution, policies or rules.

DEPENDENTS

Who are Eligible Dependents?

Dependents are residents in Canada who are:

- your spouse
- your unmarried dependent children under 21 provided they are not employed on a regular, full-time basis
- your unmarried dependent children age 21 or over are also eligible for the Supplementary Health and Dental benefits, and Dependent Life Insurance, if applicable, provided they are not employed on a regular, full-time basis and they:
 - a) are full-time students attending an accredited post-secondary institute on a continuous basis, or
 - b) are medically diagnosed as being incapacitated. Additional proof may be required from time to time.

“Spouse” means the person to whom you are married (excludes a person divorced from member) or your common-law spouse if the person has been living with the member for a period of at least one continuous year. Only one person may qualify as your spouse, at any one time.

Stepchildren, foster children, legally adopted children and children of the common-law spouse may be included the same as your own children provided, they meet the requirements set out above.

Your dependents are eligible for Dependent Life Insurance and for the Supplementary Health benefits from birth. A child who is physically or mentally incapable of self-support upon attaining age 21 may continue to be eligible under the Dependent Life Insurance and the Supplementary Health Benefits while remaining incapacitated and unmarried. Their insurance becomes effective at the same time as your coverage unless at that time they are confined for medical care or treatment in any institution or at home, in which case they will not be covered until given a final release by the doctor from all such confinement. No one will be eligible for coverage as a dependent while covered for the same type of insurance as a member. No one will be covered while in military service. If both parents of a dependent child are covered under this Plan as Members, only one of the parents will be considered to have eligible dependents.

Health Care Benefits and Dental Care Benefits will continue beyond the date an unmarried child attains the limiting ages for insurance, provided proof is submitted to the Administrator within 31 days after such date that such child:

- a) is incapable of self-sustaining employment by reason of being mentally or physically challenged;
- b) became so incapacitated prior to attainment of the limiting age; and
- c) is chiefly dependent upon you for support and maintenance

Thereafter such proof must be submitted to the Administrator as required, but not more often than yearly.

WHAT HAPPENS TO MY COVERAGE IF I BECOME TOTALLY DISABLED AND UNABLE TO WORK?

In the event that the Plan Member becomes disabled and is unable to work as a result of a work related disability, any credits on the Plan Member's account will be frozen and benefit coverage will be maintained by the Trust Fund for as long as the Plan Member continues to be disabled and is in receipt of Workplace Safety Insurance Board (WSIB) benefits up to a maximum of 12 months following the completion of 1 month of disability.

Plan Members who are disabled and in receipt of non-occupational disability benefits shall be entitled to the following Fund Assistance in the event that the Plan Member ceases to be covered for benefit coverage as a result of having insufficient monies in the **Plan Member's dollar bank to continue benefit coverage.**

- a) Members collecting Employment Insurance Disability benefits may receive Fund Assistance for up to a maximum of 26 weeks upon providing proof of collecting Employment Insurance.
- b) Members collecting Weekly Indemnity benefits may receive Fund Assistance for up to a maximum of 26 weeks, **if you don't qualify for E.I. Benefits.**
- c) Members collecting Long Term Disability benefits may receive Fund Assistance for up to a maximum of 2 years.

Fund Assistance is available to all eligible members, regardless of age.

Note: Plan Members who maintain their benefit coverage by Pay Direct payments, do not qualify for Fund Assistance in the event that they become disabled.

Should your disability continue beyond the application of the Fund Assistance payments, set out above, your coverage will be continued until the credits in your account are insufficient for the Administrator to deduct the required monthly deduction, at which time, you will qualify to maintain your coverage by Direct Payments. See **“ELIGIBILITY REQUIREMENTS”** – Maintaining Coverage by Direct Payments for details.

CHANGE OF STATUS

As advised under **“ON THE IMPORTANCE OF BEING REGISTERED”** it is your responsibility to ensure that the Administrator is advised of any change of status (married, new dependents, etc.) to ensure that proper coverage is maintained.

COVERAGE MAINTAINED ON DEATH

In the event of your death, your dependents will continue to be covered for Supplementary Health, Dental and Group Legal benefits for as long as there are sufficient earned credits in your account to cover a full monthly deduction.

Your dependents may not pay directly to the Trust Fund after your earned credits are depleted.

DETAILS OF BENEFITS

LIFE INSURANCE

In the event of a Member’s death while eligible for the benefits of the Plan, the amount of the Life Insurance Benefit shown in the **Summary of Benefits** section of this Booklet is payable to the eligible Member’s Designated Beneficiary.

DESIGNATING A BENEFICIARY

An eligible Member may designate a Beneficiary when completing and filing a Member Enrolment and Beneficiary Designation Form with the Plan Administrator.

An eligible Member may change their Designated Beneficiary at any time (subject to any insurance policy or legal/provincial limitations) by completing a new Member Enrolment and Beneficiary Designation Form and filing it with the Plan Administrator.

The Insurer will generally pay any Life Insurance Benefit to the Designated Beneficiary named on the last Member Enrolment and Beneficiary Designation Form filed with the Plan Administrator.

It is therefore very important to keep all personal information filed with the Plan Administrator up to date, as well as to review your Beneficiary Designation to be sure it reflects your current intent.

WAIVER OF PREMIUM BENEFIT FOR DISABLED PLAN MEMBERS

If an eligible Member becomes Totally Disabled before attaining age 65 and such disability continues without interruption for at least 6 months and is approved for Long Term Disability benefits, the Life Insurance Benefit will be continued, at no cost, until the eligible Member ceases to be Totally Disabled or until they reach age 65, whichever occurs first.

“Totally Disabled” means during the first 24 months in which you receive Long Term Disability benefits if you are unable to perform the essential duties of your regular occupation or employment.

After this period, you are considered Totally Disabled if your disease or injury prevents you from being gainfully employed in any occupation or employment for which you are reasonably qualified by training, education or experience, and that provides income of at least 50% of your pre-disability monthly earnings. Proof of continuing disability must be provided as required by the Insurer.

In order to qualify for the Waiver of Premium benefit, an eligible Member must notify the Plan Administrator of the disability within 6 months of the last active day at work and provide satisfactory proof of disability to the Insurer within 12 months of the last active working day.

If an eligible Member has been approved for the Plan's Long Term Disability Benefit, W.A. Health will forward the information on to the Life Insurer for waiver of premium consideration.

LIFE INSURANCE BENEFIT CONVERSION PRIVILEGE

If the Life Insurance Benefit of an eligible Member terminates or reduces, the terminated or reduced Life Insurance Benefit amount may be eligible to be converted into an individual policy, without medical evidence.

An application for an individual policy, along with the first monthly premium, must be received by the Insurer within 31 days of the date of termination or reduction of the Life Insurance Benefit. If a death occurs during this 31-day period, the amount of Life Insurance available for conversion will be paid accordingly, even if there was no application for conversion. For more information on the conversion privilege, please contact the Plan Administrator.

TERMINATION OF THE LIFE INSURANCE BENEFIT

Coverage for an eligible Member will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made to an eligible Member's Beneficiary unless a completed Claim Form and any other required documents are submitted to the Plan Administrator and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Filing Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

DEPENDENT LIFE INSURANCE

In the event of the death of a Member's eligible Spouse and/or Dependent Child(ren) the amount(s) of Dependent Life Insurance shown in the **Summary of Benefits** section of this Booklet is(are) payable to the eligible Member.

WAIVER OF PREMIUM BENEFIT FOR DISABLED PLAN MEMBERS

If an eligible Member is approved for Waiver of Premium as described earlier under the Life Insurance Benefit, they will automatically be approved for Waiver of Premium under the Dependent Life Insurance Benefit.

DEPENDENT LIFE INSURANCE CONVERSION PRIVILEGE

The Dependent Life Insurance may be converted, provided the spouse is under 66 years of age, to:

- i. non-convertible term insurance, to age 65;
- ii. a permanent plan that Canada Life Insurance Company offers to the public at the time of conversion;
- iii. one year non-renewal 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 from your spouse's age and class of risk at the time of conversion.

If your group policy terminates and your spouse has been continuously insured under it for at least 5 years, you have the same conversion privilege as above but the maximum amount of insurance that may be converted shall be \$10,000 less any amount your spouse becomes eligible for under another Group Policy within 31 days of the date of termination.

An application for an individual policy along with the first monthly premium must be received by the Insurer within 31 days of the date of termination or reduction of the Dependent Life Insurance Benefit. If a death occurs during this 31-day period, the amount of the terminated or reduced Dependent Life Insurance Benefit that was available for conversion will be paid accordingly, even if there was no application for conversion.

TERMINATION OF THE DEPENDENT LIFE INSURANCE BENEFIT

Coverage for an eligible Member and for any Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

DEPENDENT LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made to an eligible Member unless a completed Claim Form, and any other required documents are submitted to the Plan Administrator and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Filing Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT

Your Accidental Death and Dismemberment coverage is equal to the amount of your Group Life Insurance benefit.

The Accidental Death and Dismemberment plan covers you, as the Insured Member, 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed on the following Schedule of Losses as a result of an accidental injury which results directly and independently of all other causes and the Loss occurs within 365 days of the accident, the following table shows the benefits that will be paid.

SCHEDULE OF LOSSES

Loss of:	Amount Payable
Life	The Principal Sum
Both Hands or 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 Eyesight of One Eye	The Principal Sum
One Foot and Entire Sight of One Eye	The Principal Sum

Speech and Hearing	The Principal Sum
Brain Death	The Principal Sum
One Arm or One Leg	80% of Principal Sum
One Hand or One Foot	75% of Principal Sum
Entire Sight of One Eye	75% of Principal Sum
Speech or Hearing	75% of Principal Sum
Hearing in One Ear	66 2/3% Principal Sum
Thumb and Index Finger of the Same Hand	33.3% Principal Sum
Four Fingers of One Hand	33.3% Principal Sum
All Toes of One Foot	25% of Principal Sum
Thumb on One Hand	25% of Principal Sum
One, Two or Three Fingers or Toes	16 2/3% of Principal Sum

Loss of Use of:

Both Arms or Both Hands	The Principal Sum
One Arm or One Leg	80% of The Principal Sum
One Hand or One foot	75% of The Principal Sum

Paralysis:

Quadriplegia (total paralysis of both upper and lower limbs) 200% of The Principal Sum

Paraplegia (total paralysis of both lower limbs) 200% of The Principal Sum

Hemiplegia (total paralysis of upper and lower limbs of one side of the body) 200% of The Principal Sum

"Loss" as used above with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; 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 above with reference to arm or leg means complete severance through or above the elbow or knee joint; as used above with reference to thumb and index finger means complete severance through or above the first phalange; as used above with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used above with reference to toes means complete severance of both phalanges of all the toes of one foot and as used above 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 above with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used above with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and

such loss is determined to be permanent.

Indemnity provided under this Section for all losses sustained by any one Insured Member as the result of any one accident will not exceed the Principal Sum, with the exception of quadriplegia, paraplegia and hemiplegia, where indemnity will not exceed Two Times the Principal Sum.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such member was an occupant, then it shall be deemed, subject to all other terms and provisions of the policy, that such Insured Member shall have suffered Loss of Life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Policyholder's current Basic Group Life Insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Member.

All other benefits shall be payable to the Insured Member.

ADDITIONAL BENEFITS

Permanent and Total Disability Benefit

If an Insured Member suffers an injury causing Permanent and Total Disability, and the Insured Member has not retired nor attained age 65 as of the date of Injury, the Insurance Company shall pay 100% of the Insured Member's Principal Sum less any amounts under the Table of Losses which have been paid or which are payable by the Insurance Company for Losses of the Insured Member.

“Permanent and Total Disability” means Injury which

prevents an Insured Member from performing at least 2 of the 6 Activities of Daily Living, without assistance from another person and the Insured Member has been determined, on evidence satisfactory to the Insurance Company, to be and remain, as of 12 months after the date of the Injury, incapable of performing at least 2 of the 6 Activities of Daily Living, without assistance from another person for the remainder of their life. The disability must be determined to be total, permanent and irreversible and certified to be such by a Physician acceptable to the Insurance Company. The Insured Member's inability to obtain employment is not a criteria to qualify for the Permanent and Total Disability benefit.

“Activities of Daily Living” means the following 6 activities:

1. Maintaining Continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower, or washing satisfactorily by other means.

Rehabilitation Benefit

If an Insured Member suffers an injury resulting in a Loss (other than Loss of Life) for which the Insurance Company has paid a benefit set out in the Table of Losses, the Insurance Company shall pay the reasonable and necessary expenses actually incurred for the

occupational training of the Insured Member, provided that:

- a) such training is required because of such Injury and in order for the Insured Member to be qualified to engage in an occupation in which they would not have been engaged except for having suffered such Injury;
- b) the training expenses are incurred within 3 years from the date of the accident causing such Injury; and
- c) no payment shall be made for ordinary living, travelling or clothing expenses.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$15,000.

Home Alteration and Vehicle Modification Benefit

If an Insured Member suffers Injury resulting in a Loss (other than Loss of Life) for which the Insurance Company has paid a benefit set out in the Table of Losses and which Loss results in and necessitates the use of a wheelchair in order for the Insured Member to be ambulatory, the Insurance Company shall pay the reasonable and necessary expenses actually incurred for:

- a) the one-time cost of alterations to the injured Insured Member's residence to make the residence wheelchair accessible and habitable; and
- b) the lesser of:
 - (i) the one-time cost of modifications necessary to a motor vehicle, owned by the injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and
 - (j) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Insurance Company.

This benefit is payable only if:

- a) home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized

organization, providing support and assistance to wheelchair users; and

- b) vehicle modifications are made on behalf of the Insured Member and carried out by an experienced individual in such matters and modifications are approved by the provincial vehicle licensing authorities in the Insured Member's province of residence.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$15,000.

Workplace Modification and Accommodation Benefit

If an Insured Member suffers an injury resulting in a Loss (other than Loss of Life) for which the Insurance Company has paid a benefit set out in the Schedule of Losses and which Loss results in and necessitates the use of special adaptive equipment and/or workplace modification in order to reasonably accommodate the Insured Member's return to active full-time work with his/her employer, the Insurance Company shall pay to the Insured Member's employer, upon the Insured Member's return to active full-time work with the employer, the reasonable and necessary expenses actually incurred by the employer for such adaptive equipment and/or workplace modification, provided:

- a) the employer agrees in writing with the Insurance Company to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Member;
- b) the employer acknowledges in writing to the Insurance Company that the performance of the essential duties of such Insured Member's job may be altered; and
- c) the proposed special adaptive equipment and/or workplace modification have been approved in advance of an expense being incurred by the employer for such equipment or modification.
- d)

The Insurance Company shall be afforded the opportunity to examine the Insured Member to evaluate the appropriateness of the proposed modifications.

This benefit is payable only once in connection with the Injuries and Losses suffered by any one Insured Member, regardless of the number of policies providing coverage for a workplace modification and accommodation benefit, that may be issued by the Insurance Company to the Policyholder or the employer.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$5,000.

Psychological Therapy Benefit

If an Insured Member sustains Injury which results in a Loss payable under the Table of Losses (other than Loss of Life) and subsequently, as a result of such Injury and Loss, the Insured Member requires, within 2 years from the date of such Injury, Psychological Therapy as prescribed by a Physician or nurse practitioner, the Insurance Company will pay the reasonable and customary expenses for Psychological Therapy.

“Reasonable and Customary” means the lesser of:

- a) the usual charge made by Physicians or other health care providers for a given service or supply; or
- b) the charge determined to be the prevailing charge made by Physicians or other health care providers for a given service or supply in the geographical area where it is furnished; or
- c) the amount negotiated by the Insurance Company and the health care provider.

“Psychological Therapy” means the treatment or counselling by a therapist or counsellor who is licensed, registered, or certified to provide such treatment, whether such treatment is on an out-patient basis or provided while a patient at a medical facility licensed to provide such treatment.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$5,000.

In-Hospital Benefit

If an Insured Member suffers an Injury resulting in a Loss (other than Loss of Life) for which the Insurance Company has paid a benefit set out in the Table of Losses and, as a consequence of such Loss, the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than 5 consecutive overnight stays, the Insurance Company will pay:

- a) for a period of confinement in Hospital of more than 30 consecutive overnight stays, 1% of the Insured Member's Principal Sum; or
- b) for a period of confinement of 30 consecutive overnight stays or less, 1/30th of the amount determined in accordance with Item (a) above for each overnight stay in Hospital.

The Insurance Company will pay this benefit monthly, retroactive to the first overnight stay of confinement in Hospital.

The Maximum Amount Payable for this benefit for all injuries resulting from any one accident per Insured Member is \$2,500 per month.

Benefits are not payable for more than a total of 12 months of confinement for any one accident-causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than 3 months, are considered one period of confinement to Hospital for the purpose of calculating this benefit.

Family Transportation Benefit

If an Insured Member suffers Injury resulting in a Loss (other than Loss of Life) set out in the Table of Losses and if such Loss requires that the Insured Member be

confined to a Hospital located more than 100 kilometres from their permanent place of residence, the Insurance Company shall pay the reasonable and necessary expenses actually incurred for the transportation of one Immediate Family member to such Hospital. This benefit is only payable if:

- a) confinement to Hospital occurs within 365 days of the accident-causing Injury; and
- b) reimbursement of expenses is limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family member.

In this section, the term "Immediate Family member" means a spouse (or common-law spouse), parent (including stepparent), father-in-law, mother-in-law, a child (including legally adopted or stepchild), son-in-law, daughter-in-law, brother or sister (includes stepbrother or stepsister), brother-in-law, sister-in-law, grandparent, grandchildren, aunt, uncle, niece, nephew or first cousin.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$15,000.

Repatriation Benefit

If an Insured Member suffers Injuries causing Loss of Life and for which a benefit is paid or payable hereunder and:

- a) such Loss of Life occurs more than 50 kilometres from their permanent city of residence; and
- b) such Loss of Life occurs within 365 days of the date of the accident causing the injury, the Insurance Company shall pay the actual expenses incurred for preparing the deceased Insured Member for burial or cremation and shipment of the body to the city of residence of the deceased Insured Member.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$15,000.

Identification Benefit

In an Insured Member suffers Injury causing Loss of Life for which a benefit is paid or payable hereunder and the Insured Member's body requires identification, the Insurance Company will pay, to one immediate family member of the Insured Member, the reasonable and necessary expenses actually incurred by such immediate family member for:

- a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and
- b) transportation by the most direct route to such location.

This benefit is payable by the Insurance Company only if the body of the Insured Member is located not less than 150 kilometres from the said Immediate Family member's normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of \$0.40 per kilometre travelled.

This benefit is payable only once in connection with Injuries and Losses suffered by any one Insured Member, regardless of the number of policies providing coverage for this benefit for such Insured Member, that may be issued by the Insurance Company.

In this section, the term "Immediate Family member" means a spouse (or common-law spouse), parent

(including stepparent), father-in-law, mother-in-law, a child (including legally adopted or stepchild), son-in-law, daughter-in-law, brother or sister (includes stepbrother or stepsister), brother-in-law, sister-in-law, grandparent, grandchildren, aunt, uncle, niece, nephew or first cousin.

The Maximum Amount Payable per Insured Member for this benefit is \$5,000.

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Insurance Company has paid the benefit set out in the Table of Losses, the Insurance Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

- a) the actual annual cost charged by a commercial and licensed day care centre; or
- b) 5% of the Insured Member's Principal Sum; or
- c) \$5,000 per year

This benefit is payable annually for a maximum of 4 consecutive payments per Dependent Child:

- a) only for such Dependent Child who at the date of the Insured Member's Loss of Life is under the age of 13;
- b) provided such Dependent Child is enrolled in a commercial or licensed day care centre no later than 90 days following the Insured Member's Loss of Life; and
- c) provided that the Dependent Child continues their enrollment in a commercial and licensed day care centre.

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Insurance Company has paid the benefit set out in the Table of Losses, the Insurance Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent

Child of such Insured Member, up to the lesser of the following amounts:

- a) \$5,000 per school year; or
- b) 5% of the Insured Member's Principal Sum.

This benefit is payable annually for a maximum of 4 consecutive payments per Dependent Child:

- a) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the 12th grade level; and
- b) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

The Insurance Company will reimburse the person who has incurred the actual tuition expenses.

"Dependent Child" as used herein means a person who is either the natural child, adopted child or step-child of the Insured Member, or an infant to which the Insured Member is "*in loco parentis*", and who is:

- a) under 23 years of age, unmarried and dependent upon the Insured Member for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss;
- b) under 26 years of age and unmarried and in attendance at an Institution of Higher Learning and dependent upon the Insured Member for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss; or
- c) by reason of mental or physical infirmity, incapable of self-sustaining employment and who is considered a dependent child of the Insured Member within the terms of the Income Tax Act (Canada).

"Institution of Higher Learning" as used herein is a school that provides a post-secondary program of education which includes, but is not limited to, any university, private post-secondary college or trade school, and any College of General and Vocational

Education/ Collège d'enseignement général et professionnel (CÉGEP).

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Insurance Company has paid the benefit set out in the Table of Losses, the Insurance Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than 36 months after the Insured Member's Loss of Life.

The Maximum Amount Payable per Insured Member for this benefit is \$15,000.

Funeral Expense Benefit

If an Insured member suffers Injury resulting in Loss of Life, for which the Insurance Company has paid the benefit set out in the Table of Losses, the Insurance Company will reimburse the reasonable and usual expenses incurred with a mortician, crematory or a funeral home, for the services or supplies related to the burial or cremation. The Insurance Company shall also reimburse the usual expenses relative to the purchase of a cemetery plot, grave or mausoleum, including a plaque, tombstone or monument. This benefit is payable to the person who has incurred the actual expenses pertaining to the cremation, burial or funeral expenses of the Insured Member.

The Maximum Amount Payable per Insured Member for this benefit is \$5,000.

Bereavement Benefit

If an Insured Member suffers Injury which results in Loss of Life for which the Insurance Company has paid the benefit set out in the Schedule of Losses, the Insurance Company will pay the reasonable and necessary expenses actually incurred for grief counselling, provided that:

- a) the counselling is for the Spouse and/or Dependent Children;
- b) such expenses are incurred within 365 days of the date of the Loss of Life; and
- c) such grief counselling is provided by a therapist or counsellor who is licensed, registered or certified to provide such treatment and who is not a member of the Immediate Family of the Insured Member.

The Insurance Company will pay the person who has incurred the actual expense.

The Maximum Amount payable per Insured Member for this benefit is \$1,000.

Seat Belt and Air Bag Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Insurance Company has paid a benefit set out in the Table of Losses, the Insurance Company shall pay an additional amount equal to 10% of the Insured Member's Principal Sum if Injury causing the Loss results while they are a passenger or driver of a Private Passenger Type Automobile and their seat belt is properly fastened.

The Insurance Company will pay an additional benefit if a Seat Belt Benefit is payable and if the Insured Member is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is equal to 10% of the Insured Member's Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s). Verification that the Supplemental Restraint System inflated properly must be provided by the person submitting the claim.

The Maximum Amount Payable for this benefit per Insured Member is \$50,000.

Criminal Assault Benefit

If an Insured Member suffers Injury resulting in a Loss for which the Insurance Company has paid a benefit set out in the Table of Losses, the Insurance Company will pay an additional benefit equal to 10% of the Insured Member's Principal Sum if such Injury and the resulting Loss are caused by the deliberate act of another person, where such deliberate act:

- a) constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, riot or attempted riot;
- b) is not a moving violation as defined under the applicable province/state motor vehicle laws;
- c) is directed at a group of Insured Members engaged in the usual course of business or at the property or assets of the Insured Member's employer, or at the Insured Member as a representative of the group; and
- d) is not the act of a fellow employee or a member of the Insured Member's family or household.

The words act, felony, indictable offence, misdemeanour, summary conviction, offence and riot include, but are not limited to, robbery, theft, bombing, kidnapping, hijacking, larceny, sniping, murder, rioting or inciting a riot. In this section, the laws of the jurisdiction where the Injury occurs will govern as to whether an act constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, riot or attempted riot.

Cosmetic Disfigurement Benefit

If an Insured Member suffers Injury resulting in the destruction of their skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid (third degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation the Insurance Company will pay based on a percentage of the Insured Member's Principal Sum provided that the Insured Member survives for a period of at least 30 days

after the date of the accident causing the burn. The Insurance Company will pay depending on the area of the body which is burned and determined in accordance with the following table:

Body Part	(A) Body Classification
Face, Neck, Head	11
Hand & Forearm	5
Either Upper Arm	3
Torso (front or back)	2
Either Thigh	1
Either Lower Leg (below knee)	3

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the Insured Member's Body Part that is burned and then multiplying the resulting percentage [not to exceed the Maximum Percentage for that Body Part (B)] by the Principal Sum for such Insured Member.

The Maximum Amount Payable per Insured Member for this benefit for all Injuries resulting from any one accident is \$25,000.

Coma Benefit

If an Insured Member suffers Injury resulting in a Loss (other than Loss of Life) and within 90 days of the date of the accident causing Injury the Insured Member is disabled by Coma, the Insurance Company shall pay the amount that is:

- a) the Insured Member's Principal Sum;
- b) less any other amount paid or payable under this contract in connection with the same accident, Injury or Loss.

With respect to "Loss" when used in the Coma Benefit means "Coma". "Coma" means a profound state of unconsciousness with no reaction to external stimuli or response to internal needs from which the individual cannot be aroused, even by powerful stimulation, and lasts for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less.

No benefits will be paid under this condition for a medically induced coma

Parental Care Benefit

If an Injury, for which a benefit is paid or payable hereunder, sustained by an Insured Member results in Loss of Life within 365 days of the date of Injury, the Insurance Company will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible if, at the time of the accident:

- a) they are a resident in a licensed nursing care facility; or
- b) they are enrolled in a home health care program; or
- c) they are living in the Insured Member's residence; or
- d) they are receiving support and being provided for by the Insured Member as evidenced by:
 - 1. cancelled cheques;
 - 2. income tax return showing the Dependent Parent as a dependent; or
 - 3. other similar forms of proof as deemed acceptable by the Insurance Company.

"Dependent Parent" means the Insured Member's parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the Insured Member for support, maintenance and care.

The amount of the Parental Care Benefit will be an additional 10% of the Insured Member's Principal Sum to any Dependent Parents. The Maximum Amount Payable for this benefit per Insured Member is \$10,000.

The Parental Care Benefit will be payable in equal shares to the Dependent Parents. Only one Dependent Care Benefit will be payable regardless of the number of Dependent Parents.

Carjacking Benefit

If an Insured Member suffers Injury resulting in Loss for which the Company has paid a benefit set out in the Table of Losses, the Insurance Company shall pay an additional amount equal to 10% of the Insured Member's Principal Sum if Injury causing the Loss is as a result of a Carjacking of a Private Passenger Type Automobile while the Insured Member is operating, or riding as a passenger in, (including getting in or out of) such Private Passenger Type Automobile.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

The Maximum Amount Payable for this benefit is \$25,000. Only one benefit is payable under this policy for all Losses as a result of the same Carjacking.

Disability Fitness Benefit

If an Insured Member suffers Injury resulting in a Loss (other than Loss of Life) for which the Insurance Company has paid a benefit set out in the Table of Losses, the Insurance Company will pay the reasonable and necessary expenses actually incurred for the purchase of any specially designed fitness training or athletic equipment for disabled persons, which would not have been required except for such Injury.

The Maximum Amount Payable for this benefit per Insured Member is \$5,000.

In addition, the Company shall not issue payment for any expense incurred more than two years after the date of the accident.

Surgical Reattachment Benefit

If, as a result of an Injury sustained by an Insured Member, a limb or an appendage or part of either a limb or appendage of that Insured Member is completely severed, and if such limb, appendage or part is surgically reattached to that Insured Member, then the Insurance Company will pay a Surgical Reattachment Benefit to such Insured Member in accordance with the following:

- a) whether or not the Insured Member regains use of the severed limb, appendage or part, the Insurance Company will pay a benefit that is equal to 50% of the specific, accidental Loss benefit that would have been payable for the severance of such limb, appendage or part under the Table of Losses section if the surgical reattachment had not been performed;
- b) if, within 365 days immediately after the reattachment of the severed limb, appendage or part, the Insured Member suffers a total, irrevocable and permanent loss of use of such reattached limb or part of a limb, the Insurance Company will pay a benefit that is equal to the benefit under the Table of Losses section for loss of use of such limb or part of a limb minus the amount(s) paid or payable under this Surgical Reattachment provision;
- c) If, within 365 days immediately after the reattachment of the severed limb, appendage or part, such reattachment fails and the limb, appendage or part must be amputated, the Insurance Company will pay a benefit that is equal to the benefit under the Table of Losses section for the specific, accidental loss of such limb, appendage or part minus the amount(s) paid or payable under this Surgical Reattachment Benefit provision.

Serious Illness Benefit

If, while coverage is in effect and coverage has been in effect on the Insured Member for a period not less than 90 days, the Insured Member is diagnosed with any one of the Serious Illnesses listed below, the Insurance

Company will pay 10% of the Principal Sum, up to a maximum of \$50,000, provided that the Insured Member:

- a) was not Diagnosed with one of the Serious Illnesses ever before;
- b) completes the Survival Period applicable to the Serious Illness causing reason to claim; and
- c) is under the age of 65 at the time of the Diagnosis,

Covered Serious Illnesses:

Major Organ Failure (on a waiting list) Major Organ Transplant Motor Neuron Disease

Multiple Sclerosis Necrotizing Fasciitis Parkinson's Disease

Pre-existing Conditions for the first 24 months of the Insured Member's Effective date, or any increased Benefit Amount, are excluded for the first 24 months of coverage. Pre-existing Condition means:

- a) the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment within a 24-month period preceding the Insured member's Effective Date; or
- b) an illness or condition for which the Insured member, during 24 months prior to the Effective date of their coverage, incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a Medical Doctor.

The Serious Illness benefit is payable only once, regardless of the number of Serious Illnesses the Insured Member may have or be diagnosed with.

Continuance of Coverage

In the case of a member who was an Insured Member and who is either (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on an approved leave of absence, or (4) on maternity leave, the Insurance Company shall extend coverage for such member for a period not to exceed 12

months, subject to payment of premium by the Policyholder for each such member.

Further, if during the temporary absence from work with their employer, such member assumes other occupational duties, no benefits are payable for any Loss resulting from any injury which occurs during the performance of this other occupation.

Waiver of Premium

In the event an Insured Member is accepted and approved under their current Group Life policy for total disability waiver of premium, then as of the effective date of such group life waiver of premium, the premiums payable under this policy are waived in connection with such Insured Member until the first to occur of the following:

- a) the date the Insured Member attains age 65; or
- b) the date of death or recovery of the Insured Member; or
- c) the date the Insured Member is no longer eligible for total disability waiver of premium under the Group Life policy; or
- d) the date this policy is terminated.

Conversion Privilege

On the date of an Insured Member's termination of employment or during the 90-day period following termination of employment, the Insured Member may elect to convert his/her coverage for accidental Loss of Life under this policy to an individual insurance policy of the Insurance Company providing comparable coverage. Such individual policy, if conversion is elected, will be effective either as of the date that the member's application is received by the Insurance Company within the 90 days after the termination of employment or on the date that coverage under this policy ceases, whichever occurs later. The premium will be the same premium ordinarily available for individual policies of the Insurance Company as at that time. Application for an individual policy may be made at any office of the Insurance Company.

The amount of insurance benefit provided for in the new individual policy shall not exceed the lesser of \$500,000 or the Insured Member's Principal Sum, as at the effective date of their termination of employment with the Employer.

Exclusions

No coverage shall be provided under this policy, and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental injury:

- a) suicide or any attempt thereat by the Insured Member;
- b) self-inflicted Injury or any attempt thereat by the Insured Member;
- c) declared or undeclared war or any act thereof;
- d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
- e) sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- f) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
- g) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft, if the Insured Member is:
 - i. riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - ii. performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
 - iii. riding as a passenger in an Owned Aircraft, Leased Aircraft or on a Charter Flight.
- h) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft or any craft designed to fly or glide above the Earth's surface:
 - i. except as a passenger on a regularly scheduled commercial airline; or
 - ii. being used for crop dusting, spraying or seeding, firefighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or

- exploration, racing, endurance tests, stunt or acrobatic flying; or
- iii. operating to or from offshore landing sites; or
 - iv. used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
 - i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
 - j) Injury or Loss sustained while the Insured Member is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Insurance Company by the Policyholder, be refunded);
 - k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over 80 milligrams in 100 milliliters of blood;
 - l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drugs and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;
 - m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
 - n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the

- Insured Member whether with intent to cause harm or not;
- o) natural causes.

CRITICAL ILLNESS

AIG Insurance Company of Canada

The Critical Illness Benefit provides financial assistance in the event you are diagnosed with one of the covered illnesses. The benefit is designed to alleviate some of the financial stress resulting from a critical illness at a time when the focus should be on recovery. There is no restriction on the use of the benefit; you can use it in any way that will meet your particular needs.

This benefit is available only to Insured Members under the age of 70. This benefit does not apply to your spouse or dependents.

Benefit Amount

Insured Members are covered for a flat amount of \$10,000 which is referred to as the Principal Sum.

Benefit Payment Conditions

Payment of benefits upon the first diagnosis of the Critical Illnesses listed below is subject to the following:

- a) the diagnosis is made within Canada;
- b) the diagnosis is first made while the Insured Member's coverage is in force under the Policy;
- c) payment is not precluded by any general or specific exclusion or limitation set forth in the Policy or any failure to meet any condition precedent set out below.

COVERED CRITICAL ILLNESSES

The Insurance Company reserves the right to have any Critical Illness or Condition Diagnosis reviewed by a Specialist of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Insurance Company

shall have the right to request an examination of either the Insured Member or the evidence used in arriving at such Diagnosis by an independent acknowledged expert selected by the Insurance Company in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the Insured Member and the Insurance Company.

Aortic Surgery – is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: no benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia – is defined as a definite diagnosis of a chronic persistent bone marrow failure, confirmed by a biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion and treatment with at least one of the following:

- a) marrow stimulating agents;
- b) immunosuppressive agents;
- c) bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis – is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria, and resulting in neurological deficits persisting for at least 90 days from the date of diagnosis. The presence of pathogenic bacteria must be confirmed by culture or other medically accepted microbiological testing.

The diagnosis of Bacterial Meningitis must be made by a Specialist.

For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour - is defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The Benign Brain Tumour must have undergone surgical or radiation treatment or cause irreversible objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

The diagnosis of Benign Brain Tumor must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm, vascular malformations, cholesteatomas, infectious or inflammatory tumors.

Blindness - is defined as a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- a) the corrected visual acuity being 20/200 or less in both eyes; or,
- b) the field of vision being less than 20 degrees in both eyes that is first diagnosed after the effective date of the coverage while the policy remains in force.

The diagnosis of Blindness must be made by a Specialist.

Coma – is defined as a definite diagnosis of a profound state of unconsciousness with no reaction to external stimuli or response to internal needs from which the individual cannot be aroused, even by powerful stimulation, and lasts for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less.

The diagnosis of Coma must be made by a Specialist and indicate that permanent neurological deficit is present.

Exclusion: No benefit will be payable under this condition for:

- a) medically induced coma; or,
- b) a coma which results directly from alcohol or drug use; or,
- c) a diagnosis of brain death.

Coronary Artery Bypass Graft – is defined as the undergoing open-heart surgery to correct narrowing or

blockage of one or more coronary arteries with bypass grafts. The diagnosis of the condition that necessitates a Coronary Artery Bypass Graft must be made by a cardiologist and based on angiographic evidence of the underlying disease.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Partial Payment for Coronary Angioplasty: The benefit will provide 10% of the Principal Sum for Coronary Angioplasty, which is defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Deafness – is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of Deafness must be made by a Specialist

Dementia, including Alzheimer's Disease - is defined as a definite diagnosis of dementia and which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- a) aphasia (a disorder of speech);
- b) apraxia (difficulty performing familiar tasks);
- c) agnosia (difficulty recognizing objects); or
- d) disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured Member must exhibit:

- a) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another medically accepted test or tests of cognitive function; and
- b) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The diagnosis of Dementia must be made by a Specialist.

Heart Attack (Acute Myocardial Infarction) – is defined as a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- a) heart attack symptoms;
- b) new electrocardiogram (ECG) changes consistent with a heart attack; or
- c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- a) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
- b) other acute coronary syndromes, including angina

pectoris and unstable angina, or

- c) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair - is defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

Kidney Failure – is defined as a definite diagnosis of chronic irreversible failure of both kidneys to function that is first diagnosed after the effective date of the coverage while the policy remains in force, and as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of Kidney Failure must be made by a Specialist.

Life-Threatening Cancer – is defined as a malignant tumour which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Life-Threatening Cancer includes carcinoma, sarcoma, invasive malignant melanoma, lymphoma, and leukemia, as well as cancers for which chemotherapy or radiation treatments have been recommended. Life-Threatening Cancer does not provide coverage for any form of cancer defined under Partial Payment for Non-Life-Threatening Cancer.

Life-Threatening Cancer must be positively diagnosed by a Specialist and confirmed by a histopathology report. Clinical Diagnosis alone does not meet this standard.

Partial Payment for Non-Life-Threatening Cancer - this benefit will provide 25% of the Principal Sum for the following conditions:

- a) Stage 1 malignant melanoma of the skin that is less than or equal to 0.75 mm or less in thickness and is classified as T1 or T2 without lymph node or distant metastasis, excluding malignant melanoma in situ;
- b) Basal or Squamous Cell Carcinoma that has spread beyond the hypodermis (the deepest layer of skin) and has not metastasized;
- c) Stage 1 Colon cancer that is classified as T1 or T2 without lymph node or distant metastasis;
- d) Carcinoma in situ;
- e) Prostate cancer that is classified as T1a or T1b, without lymph node or distant metastasis;
- f) Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 4.0 cm in greatest dimension and classified as T1 or T2, without lymph node or distant metastasis;
- g) Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts; or
- h) Any tumour in the presence of any Human Immunodeficiency (HIV).

Non-Life-Threatening Cancer must be positively diagnosed by a Specialist and confirmed by a histopathology report.

Only one claim per Non-Life-Threatening Cancer condition is permitted for partial payment for Non-Life-Threatening Cancer.

For purposes of the policy, T1a or T1b prostate cancer means a clinically inapparent tumor that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.

For purposes of the policy, the term gastrointestinal stromal tumors (GIST) classified as AJCC Stage 1 means:

- a) Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm², or 50 per HPF; or
- b) Small intestinal, esophageal, colorectal, mesenteric and peritoneal GIST that are less than or equal to 5 cm in greatest dimension with five or fewer mitoses per 5 mm², or 50 per HPF;

Loss of Independent Existence – is defined as a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- 1) bathing - the inability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- 2) dressing - the inability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- 3) toileting - the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- 4) bladder and bowel continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical

appliances so that a reasonable level of hygiene is maintained;

- 5) transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- 6) feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs - is defined as a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as a result of an accident or medically required amputation.

The diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech - is defined as a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List - is defined as a definite diagnosis of the irreversible failure of the heart, lung, liver, kidney or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Member must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery.

The diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant – is defined as a definite diagnosis of the irreversible failure of the heart, lung, liver, kidney or bone marrow, and transplantation must be medically necessary.

To qualify under Major Organ Transplant, the Insured Member must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The diagnosis of the major organ failure must be made by a Specialist

Motor Neuron Disease - is defined as a definitive diagnosis of one of the following:

- a) amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- b) primary lateral sclerosis;
- c) progressive spinal muscular atrophy;
- d) progressive bulbar palsy; or
- e) pseudo bulbar palsy,

and limited to these entities.

A diagnosis of Motor Neuron Disease must be made by a Neurologist.

Multiple Sclerosis – is defined as a definite diagnosis of at least one of the following:

- a) two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- b) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or

- c) a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart,

The diagnosis of Multiple Sclerosis must be made by a Neurologist.

Exclusion: No benefit will be payable for the following:

- a) Solitary Sclerosis;
- b) Clinically Isolated Syndrome;
- c) Neuromyelitis optica spectrum disorders; or
- d) "Suspected" Multiple Sclerosis or "probable" Multiple Sclerosis.

Muscular Dystrophy – is defined as a definite diagnosis of muscular dystrophy, a group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movements.

The diagnosis of Muscular Dystrophy must be made by a Specialist and confirmed by electromyography and either muscle biopsy or other testing acceptable to the Insurance Company that confirms the diagnosis.

Exclusion: No benefit will be payable under this condition if the diagnosis of Muscular Dystrophy is made after the Insured Member's 25th birthday.

Occupational HIV Infection – is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Member's normal occupation, which exposed the member to HIV contaminated body fluids.

Payment under this condition requires satisfaction of all of the following:

- a) the accidental injury must be reported to the Insurance Company within 14 days of the accidental injury;
- b) a serum HIV test must be taken within 14 of the accidental injury and the result must be negative;
- c) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- e) the accidental injury must have been reported, investigated and documented in accordance with the current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

- a) the insured member has elected not to take any available licensed vaccine offering protection against HIV;
- b) a licensed cure for HIV infection has become available prior to the accidental injury; or
- c) HIV infection has occurred as a result of non-accidental injury, including, but not limited to, sexual transmission and intravenous (IV) drug use.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders - is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Member must exhibit objective signs of progressive

deterioration in function for at least one year, for which the treating Neurologist has recommended dopaminergic medication or other medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Neurologist.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Insurance Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Insurance Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Exclusion: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Quadriplegia, Paraplegia, Hemiplegia – is defined as a definite diagnosis of the total and irreversible paralysis of:

- both upper and lower limbs (Quadriplegia);
- both lower limbs (Paraplegia); or
- one side of the body (Hemiplegia).

as a result of injury or disease to the nerve supply of those limbs, for a continuous period of 90 days or more from the date of the diagnosis to determine that the paralysis is permanent.

If an Insured Member suffers a Loss of Life as a direct result of the paralysis, 30 days or more after the diagnosis of such paralysis, this benefit will be made payable to the Insured Member's beneficiary.

The diagnosis of Quadriplegia, Paraplegia, Hemiplegia must be made by a Specialist and include documented evidence of the illness or injury that caused the Quadriplegia, Paraplegia, Hemiplegia.

Severe Burn – is defined as a definite diagnosis of third-degree burns over at least 20% of the body surface.

The diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) - resulting in persistent neurological deficits is defined as a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of Stroke must be made by a Specialist.

For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in

neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system; or
- Lacunar infarcts which do not meet the definition of stroke as described above

MULTIPLE EVENT BENEFIT

If the Insured Member is diagnosed with a Critical Illness for which the Principal Sum has been paid and is then diagnosed with a subsequent Critical Illness, an additional payment equal to the Principal Sum will be payable, subject to the following:

- a) the Insured Member has been considered actively at work for at least 90 days before being diagnosed with a subsequent Critical Illness; and
- b) the subsequent Critical Illness must be in a different Critical Illness Group than the initial Critical Illness Group for which the Principal Sum has been paid (as determined in the table below).

An Insured Member is eligible for payment of the Principal Sum one time per Critical Illness Group, as follows:

Critical Illness Group	Critical Illness Conditions
Group 1	Life Threatening Cancer (unless the conditions under Cancer Recurrence Benefits are met)

Group 2	Aortic Surgery; Coronary Artery Bypass Surgery; Heart Attack; Heart Valve Replacement or Repair; Stroke
Group 3	Blindness; Deafness; Loss of Limbs; Loss of Speech; Occupational HIV Infection; Severe Burn
Group 4	Aplastic Anemia; Bacterial Meningitis; Benign Brain Tumor; Coma; Dementia, including Alzheimer's Disease; Kidney Failure; Loss of Independent Existence; Major Organ Failure on Waiting List; Major Organ Transplant; Motor Neuron Disease; Multiple Sclerosis; Muscular Dystrophy; Parkinson's Disease and Specified Atypical Parkinson Disorders; Quadriplegia, Paraplegia, Hemiplegia

Rights of Examination

As a condition precedent to recovery of insurance money under this Policy, the Insurance Company, at its own expense, has the right and opportunity to have the Insured Member examined by a health care practitioner appointed by the Insurance Company when and as often as it reasonably requires while the claim is pending.

Exclusions and Limitations

This Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

- a) the Insured Member's suicide, whether sane or insane, or any attempt at suicide or intentionally self-inflicted injury or sickness or any attempt at intentionally self-inflicted injury or sickness;
- b) declared or undeclared war, or any act of declared or undeclared war;
- c) the Insured Member's commission of or attempt to commit a felony;
- d) the Insured Member's voluntary participation in any riot or civil insurrection;
- e) any illness specifically excluded from the definitions of Critical Illness.

How to Claim

In the event of a claim, claim forms can be obtained from the Administrator.

Written notice of claim must be given to the Insurance Company within 30 days after an Insured Member's loss, or as soon thereafter as is reasonably possible.

Proof of Loss

Written proof of loss must be furnished to the Insurance Company within 90 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Insurance Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal

capacity of the claimant, later than one (1) year from the time proof is otherwise required.

Payment of Claims

Upon receipt of due written proof of loss, payments for all losses will be made to (or on behalf of, if applicable) the Insured Member suffering the loss. If an Insured Member dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as indicated on the latest completed enrolment card received by the Administrator.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at the Insurance Company's option, to any relative by blood or connection by marriage of the payee, who in the Insurance Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Insurance Company makes in good faith fully discharges the Insurance Company's liability to the extent of the payment made.

MEMBER WEEKLY SICK PAY

Amount Payable

\$600 per week will be payable if you are unable to work because of an accident or sickness provided that you are under the care of a doctor.

When Payable

Benefits begin from the first day of disability due to injury or the eighth day of disability due to sickness and are paid for a maximum of 26 weeks during any one period of disability. The waiting period is taken from the later of (a) the first day you see a doctor or (b) the day you are totally disabled and unable to work.

Note: In no event will benefits commence prior to the date you see a doctor.

The Weekly Disability Income benefit is integrated with Employment Insurance Sickness benefits (E.I.). Benefits are payable up to a maximum of twenty-six weekly payments for any one continuous period of disability, provided you are totally disabled, under the continuous care of a doctor and are unable to perform the duties of your regular occupation. No benefits will be paid, however, for the period during which you are eligible for E.I. benefits, whether you apply for them or not.

If you do not qualify for E.I. disability benefits, payments will be made under this Plan. However, you must submit proof of your disqualification by the Employment Insurance Commission.

If disability is caused by pregnancy, no benefits are payable (1) during the period commencing ten weeks prior to the calendar week of the expected date of delivery and extending to the end of the sixth week after the calendar week in which the actual confinement terminated; or (2) during any maternity leave of absence period granted to you by your employer; or (3) for any week or part of a week during which you are eligible to collect Employment Insurance Commission maternity benefits.

Successive Disabilities

Successive disabilities separated by less than two weeks of full-time work will be considered one disability, unless the subsequent disability is due to an entirely different and unrelated cause. Disabilities arising from different and unrelated causes will be considered as a new disability providing, they commence after you return to full-time work, for at least one full day.

MEMBER LONG TERM DISABILITY

Amount Payable

Long Term Disability coverage assures you a monthly income if you are totally disabled for a long period. For the amount of your monthly benefits, see the “**SUMMARY OF BENEFITS**”.

When Benefits Start

Long Term Disability benefits start after the continuous period of total disability shown in the “**SUMMARY OF BENEFITS**”.

How Benefits are Paid

The maximum period to which a Plan Member will be eligible for benefit coverage is reduced to a period of 2 years providing the Plan Member continues to be totally disabled but not beyond age 65. No benefits, however, will be paid for a total disability resulting from pregnancy (a) during the period commencing ten weeks prior to the calendar week of the expected date of delivery and extending to the end of the sixth week after the calendar week in which actual confinement terminates; (b) during any maternity leave of absence period provided by your employer; (c) for any day for which you are or could be eligible to collect Employment Insurance Commission maternity benefits.

Definition of Totally Disabled

You must be unable to perform each and every basic duty of your occupation during the 2 years of disability. You do not have to be confined to your home but must be under the regular care of a doctor.

Total disability is not considered to exist if you are gainfully employed (except under an approved rehabilitation program as explained later).

Successive Disabilities

If you receive benefits for a disability and again be-

come totally disabled while covered, the later disability will be regarded as a continuation of the prior one unless you have been back to full-time work for at least six months. However, if the later absence is due to an unrelated cause and you have returned to full-time work, it will be considered a new disability.

Rehabilitation Feature

With the agreement of the Administrator (you must make an application), you can continue receiving Long term Disability benefits for a limited time while performing some type of work. Thus, you may get back into a gainful occupation with the assurance that for a specified period you will not lose your eligibility for benefits even though working. During this period, your monthly Long-Term disability will be your regular payment, less 80% of your earnings from the rehabilitative job.

Exclusions

The Long-Term Disability Plan covers most types of disability. It does not cover disabilities resulting from;

- (a) an act of war;
- (b) intentionally self-inflicted injury;
- (c) attempted suicide (whether or not sane);
- (d) during imprisonment; or
- (e) committing or attempting to commit a criminal offense.
- (f) Motor Vehicle Accidents

Offset to Benefits

The amount payable to you under the Long-Term Disability benefit is calculated by deducting from your benefit any income to which you may be entitled under any WSIB Act or similar statute. (If you qualify for these benefits you must apply for them). The amount which a Plan Member is entitled to receive in Long Term Disability benefits will be reduced by any amount the Plan Member is entitled to receive in WSIB benefits or Canada Pension Plan Disability benefits, however, the benefit reduction shall not reduce the

amount of LTD below a minimum benefit entitlement of \$500 per month payable from the Plan except that the total income to which a Plan Member would be entitled to receive in LTD benefits shall not exceed 85% of the Plan Member's pre-disability earnings.

Independent Medical Examinations

In accordance with the terms of the contract, the Administrator may refer to any Plan Member who is claiming Short Term or Long-Term Disability benefits for an independent medical examination. Failure to attend a scheduled appointment may result in benefits being delayed or discontinued.

Addiction & Mental Health Counselling Services

LiUNA Local 1059 and CMHA-Thames Valley Addiction & Mental Health Services partnered in an effort to provide confidential addiction and mental health counselling to members of the Union, including immediate family members.

Should you or your dependent family member be dealing with substance use, gambling, gaming or mental health concerns, contact the following:

Joshua Keene RSSW CPGC
200 Queens Ave., Suite 260
London, ON
☐ (226) 376-2629
☐ josh.keene@cmhatv.ca
Mon - Fri 8:30 am to 4:30 pm
Extended hours by appointment only

Crisis Centre FAQ

What is the Mental Health & Addictions Crisis Centre?

The Crisis Centre will provide 24/7 walk in support for individuals experiencing a mental health and/or addictions crisis that do not require hospital or emergency service interventions. Opening January 11th, 2016, and located at 648 Huron St., London, the Crisis Centre houses the Crisis Assessment Team, Crisis Mobile Team and can provide access to 5 off-site crisis stabilization beds. The building is a warm,

welcoming environment that will be open for walk in self-referrals and community referrals 24 hours a day, 7 days a week.

Who can use the Mental Health & Addictions Crisis Centre?

Any person 16 and older will be able to walk into the Crisis Centre if they are experiencing a mental health or addictions crisis.

What kind of services will the Centre provide?

The Crisis Centre will provide supportive counselling and assessment for immediate crisis issues and referrals to other services for on-going, non-crisis issues.

Referrals can be made by staff to treatment and case management services, social and recreational activities, life skills development, vocational and housing supports, withdrawal assessment and Tele withdrawal Management Support. The centre will also house the Crisis Mobile Team which can respond in the community and can provide referrals to the crisis stabilization beds for individuals experiencing non-emergency crisis issues.

What if an individual needs support but is not in crisis?

If you feel an individual is in need of emotional support, you can suggest they call the Crisis Response Line at the London Distress Centre at (519) 433-2023 or 1 (866) 933-2023. Volunteers are able to connect with our Crisis Mobile Team if needed.

GreenShield Online Pharmacy

The GreenShield Online Pharmacy is a convenient pharmacy service now available to Local 1059 Members and their dependents. Members receive a preferred dispensing fee and unparalleled convenience on all pharmaceutical needs.

The following enhanced benefits are offered to Local 1059 Members:

- \$0 dispensing fee on all prescriptions and

renewals (in other words: no out of pocket expense)

- Get prescriptions delivered for free anywhere in Ontario with next day delivery/local curb side pick-up for prescriptions ordered by 11:00 am is available in London and surrounding areas.
- Ability to speak with a pharmacist by phone, video or online chat
- In addition to prescription medications, Green Shield pharmacy also offers over 10,000 health essentials like personal care products, vitamins, supplements, and more
- Receive 20% off your first GreenShield pharmacy order with promo code LIUNA20 and 5% off all future orders

Transferring is easy:

□ app.greenshieldplus.ca/en/sign-up

□ 1 (855) 844-2242

Members Health

Members Health provides access to licensed Doctors via face-to-face video call from your phone, tablet or PC. The service is available 24 hours a day, 7 days a week, and 365 days a year and offers the following:

- Same day Doctor appointments
- Prescriptions sent directly to a pharmacy of your choice
- Lab and Diagnostics are ordered for you while on the video call
- Finding a Family Doctor
- Specialists and surgeon's referrals

To book a video call appointment with a Doctor:

□ 1 (800) 484-0152 □ www.Members-Health.com

Medical Cannabis

Please obtain the Medical Cannabis Referral Form from W.A. Health or the Union Office to obtain prior authorization.

CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS

No health, dental or disability 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 who suffer an impairment as a result of an automobile accident through the “no fault” scheme established by the Province of Ontario. The LIUNA Local 1059 Benefit Trust 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 that 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/she:

- 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
- c) 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 Member 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
 - orthopedic 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.

MEMBER AND DEPENDENT SUPPLEMENTARY HEALTHCARE BENEFITS

General

These benefits apply to expenses for treatment resulting from an accident, sickness or pregnancy. They are in addition to benefits available through the Ontario Health Insurance or any other Government Plan. They cannot, by law, duplicate such coverage but they do provide valuable supplements to such coverage.

Maximum Amount

The total amount of benefits payable to or on behalf of you and your dependents shall not exceed \$100,000 per person unless reinstatement of the maximum benefit is applied for and approved by the Administrator.

Local 1059 implemented an annual prescription drug maximum of \$20,000 per dependent inclusive in the \$100,000 lifetime maximum. The prescription drug maximum includes but is not limited to the following:

Fertility Drugs, ED Drugs, Medical Cannabis, Smoking Cessation, ODB Deductibles, Dispensing Fees, etc.

On the first day of the calendar year following the lifetime maximum of \$100,000 being reached, the Plan Administrator will restore \$10,000 for all Extended Health Care benefits. On the first day of each calendar year the Plan Administrator will automatically restore your extended healthcare benefits to an annual maximum of \$10,000.

Eligible Expenses

The following services and supplies are covered under the Plan when medically necessary and ordered by a doctor. An expense is eligible to the extent that coverage is not prohibited by provincial health insurance plans or because of other limitations described later.

i) Drugs

Charges for drugs and medicines that are medically necessary for treatment of a sickness or injury will not exceed 3 months' supply, (including oral contraceptives, intra uterine device, birth control rings, ventilator, diaphragms, contraceptive patches, and subdermal implants) which can only be obtained by a written prescription from a physician, and which are dispensed by a licensed pharmacist.

Vaccinations and immunizations for preventive treatment of communicable diseases, including serum for allergy shots.

Biological Drugs - Biosimilar

Vitamins, minerals, foods, dietary supplements, proprietary patent medicines, nutritional products, anti-obesity and weight loss medications whether or not a prescription is given for medical reasons, are not eligible for reimbursement.

Erectile Dysfunction drugs are covered at 50% up to a maximum of \$500 per calendar year.

Fertility Drugs are limited to a lifetime maximum of \$1,500. In-vitro fertilization is not covered.

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 age 65 and over who are obliged to make the payments when in receipt of drugs dispensed through the Ontario Drug Benefit Program.

Please continue to use your pay-direct drug card for the ODB deductible (\$100) and all receipts for \$4.11 & \$6.11 after the deductible has been satisfied.

Dispensing Fees will only be reimbursed up to \$9.00.

Vision Care - Other Service Providers

Eye examination: Up to a maximum of \$100 once every 24 consecutive months.

Glasses: The cost of one set of prescription glasses (including safety glasses) including frame and lenses in any 12 consecutive month period up to a maximum of \$500.

OR

Contact Lenses: Charges for contact lenses, purchased for cosmetic purposes only, (instead of glasses) are paid to a maximum of \$200 during any 12 consecutive month period.

Note: Unlimited cost if they are the only means available for the restoration of the visual acuity of the better eye to at least 20/70, or if the charges for the lenses are incurred after cataract surgery.

OR

Laser Eye Surgery: Charges incurred for laser eye surgery will be reimbursed at 75% up to \$3,000 Lifetime Maximum.

Cataract Surgery and Refractive Lens Surgery: Charges incurred for Cataract surgery/and refractive lens surgery will be reimbursed at 75% up to \$3,000 Lifetime Maximum, for each procedure.

Limitation: No payment will be made for sunglasses, plastic coatings and tints, nor for services not reasonably necessary for vision care of the individual.

ii) **Vision Care - LiUNA Local 1059 Optical Centre**

LiUNA Local 1059 is proud to offer on-site optical services to its eligible Members and their dependents at the Wellness Centre located at 635 Wilton Grove Rd. The benefit plan covers all costs up front and there are no out of pocket expenses when you use the Optical Centre for your optical needs.

Enhanced Benefits only at the LiUNA Local 1059 Optical Centre:

- No out-of-pocket payments are necessary, unlike at other optical offices
- No cost eye exams for vision and general eye health, including visual assessment, testing for glaucoma, and a colour-blind assessment
- Eye Exams: 100% covered every 24 months.
- Glasses (including safety glasses): 100% covered, one pair, any frame, any lenses in any 12 consecutive month period. No exclusions, no maximum. The member only can apply an annual \$500.00 maximum towards regular prescription glasses and prescription safety glasses in the same year.
- Tints, plastic scratch coating and transition lenses: 100% covered

OR

- **Contact Lenses:** To a maximum of \$250 every 12 consecutive months.

Hours of Operation

Mon. 9:00 am to 8:00 pm **Tue.** 9:00 am to 8:00 pm

Wed. 9:00 am to 8:00 pm **Thu.** 9:00 am to 8:00 pm

Fri. 9:00 am to 6:00 pm **Sat.** 9:00 am to 4:00 pm

Sun. Closed

□ (519) 963-2969 □ optical@liuna1059.ca

iii) **Ambulance Service:**

Charges for ground and air services to transport you to the nearest hospital where adequate treatment can be provided. The maximum amount allowed per calendar year is \$1,000 for ambulance charges plus \$500 for special ambulance attendant fees.

iv) **Nursing:**

Fees for private-duty nursing by a registered graduate nurse, or licensed practical nurse or a registered nursing assistant, other than a nurse who is a member of the patient's family, or who ordinarily resides in your home when ordered by a licensed Doctor or as medically necessary for a disability that requires the specialized training of the RN or LPN or a CNA and the approximate length of time and hours per day required. Approval must be obtained for all nursing care benefits.

v) **Vaccinations and Immunizations:**

Vaccinations and immunizations for preventive treatment of communicable diseases, including serum for allergy shots.

vi) **Dental Accidents**

The following dental services received within 12 months of an accident are eligible to the extent permitted by provincial plans; treatment by a physician, dentist, or dental surgeon of (1) injuries to natural teeth including replacement of such teeth, treatment of a fractured jaw and related x-rays or (2) treatment or removal of malignant tumors.

vii) **Orthopedic Supplies**

Orthotics, arch supports, lifts, wedges, Dennis Brown splints and shoes purchased and used in the application of such splints shall be paid at 75% of the cost up to a maximum of \$500 once every 12 consecutive months. If orthopedic shoes (excluding sandals or running shoes) that are not part of a brace or splint are prescribed by a doctor, 50% of their cost will be eligible when recommended by a licensed Medical Doctor once every 12 months. Repairs are not covered.

Hearing Aids

Not to exceed two hearing aids nor an eligible expense of more than \$3,500 during any 5 year period. Proof of receipt from the Ontario Assistive Device Program must be submitted in order to have claims paid. Batteries and examinations are not covered.

viii) **Other**

Charges for other services or treatments including:

- Continuous Glucose Monitor (estimate required for initial purchase)
 - Receiver limited to one purchase per lifetime
 - Transmitter allowed once every 3 months
 - Sensors purchased monthly (maximum of 3 months at any one time)
- Charges for treatment of a Physiotherapist (including shockwave therapy) or occupational therapist who is registered and legally practicing within the scope of their license will be payable at 80% (Plan) 20% (Eligible Plan Member), up to \$1,500 per calendar year maximum.
- Charges for treatment of a Massage Therapist who is registered and legally practicing within the scope of their license will be payable at 80% (Plan) 20% (Eligible Plan Member), up to \$1,800 per calendar year maximum.

- Oxygen and rental of equipment for its use (Residents of Ontario to apply to ADP)
- Artificial limbs, larynx and eyes; casts (including air casts), walker and canes when recommended by a doctor (provide **Doctor's** letter stating diagnosis, recommendation and medical necessity. If residents in Ontario, the claimant must submit claim to Assistive Devices Program first and resubmit approval or rejection notice to the Administrator for approval).
- Trusses and crutches.
- Braces & Splints (wrist, back, leg, etc.) when recommended by a licensed Doctor shall be paid at 75% of the cost (Any Brace or Splint over \$500 must have a quote submitted with a copy of the MD referral stating diagnosis).
- Breast prosthesis once every 5 consecutive years and supplies including surgical bras are limited to 2 per calendar year.
- Colostomy & Ileostomy supplies (submit to Assistive Devices Program first.
- Insulin & Insulin Pump Supplies (require copy of ADP Grant with every submission - 3-month frequency).
- Rental of a wheelchair, hospital type bed and other durable therapeutic equipment. (Requires a medical doctors note)
- X-rays and laboratory examinations as deemed medically necessary and are not a test that is currently provincially funded.
- Surgical stockings or surgical hoses shall be paid at 50% of the cost up to a calendar year maximum of \$500 with a limit of 4 pairs per calendar year when medically necessary as ordered by a licensed Doctor.
- TENS Unit: Provide licensed Medical Doctor's referral indicating medical condition and an estimate indicating the cost of purchase.

- CPAP/APAP, IPPB, BiPAP, and VPAP machines, provide copy of sleep study, Doctors referral and confirmation of payment from ADP, limited to a combined maximum of one occurrence per person every 60 consecutive months.
 - Masks – max 2 per year, minimum 6 months from last date of purchase and supplies for all of the above machines are covered.

ix) **Service of Chiropractor**

Reimbursement for charges (including shockwave therapy) subject to a maximum of \$35 per visit, up to 20 visits per calendar year.

x) **Service of Osteopath, Naturopath, Podiatrist, Chiropodist and Acupuncturist**

Reimbursement for charges up to \$500.00 annual maximum per practitioner type with an overall maximum of \$1500.00 annually.

xi) **Speech Therapy**

Restoratory or rehabilitary speech therapy by a qualified speech therapist. Treatment must be for speech loss or impairment due to illness (or surgery on account of illness) other than a functional nervous disorder. If the condition is due to congenital abnormality, corrective surgery must have been performed prior to the therapy. Doctor referrals are required each year stating duration of treatment.

xii) **Psychologist/Psychotherapist/Social Worker**

Service by a duly licensed Psychologist/ Psychotherapist/Social Worker who is registered and legally practicing within the scope of their license will be payable on a 80% (Plan) 20% (Eligible Plan Member) Coinsured basis up to a maximum of \$2,000 per calendar year provided that the Plan Member or Dependent has been referred for diagnosis and treatment of mental, nervous or emotional disorders by a licensed Medical Doctor.

Services by a Psychiatrist are not covered under the Plan.

xiii) **Wigs**

Charges (normal, reasonable and customary amount) are incurred for the purchase of a wig due to cancer treatment, once per lifetime. A licensed Medical Doctor's (MD) letter confirming the member or dependent is undergoing cancer treatment is required (contact the Administrator).

xiv) **Smoking Cessation**

The Plan will cover smoking cessation treatments, which require a prescription or laser therapy, when recommended by a medical doctor. The Plan will reimburse 50% of the cost of the treatment up to \$400 per year with a maximum of 2 interventions per lifetime. Over the counter treatments are not covered.

xv) **Medical Cannabis**

Charges for eligible medical cannabis products are reimbursed provided approval has been given. Prior authorization applications can be obtained from the Administrator. Prior Authorizations must be done every six months. Maximum of \$500.00 every 3 months, starting on January 1st of each year. Annual maximum of \$2000.00. All provider billings will be on a pay and submit basis.

xvi) **Travel Premium**

Plan members traveling out of Canada will be required to purchase their own medical protection travel plan. For those Plan members who purchased a medical protection policy covering a period in which they were eligible under the LIUNA Local 1059 Benefit Plan, the Plan will reimburse the premiums up to a maximum of \$200 per family in any calendar year. Send claim to Claimsecure along with receipt of payment.

LiUNA Local 1059 Chiropractic, Physiotherapy & Massage Clinic

LiUNA Local 1059 is proud to offer on-site chiropractic, orthotics, physiotherapy and registered massage therapy services to its eligible Members and their dependents at the Wellness Centre located at 635 Wilton Grove Rd. The benefit plan covers all costs up front and there are no out of pocket expenses when you use the Chiropractic, Physiotherapy & Massage Clinic for your chiropractic, orthotics, physiotherapy and registered massage therapy treatments.

Enhanced Benefits only at the LiUNA Local 1059 Chiropractic, Physiotherapy & Massage Clinic:

- The Plan covers 100% of costs, so no out-of-pocket payments or co-payments are necessary
- Members and dependents are entitled to more visits per year than if you use a different clinic
- For Members who currently have a WSIB or Motor Vehicle Accident claim, all billing and paperwork for WSIB or car insurance companies will be processed directly by the clinic, ensuring that the care you receive is convenient and stress free.

Hours of Operation

Mon. 10:00 am to 8:00 pm

Tue. 8:00 am to 8:00 pm

Wed. 8:00 am to 8:00 pm

Thu. 8:00 am to 8:00 pm

Fri. 9:00 am to 4:00 pm

Sat. 8:00 am to 1:15 pm

Sun. 9:00 am to 2:30 pm

☐ (519) 286-1310 ☐ info@middlesexspineandsportclinic.ca

All hours are subject to change; clinic closes occasionally on Saturday or Sunday.

Exclusions

Supplemental Health benefits do not cover charges for the following:

- Services and supplies (a) to the extent provided under any law or government plan under which the individual is eligible for coverage; (b) furnished by or on behalf of any government, unless payment is legally required; (c) for which insurance benefits are prohibited by law or regulation. (Members 65 and over should note that certain drugs may be eligible under the government plan for reimbursement and that payment for those drugs will not be made under this Plan); or (d) which the individual received without charge
- Any claim entitled to compensation under any Workplace Safety Insurance Board (WSIB) Act.
 - Anything not ordered by a doctor or not necessary for medical care or, the portion of a charge in excess of the reasonable and customary charge (the usual charge when there is no insurance, not exceeding the prevailing charge in the area for a comparable supply or a comparable service by a person of similar training and experience).
- Services or supplies received as a result of an act of war occurring while the individual is covered.
- Treatment of periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, except as described under “Dental Accidents” as listed under “ELIGIBLE EXPENSES”.
- Nursing, speech therapy, physiotherapy or occupational therapy rendered by yourself or your spouse, or a child, brother, sister or parent of your spouse or yourself.
- Examinations in connection with hearing aids.
- Machine to measure cholesterol.
- Charges for “check-ups” (including screening, routine physical examinations and research studies) unless part of the treatment of an illness, injury or pregnancy (including pre and post-natal

care).

- Telephone consultations (except through members health)
- Surgery of any type.
- Vitamins, minerals, foods and dietary supplements whether or not a prescription is given for medical reasons.
- Blood pressure monitor.
- Nicorette Gum, NicoDerm Patches or any over the counter products for smoking withdrawal programs.
- Circumcisions.
- Drugs or creams prescribed or recommended for hair growth.
- Bed wetting alarms.
- Semi-private or private room in the hospital.
- Weight Loss Programs.
- Intentionally self-inflicted injuries, while sane or insane.
- Cosmetic treatment, other than due to an accidental bodily injury which was sustained while the individual was insured.
- Skin peeling.
- Expenses which result directly or indirectly from committing or attempting to commit a criminal offense.
- Shampoos.

Co-ordination of Benefits

The purpose of health care insurance is to help meet actual expenses. In line with that purpose this Plan contains a non-profit provision. Benefits payable under this Plan may be reduced so that you will not receive more in benefits from all plans covering you and your dependents than actual expenses. "Plans" include medical and dental care benefits under a government program and Group Insurance or other coverage for a group of individuals, including student coverage obtained through an educational

institution above the high school level.

MEMBERS AND DEPENDENT DENTAL BENEFITS

Electronic Dental Claims Submission

Dentists can directly bill Local 1059 Benefit Plan using the following information:

Policy or Group Number: 1059

Subscriber ID: 8-digit number followed by LU, found on the ClaimSecure Benefit Card.

Network: ClaimSecure

Any questions or assistance to set up this new carrier ID can be directed to ClaimSecure.

□ 1 (888) 513-4464

LiUNA Local 1059 Dental Studio

The Local is proud to offer on-site dental services to its eligible Members and their dependents at the Wellness Centre located at 635 Wilton Grove Rd. The benefit plan covers all costs up front and there are no out of pocket expenses when you use the LiUNA Local 1059 Dental Studio for your dental care needs.

Enhanced Benefits only at the LiUNA Local 1059 Dental Studio:

- Benefit coverage is 100% of the current schedule of benefits
- All dental fees to an annual maximum of \$2,500 per person are 100% covered when you use the on-site Dental Studio for your dental care needs, unlike at other dentists' offices
- All covered services, including routine and remedial services like dental fillings, dental surgery, are paid for by the Plan to a maximum of \$2500/year with no expense to the Member. Orthodontics are paid 100% up to \$6,000 (lifetime maximum) per person under age 21. This family benefit is available to those members that have 12 months of continuous eligibility under the Local 1059 benefit plan.

Hours of Operation

Mon. 9:00 am to 6:00 pm

Tue. 9:00 am to 7:00 pm

Wed. 9:00 am to 6:00 pm

Thu. 9:00 am to 7:00 pm

Fri. 9:00 am to 4:00 pm

Sat. 8:00 am to 4:00 pm

Sun. 9:00 am to 2:00pm (every other Sunday)

□ (519) 286-1206 □ info@1059dental.com

□ www.1059dental.com

General

These benefits apply to expenses for treatment performed or ordered by a **“Dentist”** performed outside the LiUNA Local 1059 Dental Studio. A **“Dentist” includes** a duly licensed dentist, a licensed dental hygienist, dental mechanic, denture technician, denturologist or denturist practicing within the scope of his/her profession and any other Physician furnishing any dental services which he/she is licensed to perform.

Maximum Amount

The total amount of benefits payable to or on behalf of you and your dependents shall not exceed \$2,500, being payable for any one person in any one calendar year. Orthodontic treatments (Plan Member or dependents up to age 21) are payable at the rate of 75% of the eligible charges up to the lifetime maximum payment of \$3,000.

Calendar Year

A “Calendar Year” consists of a period of twelve months commencing on January 1st and ending December 31st.

Eligible Expenses

The following services and supplies are covered under the Plan when reasonable and necessary and when performed or ordered by a “Dentist”. For services performed, reimbursement of eligible expenses will not exceed the suggested fee listed in the Current Ontario Dental Association’s Fee Guide for General Practitioners, less 2 years, for the least expensive treatment that will provide a professionally adequate result. Eligible expenses shall be considered to have been incurred on the date the service or supply

was provided.

- 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 limited to once every 6 months, new patient examinations every 24 months, emergency and specific exams limited to once every 12 months;
 - b. Bite-wing x-rays – limited to two series every 12 months;
 - c. Full mouth series of x-rays, provided that a period of at least 24 consecutive months has elapsed since such service was last rendered.
- 2) Professional visit after hours;
- 3) Special consultations required by the attending Dentist;
- 4) Prophylaxis (cleaning and scaling of teeth) limited to once every 6 months;
- 5) Topical application of fluoride solutions limited to once every 6 months for children age 16 or younger;
- 6) Necessary treatment for the relief of dental pain;
- 7) Dental surgery, including associated postoperative care;
- 8) General anesthesia required in relation to dental surgery;
- 9) Extractions and alveolectomy at time of tooth extraction;
- 10) Periodontic services (treatment of soft tissues and bones supporting the teeth) including periodontic appliance for bruxism;
- 11) Endodontic services (root canal and pulpal therapy);
- 12) Amalgam and synthetic restorations including white fillings on molar teeth, retentive pins, stainless steel crowns;

- 13) Dentures (full and partials) and denture repairs;
- 14) Relines and rebases to existing dentures (limited to once every 24 months);
- 15) Space maintainers;
- 16) Crowns, bridges;
- 17) Gold inlays and crowns (when teeth cannot be restored with a filling material);
- 18) Implants

Orthodontics

(Plan members and dependents up to age 21).

This benefit applies to orthodontic treatment for a member and dependents who are covered for Dental Insurance.

The maximum lifetime benefit is \$3,000, which is available to each covered Member or dependent.

The Plan pays 75% of up to \$4,000 of eligible charges to a lifetime maximum of \$3,000, e.g.

Eligible Charges	Plan Pays
\$ 1,500	\$ 1,125
\$ 2,000	\$ 1,500
\$ 3,000	\$ 2,250
\$ 4,000	\$ 3,000 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 payments 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 in 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 during the rest of the monthly installment period in progress.

Treatment Plan Provisions

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

All oral examinations will be treated as recall examinations unless the patient is seeing a dentist for the first time.

Bridges & implants are eligible provided the work is made necessary by the extraction of one or more natural teeth while the patient is insured, except where the Plan Member has been continually in benefit for a period of 2 consecutive years or more, at which time the Plan Member and or Dependents would be entitled to benefit coverage without fulfilling the requirements to have natural teeth extracted while covered by the Plan.

Dentures are eligible provided the work is made necessary by the extraction of one or more natural teeth while the patient is insured, except where the Plan Member has been continually in benefit for a period of 2 consecutive years or more, at which time the Plan Member and or Dependents would be entitled to benefit

coverage without fulfilling the requirements to have natural teeth extracted while covered by the Plan.

Denture replacement is eligible after a member has been eligible for dental benefits for at least 12 months. The replacement of a denture which was paid for by this

Plan is not an eligible expense, unless a period of 60 months has elapsed.

Exclusions

- 1) Replacement of dentures which have been lost, misplaced or stolen is not an eligible expense.
- 2) Accidental injuries covered by the Supplementary Health Care Plan are not covered by this Plan nor are charges which are reimbursable under any government plan (including but not limited to WSIB).
- 3) A series of treatments or procedures started before the patient was eligible for dental benefits is not covered. X-rays are not considered to be the commencement of a series.
- 4) Anything not furnished by a dentist, except x-rays ordered by a licensed dental hygienist under the dentist's supervision; anything not necessary or not customarily provided for dental care.
- 5) Services (a) provided by or for the Canadian Government, or (b) furnished by or for any other government unless payment is legally required, or (c) to the extent provided under any governmental program or law under which the individual is or could be covered.
- 6) An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered.

- 7) A crown, gold restoration, or a denture or fixed bridge or addition of teeth to one, if the work involves a replacement or modification of a crown, gold restoration, denture or bridge installed less than five years before.
- 8) TMJ & related services.
- 9) Bleaching, veneers, on lays.
- 10) Mouth guards.
- 11) NTI, jaw repair or surgery

Bereavement Benefit

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 weekends) for each day 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, grandchildren.

Immediate family shall include legal, common-law and adoptive relationships. The maximum benefit payable shall be \$175.00 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 this benefit a member must have been in benefit at the date of the death.

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.

Parental Leave Benefit

Eligible Active Members who wish to spend time with their family immediately following the birth of a biological or newly adopted child may be eligible to receive parental leave benefits.

Requirements

To be eligible for this benefit you must:

- Be absent from work immediately following the birth of your child
- You and your employer must complete a parental leave claim form available from the Administrator or Union Office confirming that you were employed at the time of your absence
- Provide a copy of the birth certificate or a temporary health card from the hospital
- In the case of adoption, benefits commence the date on which your child was placed with you by an adoption agency, and you must submit adoption papers
- Provide an updated Member Enrolment Form with the child's name

Benefit

If you have met the requirements above, you may be eligible for the following benefit:

- \$250 a day up to a maximum of 3 consecutive business days

General Information: The Parental Leave benefit is for members only. The maximum benefit entitlement is 3 days even for multiple births, from one pregnancy. Members making Pay-Direct contributions are not eligible for the Parental Leave Benefit.

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

NON-OCCUPATIONAL DISABILITIES – An accident which does not occur in the course of employment, or

sickness not covered by WSIB or other occupational disease law.

DOCTOR - A licensed physician or dentist practicing within the scope of his/her profession.

HOSPITAL - A legally operated institution providing in-patient care and treatment through medical diagnostic and major surgical facilities on its premises, under supervision of a staff of doctors and with a 24-hour-a-day nursing service. An institution accredited as a hospital by the Canadian Council on Hospital Accreditation or approved for resident inpatient care under a provincial hospital service program also will be considered a “hospital”. The term does not include any other institution, or part of one, used mainly as a facility for convalescence, nursing, rest, the aged, or care of drug addicts or alcoholics.

HOW TO SUBMIT A CLAIM

Online Real-Time Claims

Your ClaimSecure identification card allows your pharmacist and dentist to submit claims electronically for instant adjudication of all your prescription drug and basic dental claims.

eClaims Submission

This feature allows you easy online submission and prompt payment (maximum 5 business days) of your extended health care and vision care claims, as well as any prescription drugs and/or dental claims that were not submitted electronically by your pharmacist or dentist.

Please retain all original receipts for 12 months after your submission.

Note: *in order to submit claims electronically, you must register for an eProfile account and then enrol in the direct deposit payment service, which will instantly*

activate your Member eClaims service. Please go to www.claimsecure.com. You will need your group and certificate number to get started. You can find both of these on your current ClaimSecure prescription drug card.

Once this is done, choose ‘My Claims’ and then ‘Submit Claims’ and follow the easy step-by-step instructions.

eProfile™

This is an online tool for members to submit claims electronically as well as a tool to access information on their health and dental plan.

To register for your eProfile account simply logon to www.claimsecure.com, click the ‘Register Now’ button on the screen and follow the instructions. Enrolment takes only a few minutes and then you’re ready to go – it’s that easy and it’s free.

Here is a list of some of the services available through your eProfile account:

- Real time adjudication including instant messaging of claims eligibility
- Electronic submission of claim receipts (if required)
- Claim reversal feature in the event of an error
- Automated email notification of successful payment
- Query your health and dental plan coverage from the convenience of any computer, any time, any place
- Instantly find out whether your plan covers a specific drug, dental procedure or extended health care service or appliance

- Identify if there are any applicable co-payment requirements and/or frequency or benefit maximums for any eligible benefit
- View your claims history as well as the status of recently submitted claims

Manual Reimbursement Claims

All manual reimbursement of claims for Prescription Drugs, Extended Health Care, Vision and Dental must be submitted on the appropriate claim forms as soon as possible to ensure prompt payment.

Claims forms are available from the ClaimSecure website at www.claimsecure.com or www.liunalocal1059.com or the Local Union Office

All manual reimbursement claims for Prescription Drug and Dental claims must be submitted, together with the original receipt(s) and on a properly completed claim form that is dated and signed by the Member (employee) or Claimant, and must clearly indicate the following:

- a. the name of the Plan, which is the “LiUNA Local 1059 Benefit Plan”;
- b. the Member’s name, address, date of birth, telephone number, group number and certificate number;
- c. if the claim is for a spouse or dependent, the claimant’s full name, date of birth, gender and relationship to the Insured Member;
- d. the date(s) the service was rendered, or the purchase was made.

In addition, each prescription drug receipt must show:

- a. the patient's full name;

- b. name of the medication and Drug Identification Number (DIN);
- c. the quantity dispensed.

Your eligible expenses should be listed separately, by insured individual, on the appropriate claim form and submitted, together with the original receipts.

When submitting a claim for prescription glasses, the receipt should show the total charge as one amount for the lenses and frames. It should also show the full name of the patient and the date of purchase.

Please mail all manual reimbursement claims for Prescription Drugs, Extended Health Care, Vision, Dental and Travel claims to:

ClaimSecure

P.O. Box 6500, Station A

Sudbury, Ontario P3A 5N5

Toll Free Phone # 1-888-513-4464

Please mail all Group Life, Dependent Group Life, Accidental Death & Dismemberment, Critical Illness, Weekly Indemnity, Long-Term Disability, Parental, Bereavement, Legal and Jury Duty claims to the Plan Administrator at:

W.A. Health Inc.

149 Main Street East
Hamilton, ON L8N 1G4
Tel: (289) 768-3621
Toll Free: 1-877-671-0459
Fax: (289) 768-3620
E-mail: customerservice@wahealth.ca

Note: Failure to fully complete claim forms may delay your payment.

Life Insurance, Accidental Death & Dismemberment, Weekly Indemnity and Long-Term Disability

- a. **Death Claim** - your beneficiary should contact W.A. Health who will advise as to the documentation required.
- b. **Dependent Life, Accidental Dismemberment/Loss of Use, Weekly Indemnity and Long-Term Disability Claims** - you or someone authorized to act on your behalf should contact W.A. Health for the proper forms.

In the event that the Insurer or Claims Adjudicator determines the claim expenses submitted are not eligible for reimbursement under the Plan's Benefits, or that they are not Medically Necessary, or Reasonable or Customary, the claim (or a portion thereof) will be denied.

It is a serious offence to submit a claim to the Plan for expenses which are rightfully the responsibility of another party, or for an expense for which there was no loss. For example, claims for expenses due to an illness or disability which is work-related are to be submitted to the Workplace Safety Insurance Board.

The Trustees may take action to recover any funds paid to an eligible Member or to a provider of services or supplies on account of a misleading or fraudulent claim submission. The Trustees may terminate all of the Benefits of an eligible Member who has intentionally submitted inappropriate or fraudulent claims or provided inaccurate or misleading information to the Plan.

Remember

All changes which affect your status or your family's insured status must be reported **WITHIN 30 DAYS** of their occurrence to the Plan Administrator, otherwise loss of benefits may result, and a waiting period of 90 days may have to be satisfied.

These changes include:

- a. addition of a spouse or common-law spouse and dependents, as described in the General Provisions section of this booklet;
- b. addition of newborn or adopted children;
- c. continuation of benefits for dependent children attaining 21 years of age and still attending school;
- d. termination of benefits for dependent children under the age of 21 who marry or become self-supporting;
- e. termination of benefits for a spouse or common-law spouse if such person ceases to meet the definition of spouse, as described in the General Provisions section of this booklet.

BENEFIT DEADLINE FOR FILING A CLAIM

All claims submitted for reimbursement of a loss must

be submitted for consideration prior to the maximum period allowed by the Insurers or Claims Adjudicators of the Plan's Benefits.

The claim filing deadlines listed below are strictly adhered to when submitting claims to the Insurer and/or the Claims Adjudicators. Claims which are not received within the stipulated time frames will not be considered eligible. It is therefore recommended that all claims be submitted as soon as possible after the expense or loss is incurred.

Life Insurance & Dependent Life

Within 12 months from the Date of Death

Accidental Death & Dismemberment

Within 30 Days from the Date of the Accident

Weekly Indemnity

Within 6 months of the date of Disability

Long Term Disability

Within 9 Months from the Date of Disability

Supplementary Health Care

Within 12 months from the Date of the expense

Emergency Out-of-Province

Within 90 Days from the Date of the Expense

Dental Care

Within 12 months from the Date of the Expense

Failure to give notice of claim or furnish proof of claim within the claim filing deadlines stated above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice

or furnish proof within the required claim filing deadline. Under no circumstances will the Insurers accept notice of claim beyond one (1) year.

In the event of termination of a Member's eligibility for the Benefits of the Plan, or if a Benefit is terminated under the Plan, or if the insurance policy(ies) are terminated, a claim must be submitted within 90 days following the date of termination, with the exception of the AD&D, which remain as 30 days.

LEGAL ACTION

An eligible Member may not commence legal action against the Insurer(s) less than 60 days after proof has been filed as outlined under the CLAIM FILING DEADLINES section of this Booklet. Every action or proceeding against the Insurer(s) for the recovery of money payable under this Plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

The Insurers, W.A. Health and/or Claims Adjudicators shall have the right and opportunity to examine any person whose injury or illness is the basis of a claim, when and as often as it may be reasonably required during the pendency and payment period, if any, of such claim.

THE INSURANCE COMPANIES ARE:

The Group Life and Dependent Group Life benefits are underwritten by Canada Life.

The Accidental Death & Dismemberment benefit is underwritten by AIG Insurance Company of Canada.

The Critical Illness benefit is underwritten by AIG Insurance Company of Canada.

All other benefits are self-insured and paid directly from fund assets.

The Insurance Companies and funding arrangements are subject to change.



GROUP LEGAL PLAN

**LIUNA LOCAL 1059
GROUP LEGAL TRUST**

PLAN INTRODUCTION LETTER

The Board of Trustees are pleased to offer a Group Legal Plan to eligible Members and their dependents provided by the LiUNA Local 1059 Group Legal Trust. This booklet has been published to give you an up-to-date description of the benefits provided by the Trust.

The Group Legal Plan provides eligible Members and their dependents with the opportunity to be reimbursed for fees incurred for legal representation. We encourage you to read this booklet carefully to familiarize yourself with the Group Legal benefits available to you and your family and the conditions under which they are payable. It is important that you understand the provisions of the Plan, the rules governing the eligibility for the benefits and the procedures to follow when making a claim.

The Plan provides coverage specifically for those legal services described in this benefit booklet up to the maximum amounts indicated in the schedule of benefits. Charges for legal services not listed in the schedule of benefits or charges beyond the maximum payable by the Plan are the responsibility of the Member. Non-legal services such as disbursements, taxes, registration and government fees are not covered by the Plan. All claims are subject to the rules and exclusions applicable to the Plan of Benefits.

The final determination of any claim, question or problem that may arise will be governed by the Trust Agreement, the current Schedule of Benefits and the official provisions as established from time to time by the Board of Trustees.

We hope to continue to provide the best benefits affordable, however due to the evolving economic climate, benefits provided in this booklet may be subject to change. As circumstances may warrant and in order to protect the Fund, the Trustees have the right to amend, delete, add, modify or suspend the Plan's benefits, monetary or otherwise, as they apply to all current and

future Plan Members.

Should you have any questions regarding your benefits, or require assistance in filing a claim, please do not hesitate to contact the Administrator, W.A. Health at 1 (877) 671-0459.

Sincerely,
The Board of Trustees

Brandon MacKinnon
Jim MacKinnon
Carlo Mastrogiuseppe

Ryan Aarts
Alfonso Balassone
Tyson VanLeeuwen

ELIGIBILITY

Plan Members of the LiUNA Local 1059 Benefit Trust who are employed by contributing employers and on whose behalf contributions to the Group Legal Plan have been received and who are currently eligible for benefit coverage under the LiUNA Local 1059 Health & Welfare Benefit Plan shall be entitled to benefit coverage in the Group Legal Plan. Plan Members and their eligible dependents shall continue to be eligible for legal benefits as long as they remain eligible for benefits in the LiUNA Local 1059 Health & Welfare Benefit Plan.

Group Legal Benefits are provided for Plan Members who maintain their coverage in the Health & Welfare Benefit Plan by paying direct.

Group Legal Benefits are not provided for Plan Members whose coverage in the Health & Welfare Benefit Plan is extended by Fund Assistance.

Termination of Coverage

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

CLAIMS PROCEDURES

Eligible Members and their dependents are entitled to the use of a service provider of their own choice. If you require assistance with finding a lawyer or paralegal, please contact the Law Society of Ontario.

- (416) 947-5255
- 1 (855) 947-5255
- www.lsrso.info

Group Legal claims must be submitted within 24 months of the date of service or the date of offence for Highway Traffic Act claims. The Member must be eligible for benefit coverage on the date of service or the date of offence.

Group Legal benefits are taxable and Members will receive a T4A for benefits paid for the calendar year.

Supporting Documents

Each claim must be accompanied by an itemized statement of account on letterhead from your lawyer. The statement of account must include date(s) of service, client name(s), description of the services rendered and indicate a legal fee separate from the disbursements and taxes. Trust Ledger Statements and Retainer Agreements are insufficient documents to allow payment on claims.

A copy of the traffic ticket, summons or a notice of trial must be submitted for Highway Traffic Act claims where the date of offence will be used to determine eligibility for reimbursement.

Electronic Funds Transfer (EFT) Claims Payment

You may choose to have reimbursement for your claims deposited directly into your bank account. The direct deposit form is also available by contacting the Administrator. You will receive a **“Notice of Payment”** providing you with details of payment of your claim. All transactions will be subject to the W.A. Health Privacy Policy.

Paper Claims

You may continue to submit paper claims by mail. Claims forms are available on **Local 1059's website** at www.liunalocal1059.com or from the Administrator.

Submit claims to the Plan Administrator:

W.A. Health
149 Main Street East
Hamilton, Ontario
L8N 1G4
Email: claims@wahealth.ca

SCHEDULE OF BENEFITS

The following is a schedule of benefits covered by the Group Legal Plan for legal services incurred on or after July 1, 2025. Claims for services incurred prior to this date will be adjudicated in accordance with the previous schedule of benefits.

Unless otherwise specified, all Plan maximums are based on a calendar year. The amounts set out in this schedule are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete. Charges beyond the maximum payable by the Plan or for non-legal services such as disbursements, taxes, registration fees, property appraisals, fines, title insurance, administration fees or court costs are the responsibility of the Plan Member. All claims are subject to the rules and exclusions applicable to the Plan of Benefits on pages 75-77.

“A” - Real Estate

A Plan Member and the dependent spouse shall be entitled to legal services in connection with the **Plan Member's** principal family residence. Legal services include a purchase or sale of a family dwelling, purchase of a lot on which to build a family dwelling (building permit must be issued within 1 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 transfer of title, arrangement of new or renewal of mortgage, mortgage incidental to purchase and discharge of mortgage.

Legal services provided in connection with a commercial or income producing property are not covered under the Plan.

The required transfer of title on a property is included in the maximum amount of \$1500 payable for the purchase claims. Code "A6 Mortgage New or Renewal" is only payable for mortgages un- related to a purchase.

Codes	Maximum Amount
A1 Purchase Family Dwelling	\$1500
A2 Sale Family Dwelling	\$750
A3 Purchase Lot for Family Dwelling	\$750
A4 Purchase/Sale Vacation Property	\$750
A5 Transfer of Title	\$400
A6 Mortgage New or Renewal	\$600
A7 Mortgage Incidental to Purchase	\$300
A8 Discharge of Mortgage	\$300

NOTE: Plan maximums include 1 purchase, 1 sale, 1 transfer of title, 1 mortgage new or renewal or mortgage incidental to purchase and 2 discharges of mortgages in any 12-month period. Benefits relating to a vacation or recreational property are limited to a lifetime Plan maximum of 1 per Plan Member. Mortgage services provided by a financial institution must identify the amount of the legal fee included in the administration fee. If 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"**. Title insurance, title examining counsel fees, property appraisals, mortgage and land registration fees are not covered

under the Plan.

“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 shall include the preparation of a separation agreement, filing a petition of divorce or separation, establishing the custody and access of children, support payments, effecting an equitable distribution of property and all other proceedings relating to the dissolution of the relationship.

Reimbursement of the legal expense associated with an initial consultation for a family matter is also covered under the Plan. Ensure that the statement of account from the service provider clearly indicates the date and fee charged for the service. See section “C” on page 68.

If proceedings are non-contested, it is recommended that independent counsel be sought.

Cheques for legal services provided to a Plan Member’s dependent spouse may be mailed directly to the spouse or the service provider for Divorce Spouse, Property and Custody Support Spouse and Separation Agreement Spouse.

Please ensure that the spouse’s mailing address and phone number are provided.

Codes	Maximum Amount
B1 Divorce Member	\$1,000
B2 Divorce Spouse	\$1,000
B3 Property and Custody Support Member	\$1,500
B4 Property and Custody Support Spouse	\$1,500
B5 Separation Agreement Member	\$1,500
B6 Separation Agreement Spouse	\$1,500



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 statement of account from the service provider 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. When a lawyer prepares a separation agreement, you would be entitled to a reimbursement up to \$1000.00. You would not be entitled to claim for **“Property and Custody Support”** when issues of property, custody, access or support are outlined in the separation agreement. Mediation is not a covered service under the Plan.

Outlined in this section are the maximum amounts payable for each service despite 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.

Code	Maximum Amount
C1 Preventive Law	\$400

“D” - Non-Complex Legal Documents

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

Codes	Maximum Amount
D1 Power of Attorney - Personal Care	\$ 100
D10 Power of Attorney - Property	\$ 100
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 (does not include the creation of any trust or other estate). A Plan Member and the dependent spouse shall also be entitled to the periodic review and amendment of all testamentary instruments. Preparation of a simple will, revision of a will or preparation of a codicil is limited to 1 service in any 12-month period. Generally, powers of attorney are prepared in conjunction with wills. See section “D” on page 99. Probation of a will is not a covered service under the Plan.

Codes	Maximum Amount
E1 Simple Will Member	\$350
E2 Simple Will Spouse	\$350
E3 Revised Will or Codicil Member	\$150
E4 Revised Will or Codicil Spouse	\$150

“F” - Landlord and Tenant Matters

Plan Members and their eligible dependents as tenants shall be represented in connection with any claims or controversies arising out of a lessor-lessee relationship in respect of their dwelling. Representation for matters before the Landlord and Tenant Board will be paid under this section. Proceedings in which the Plan Member or an eligible dependent is the landlord is not

a covered service under the Plan.

Code	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 and proceedings brought before the small claims court will be paid under G7.

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 (voluntary petition, not involving a business). The bankrupt must be discharged prior to submitting the claim. A Form 13 **Trustee’s** Final Statement of Receipts and Disbursements must be submitted. Consumer proposals are not a covered service under the Plan.

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

“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.

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 affected, 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. 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 75.

Proceedings brought before the small claims court will be paid under code G7.

Codes	Maximum Amount
H1 Defendant Representation	\$3,000
H2 Plaintiff Representation	\$3,000

NOTE: Outlined in this section are the maximum amounts payable for each service despite 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 themselves or their dependents, or on behalf of a relative who the Plan Member or spouse directly sponsored into Canada.

Services provided by Immigration Consultants are not covered under the Plan.

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

NOTE: Outlined in this section are the maximum amounts payable for each service despite 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 LiUNA Local 1059 Benefit Trusts or benefits provided by a contributing employer to this Group Legal 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 entitled to legal representation in connection with automobile related events.

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

Plan Members and their eligible dependents shall be entitled to limited legal representation when charged under Provincial or Federal Statutes for summary convictions, indictable and hybrid offences.

The Plan will only allow reimbursement up to the maximum amount indicated for representation on all charges arising out of a single incident. In the event that several charges are laid under the Criminal Code of Canada on a single occasion but arising out of separate incidents, the Plan will only allow reimbursement up to the maximum amount indicated.

A copy of the traffic ticket, summons or a notice of trial must accompany claims for highway traffic act matters. The Plan Member must be eligible for benefit coverage on the date of offence for highway traffic act claims.

Reimbursement of the legal expense associated with an initial consultation for charges under the Criminal Code of Canada is also covered under the Plan. Ensure that the statement of account from the service provider clearly indicates the date and fee charged for the service. Please see section “C” on page 68.

Codes	Maximum Amount
M1 Highway Traffic Act	\$500
M2 Provincial Offences Act or Offences under Municipal By-laws	\$500
M3 Criminal Code of Canada	\$1,000
M4 Record Suspension (Pardon)	\$600

NOTE: The Plan covers the legal cost for services provided for the processing of an application for a record suspension (formerly known as a pardon). Federal government processing fees, electronic fingerprinting, local police records check, and U.S. entry waivers are excluded from coverage under the Plan.

Representation for driving while impaired or driving over 0.8 mg is limited to 1 charge in a calendar year and a lifetime maximum of 2 charges. Parking violations and fines are excluded from coverage under the Plan.

Outlined in this section is the maximum amount payable for each service despite 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

“O” - Jury Duty

Plan Members who are called to perform jury duty or jury selection shall be entitled to payment of lost earnings up to \$200 per day when absent from work less any fee received from the court. The benefit is not payable on weekends and periods of unemployment.

Jury duty claim forms may be obtained from the Administrator or the Union Office and completed by the Plan Member and the employer. Completed claim forms must be accompanied by proof of attendance outlining the days attended, proof of the per diem allowance paid by the court or the Sheriff 's letter and submitted to the Administrator.

Codes	Maximum Amount
O1 Jury Duty	\$200/day

MAXIMUM REPRESENTATION

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

EXCLUSIONS

The following services are excluded from coverage under the Plan:

1. Disbursements, taxes, court costs, filing fees, land transfer taxes, administration fees, process server fees, registration fees and property appraisals.
2. Title searches, survey fees, title insurance and title examining counsel fees.
3. Fines and penalties, whether civil or criminal and parking violations.
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 disputes 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 LiUNA Local 1059 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 are excluded from coverage.
19. Services rendered by immigration consultants.
20. Probation of a will and estate matters.
21. Preparation of tax returns and consumer proposals.
22. Federal government processing fees for a record suspension, local police records check, electronic fingerprinting and U.S. entry waivers.
23. 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 the 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.

“**Employee**” please see page 12 for definition.

“**Dependents**” please see page 14 for definition.

“**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 LiUNA Local 1059 who is employed by a contributing Employer and who is eligible to receive benefits under the Plan.

“**Plan**” means the LiUNA Local 1059 Group Legal Plan.

“**Trust Agreement**” means the Agreement between the Employers and the Union pursuant to which the Trust Fund was established.

“**Trust Fund**” means the LiUNA Local 1059 Group Legal Trust established pursuant to the Trust Agreement.

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

IMPORTANT INFORMATION FOR SERVICE PROVIDERS

In order to assist in the efficient processing of a Group Legal claim, it is crucial that the supporting documentation be submitted. For your benefit we reiterate the importance of the **itemized statement of account on legal letterhead** detailing the services rendered, legal fees separate from the disbursements and taxes. Please indicate the name of the client(s) and the amount charged for each service. Non-legal fees, fees in excess of the Plan maximum and fees of members who are ineligible for coverage are the responsibility of the Plan Member.

Attention must be paid to provide us with a clear description of the services rendered. For instance, **Real Estate Matters** often includes the preparation of a mortgage and discharge but rarely is it itemized on the statement of account and while the closing date further



facilitates processing, it is on rare occasion provided. Survivorship applications will be paid under code “**A5 Transfer of Title**”. Title insurance, title examining counsel fees, property appraisals, mortgage and land registration fees are not covered under the Plan.

Statements of account relating to **Divorce and Domestic Proceedings** must clearly specify the family matter and provide a description of services. The block fees set out herein are payable only for services provided and are not accumulative. When a lawyer prepares a separation agreement the claim may be reimbursed up to \$1000.00. The Plan Member would not be entitled to claim for code “**B3 Property and Custody Support Member**” when issues of property, custody, access or support are outlined in the separation agreement.

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. When a consultation takes place regarding family or criminal matters it is important that **Consultation** be identified on the statement of account so as to allow for the Plan Member to receive an additional benefit. Failure to provide the information could result in a delay in the processing of the claim.

Reimbursement for **Bankruptcy** requires the submission of a Form 13 **Trustee’s** Final Statement of Receipts and Disbursements.

Highway Traffic Act claims must be accompanied by a copy of the traffic ticket, summons or notice of trial where the date of offence will determine the eligibility for reimbursement.

The Plan Member must be eligible for benefit coverage on the date of service (or offence for Highway Traffic Act matters) and claims must be submitted within 24 months of that date.

Maximum representation shall not exceed \$4,500 of legal service in a calendar year. For **Exclusions**, please see page 75. The maximum amounts set out under each section are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete. Charges beyond the maximum payable by the Plan or for non-legal services such as disbursements, taxes, registration fees property appraisals, fines, title insurance, administration fees or court costs are the responsibility of the Plan Member.

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. The Plan provides coverage for legal expenses specifically for those services described in this benefit booklet, up to the maximum amounts indicated, which have been approved by the Board of Trustees.

All claims are subject to the rules and exclusions applicable to the Plan of Benefits starting page 80.



H E A L T H

ADMINISTRATOR

149 Main Street East
Hamilton, Ontario L8N 1G4

- ☐ (289) 768-3621
- Toll-Free 1 (877) 671-0459
- ☐ Fax (289) 768-3620
- ☐ admin@wahealth.ca
- ☐ www.wahealth.ca



LEGAL COUNSEL

