LiUNA!

BENEFIT PACKAGE

Designed for you and your family

Supplementary Health

Dental Care Benefits

Group Legal Plan

The Labourers' Multi-Local Welfare Trust of Ontario

The Labourers' Multi-Local Group Legal Trust of Ontario

Revised January 2021

THE LABOURERS' MULTI-LOCAL WELFARE TRUST OF ONTARIO

ADMINISTRATORS AND CONSULTANTS

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TABLE OF CONTENTS

THE LABOURERS' MULTI-LOCAL WELFARE TRUST OF ONTARIO

INTRODUCTION

Dear Member:

This booklet describes the conditions of eligibility, coverage and claims procedures under The Labourers' Multi-Local Welfare Trust of Ontario, which, for description ease, we refer to as the Trust.

The Trust was created on January 1, 1981 and now covers the members of Local 607 Thunder Bay and Local 1036 Sault Ste. Marie and other participants authorized by the Trustees.

Every effort has been made to ensure that the coverage descriptions in this booklet are consistent with the Plan Text and the insurance policy the Trust has with third party insurers, as well as relevant law.

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

The Trustees hope that the benefit coverages provided by the Trust, 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

Wayne Scott
Harold Lindstrom
Terry Varga

MEMBERSHIP

In order to be eligible for benefits you must be a member of Local 607 or Local 1036 and maintain your membership in good standing. If you fail to keep up with your membership you are not eligible for benefits except as approved by the Board of Trustees.

THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete and send a member information card to the Administrator. On this card you name the beneficiary to whom your Life insurance should be paid.

If you have sent a member information card to the Administrator already and you have no desire to change your beneficiary, it is not necessary for you to complete another card. However, if you would like to change your beneficiary, or have not completed a member information card, you should ask your Union Office for one of these cards.

Should your dependent status change (i.e. should you marry or acquire new dependents), you must request a new member information card on which you may update your current dependent status.

THE ADMINISTRATOR IS:

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SUMMARY OF BENEFITS

Local 607 Thunder Bay
Local 1036 Sault Ste. Marie

Contributions made on behalf of plan members working for employers who have made contributions to the Labourers' Multi-Local Welfare Trust of Ontario in accordance with the collective agreement will pay for both supplementary health and dental benefits as described below.

Member Only:

Life Insurance $100,000
Accidental Death and
Dismemberment $100,000
Weekly Sick Pay (Per Week) Class 2 .....$547

Benefits are payable from:
1st day accident/hospitalization
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 – Class 2
For disabilities occurring on or after May 1, 2018, a maximum benefit of $1,500 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 benefits $500 per month.

Dependents Only:

Life Insurance
Spouse $10,000
Unmarried Dependent Children $10,000

Members and Dependents:

(Spouse and unmarried children from birth)*

*See "Who are Eligible Dependents?"

Supplementary Health Care
Deductible . . . . . .Nil
Co-insurance 100%
Lifetime Maximum . . . . .$100,000 per person

Covered Expenses: For details see **MEMBER AND DEPENDENT SUPPLEMENTARY HEALTH BENEFITS**

Dental Benefits

Deductible . . . . . .Nil
Co-insurance 100%
Annual Maximum $2,500

Reimbursement will be based on the suggested fee listed in the 2020 Ontario Dental Association's fee guide for general practitioners (updated from time to time).

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

Orthodontic treatments payable at the rate of 50% of the eligible charges up to a lifetime maximum of $2,000.

Covered Expenses: For details see **MEMBER AND DEPENDENT DENTAL BENEFITS.**

GENERAL CONDITIONS

Who is covered by the Plan?

All eligible Members of the participating locals under the Labourers' Multi-Local Welfare Trust of Ontario and their eligible dependents are covered for the benefits maintained by their local. The participating locals are Local 607 Thunder Bay and Local 1036 Sault Ste. Marie.

ELIGIBILITY REQUIREMENTS

Initial Eligibility – Member

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 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 24 months following the month for which your coverage was last paid by current or accumulated employer contributions of 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

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"**, or

iii) you do not choose to maintain your coverage by making Direct Payments, or

iv) you have made Direct Payment for 24 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

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.

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 **"DETAILS OF BENEFITS"** section of the booklet, outlines the coverage provided by the Fund.

DEPENDENTS

Who are Eligible Dependents?

Dependent means a resident of Canada who is your:

- Spouse
- Unmarried dependent child under the age of 21 who is not employed on a regular full time basis, or if over the age of 21 who is not employed on a regular full time basis and is
    a) a full time student attending a high school, college, or university
    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 and excludes a person divorced from the member or your common-law spouse (a person with whom you reside and who you publicly represent as your spouse). Only one person may qualify as your spouse, at any one time, if the person has been living with the member for a period of at least one continuous year.

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. This does not apply to new-born infants. 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.

A Child who is physically or mentally incapable of self-support upon attaining age 21 may continue to be eligible under the Supplementary Health benefits, while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. To be eligible for this extended coverage, a permanently disabled child must have been covered as a dependent immediately prior to his 21st birthday.

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 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 15 weeks.

b) Members collecting Weekly Indemnity benefits may receive Fund Assistance for up to a maximum of 11 weeks. (Maximum 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 MAINTENANCE ON DEATH

In the event of your death, your dependents will continue to be covered for Dependent Life, 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.

Note: Dental benefits must be in force at the time of your death in order to be continued, as set out above.

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

DETAILS OF BENEFITS

MEMBER LIFE INSURANCE

Amount Payable

Your Group Life Insurance shown in the **"SUMMARY OF BENEFITS"**, will be paid to any beneficiary you name if you die from any cause. You may change your beneficiary whenever you wish, subject to provincial laws.

Conversion Privilege

Your Life Insurance continues for 31 days following either the termination of your employment, or your classification changing to one in which you are not insured. During this 31 day period you may convert the amount of your Group Life Insurance, up to the principle amount (presently $100,000) provided you are under 66 years of age to:

i) non-convertible term insurance to age 65;

ii) a permanent plan that Manulife 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 a plan described above without submitting evidence of health.

The premium rate will be determined from your age and class of risk at the time of conversion.

Insurance During Total Disability

If you become totally disabled before you reach age 65, and such disability continues without interruption for at least 6 months, your Group Life Insurance, shown in the **"SUMMARY OF BENEFITS"**, will be continued at no cost to you up to a maximum of 2 years from the date that you qualify for Long Term Disability Benefits provided you remain totally and continuously disabled and are younger than age 65 and have qualified for Fund Assistance. (Note: Plan Members on self-pay on the date that they become disabled do not qualify for Fund Assistance). In order to qualify for the Waiver of Premium benefit you must notify the Administrator of your disability within one (1) year of your last active day at work and must furnish proof of your disability, satisfactory to the

Administrator. You will be required to submit continuing proof of your disability from time to time, as requested by the Administrator. All coverage under this provision will terminate when you reach age 65. (The above provision also applies to your Accidental Death and Dismemberment Insurance).

DEPENDENT LIFE INSURANCE

Amount Payable

The amount of Dependent Life Insurance shown in the **"SUMMARY OF BENEFITS"**, will be paid to you if one of your covered dependents dies.

Conversion Privilege

The Dependent Life Insurance continues for 31 days following your death, your classification changing to one in which you are not insured or your termination of employment. During this 31 day period your spouse's amount of 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 The Manufacturers 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 a 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 less any amount your spouse becomes eligible for under another Group Policy within 31 days of the date of termination.

Member accidental death, the amount of your accidental death benefit shown in the **"SUMMARY OF BENEFITS"**, will be paid to your named beneficiary if your death is caused as a result of an accident on or off the job.

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Amount Payable

This insurance will be paid to you for the following losses resulting solely from accidental bodily injury, on or off the job, in addition to any other insurance payment you may receive. For a benefit to be payable, the loss must occur within 365 days after the accident and you must survive at least 24 hours from the time of the accident causing the loss. You will receive the amount shown below for loss of:

Life .....The Principal Sum
Both Hands .....The Principal Sum
Both Feet .....The Principal Sum
Entire Sight of Both Eyes .....The Principal Sum
One Hand and One Foot .....The Principal Sum
One Hand and Entire Sight
of One Eye .....The Principal Sum
One Foot and Entire Sight
of One Eye .....The Principal Sum

Speech and Hearing .....The Principal Sum
One Arm .....3/4 The Principal Sum
One Leg .....3/4 The Principal Sum
One Hand .....2/3 The Principal Sum
One Foot .....2/3 The Principal Sum
Entire Sight of One Eye ...2/3 The Principal Sum
Speech or Hearing
(both ears) .....2/3 The Principal Sum
Hearing (one ear) .....1/3 The Principal Sum
Thumb and Index Finger
of Either Hand .....1/3 The Principal Sum
Four Fingers of
One Hand .....1/3 The Principal Sum
Four Toes of One Foot ....1/4 The Principal Sum
Thumb only
of One Hand .....1/4 The Principal Sum
One, Two or Three Fingers
or toes .....1/6 The Principal Sum
Loss of use of:
Both Legs .....Two times the Principal Sum
Both Arms and
Both Legs .....Two times the Principal Sum
Both Arms .....Two times the Principal Sum
One Arm and One Leg .....The Principal Sum
Both Hands .....The Principal Sum
One Arm .....3/4 The Principal Sum
One Leg .....3/4 The Principal Sum
One Hand or one Foot ....2/3 The Principal Sum

Loss of arm, leg, hand or foot means loss by severance at or above the elbow, knee, wrist or ankle respectively. Loss of thumb or finger means loss by severance at or above the proximal phalanx. Loss of toe means the complete loss of one entire phalanx of the big toe and all phalanges of the other toes. Loss of sight means total and irrecoverable loss of sight. Loss of speech means total and irrecoverable loss of speech. Loss of

hearing means total and irrecoverable bilateral loss of hearing (hearing in both ears). Loss due to paraplegia, quadriplegia, hemiplegia or any other loss of use benefit is covered only if the loss is total and permanent and has been continuous for a period of twelve months from the date of the accident.

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

a) The Principal Sum for all losses except quadriplegia, paraplegia and hemiplegia.

b) Two Times the Principal Sum, or the Principal sum if Loss of Life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

If, due to an accident, you are exposed to the elements and as a result, suffer one of the losses listed above, within 365 days of the accident, benefits will be payable in accordance with the amounts specified above.

The total payment for one accident may not be for the greatest of more than one of the losses.

Your accidental death and dismemberment plan also includes the following benefits. The following benefits are brief descriptions, please contact your plan administrator for complete details and limitations:

Aggregate Limit

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

Waiver of Premium Benefit

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your life insurance coverage, the Insurer will also waive the payment of your accidental death and dismemberment insurance premiums.

Your entitlement to Waiver of Premium Benefit ceases on the earlier of a) the date your Waiver of Premium for Life Insurance ceases, or b) the date the policy or this coverage terminates.

Aircraft Coverage

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

Exposure and Disappearance

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

Repatriation Benefit

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

Occupational Training Benefit

In the event of your accidental death, the Insurer will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order

to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of $10,000.

Rehabilitation Benefit

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

Family Transportation Benefit

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

"Immediate family" means a person at least eighteen years of age who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat Belt Benefit

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

(1) wearing a properly fastened seat belt; and

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

Hospital Indemnity

A daily benefit (1/30th of 1% of your Principal Sum, maximum of $2,500 per month) will be payable if you are confined in a hospital for at least 5 days and are under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per injury.

Education Benefit

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

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

“Institute for higher learning” includes any university, college CEGEP or trade school.

Exclusions

No loss is covered which results from:

(1) suicide, or an attempt at suicide;

(2) intentionally self-inflicted injury;

(3) war (including undeclared war and armed aggression);

(4) travel in any type of aircraft which is flown for a purpose other than the transportation of passengers or aboard which the insured has duties as a crew member;

(5) full-time active service in the armed forces of any country.

MEMBER WEEKLY SICK PAY

Amount Payable

$547 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 with the first day of disability due to accident or hospitalization. If disability is due to illness the Plan has a 7 day waiting period and you must apply for Employment Insurance Sick Benefits. 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 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 to be deemed totally disabled. 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 become total 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 and/or the Insurance Company (you must make 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 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.

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 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 insured contract, the Administrator may refer 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.

CLAIMS ARISING OUT OF AUTOMOBILE ACCIDENTS

Effective January 1, 1995 no benefits will be paid for any claims arising as a result of an Automobile Related Accident which occurs on or after January 1, 1995.

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

Certain benefits may be available to Plan Members of the Plan who suffer an impairment as a result of an automobile accident through the "no fault" scheme established by the Province of Ontario. The Labourers' Multi-Local Plan 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:

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

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

A Plan Member shall also be disentitled to benefits under the Plan if the Plan Member accepts a settlement respecting the "no fault" benefits to which he or she would otherwise have been entitled. The Plan 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
- orthopaedic supplies
- hearing aids
- physiotherapy and occupational therapy
- artificial and assistive devices
- physiological services

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

MEMBER AND DEPENDENT SUPPLEMENTARY HEALTH 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.

At any time after benefits of at least $1,000 have been paid, you and your dependents may apply for reinstatement of the maximum benefit by submitting evidence of good health that is satisfactory to the Administrator. Also, however, on the first day of each year, each person will have the maximum reinstated to the lessor of $25,000 or the amount needed to restore the $100,000 maximum without evidence.

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, and ventilator) which can only be obtained by a written prescription from a physician and which are dispensed by a licensed pharmacist. (Vitamins, minerals, foods, dietary supplements, proprietary patent medicines and nutritional products, 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.

Charges for fertility drugs are limited to a single series of treatments up to a life time maximum of $1,500. Invitro fertilization is not covered.

Dispensing Fees

The Plan will reimburse the dispensing fees up to $6.11 per prescription or refill. Fees charged by the Pharmacists in excess of the current plan maximum will be the responsibility of the Plan Member.

Ontario Drug Benefit Program

The Plan will reimburse members age 65 and over for the annual deductible and the dispensing fees up to $6.11 per prescription or refill when in receipt of drugs dispensed through the Ontario Drug Benefit Program (ODB).

ii) **Vision Care**

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

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

Contact Lenses:

(a) 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;

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

Laser Eye Surgery: Charges incurred for laser eye surgery (instead of glasses or contact lenses) will be reimbursed to a maximum of $500 during any 12 consecutive months.

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

iii) **Ambulance Service** for local travel.

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** (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) **Orthopaedic Supplies**

Arch supports, lifts, wedges, Dennis Brown splints and shoes purchased and used in the application of such splints up to a maximum of $500 once every 12 consecutive months. If orthopaedic 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 Doctor once every 12 months. Repairs are not covered.

viii) **Hearing Aids**

Not to exceed one hearing aid nor an eligible expense of more than $1,000 during any 24 consecutive months. Batteries are not covered.

ix) **Other**

Charges for other services or treatments including:

- Treatment by x-rays or radioactive substances;
- Physiotherapy or occupational therapy (other than by a member of the family);
- Charges for treatment of a Physiotherapist or Massage Therapist who is registered and legally practicing within the scope of their license will be payable on a 80% (Plan) 20% (Eligible Plan Member), Co-insurance basis up to $1,500 per calendar year maximum provided the Plan Member or dependent has been referred for treatment by a licensed Doctor (MD).
- Oxygen and rental of equipment for its use;

- Artificial limbs, larynx and eyes; casts, walker, cane and splints when recommended by a Doctor (provide Doctor's letter stating diagnosis, recommendation and medically necessary. If residents in Ontario claimant must submit claim to Assistive Devices Program first and resubmit approval or rejection notice to the Administrator for approval);
- Trusses, braces, crutches, breast prosthesis once every 5 consecutive years and supplies including surgical bras limited to 2 per calendar year;
- Electronic heart pacemaker;
- Anesthetic and its administration;
- Blood and blood plasma;
- Colostomy supplies, insulin;
- Rental of a wheelchair, iron lung, hospital type bed and other durable therapeutic equipment;
- X-rays and laboratory examinations;
- Surgical dressings;
- Surgical stockings or surgical hose limited to 12 pairs every calendar year when medically necessary as ordered by a licensed Doctor.

x) **Service of Chiropractor** up to a maximum of $500 per calendar year.

xi) **Service of Osteopath, Naturopath, Podiatrist or Chiropodist** up to $500 per calendar year per practitioner.

xii) **Speech Therapy**

Restoratory or rehabilatory 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 referral is required stating duration of treatment.

xiii) Hospital charges in excess of the provincial hospital plan coverage, for services and supplies (other than room and board) needed for medical care, excluding professional services. Pay difference between public and semi-private coverage.

xiv) **Out of Country**

While on vacation the Plan will reimburse for claims as a result of an emergency.

xv) **Psychologist**

Service by a duly licensed Psychologist 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 $1,500 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 Doctor (MD).

Exclusions:

Supplementary 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 over age 65 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 peripical 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.
- 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 or Nicoderm Patches for smoking withdrawal programs.
- Circumcisions.
- Drugs or creams prescribed or recommended for hair growth.
- Bed wetting alarms.
- Weight Loss Programs.
- Acupuncture.
- Intentionally self-inflicted injuries, while sane or insane.
- Services rendered by a psychiatrist are not covered.

- 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

General

These benefits apply to expenses for treatment performed or ordered by a "Dentist". 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 50% of the eligible charges up to the life-time maximum of $2,000.

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 on or after January 1, 2021 reimbursement of eligible expenses will not exceed the suggested fee listed in the 2020 Ontario Dental Association's fee guide for general practitioners (updated from time to time) 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 six months, new patient examination every 24 months;

b. Bite-wing x-rays – limited to two series every 12 months;

c. Full mouth series of x-rays, including bitewing if necessary, 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 six months;

5) Topical application of fluoride solutions limited to once every six 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) Scaling and root planning combined is limited to 12 units per calendar year.

11) Periodontic services (treatment of soft tissues and bones supporting the teeth) including periodontic appliance for bruxism;

12) Endodontic services (root canal and pulpal therapy);

13) Amalgam and synthetic restorations including white fillings on molar teeth, retentive pins, stainless steel crowns;

14) Dentures (full and partials) and denture repairs;

15) Relines and rebases to existing dentures (limited to once every 24 months);

16) Space maintainers;

17) Crowns, bridges;

18) Gold inlays and crowns (when teeth cannot be restored with a filling material;

19) Implants will be reimbursed towards the equivalent cost of bridgework using the Alternative Benefit Clause.

Orthodontics

(Program to Straighten Teeth)

(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 life time benefit is $2,000, which is available to each covered Member or dependent.

The Plan pays 50% of up to $4,000 of eligible charges to a lifetime maximum of $2,000, e.g.

Eligible Charges	Plan Pays
$ 1,500	$ 750
$ 2,000	$ 1,000
$ 3,000	$ 1,500
$ 4,000	$ 2,000 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 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.

Orthodontics

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 are eligible provided the work is made necessary by the extraction of one of 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) furnished 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 of modification of a crown, gold restoration, denture or bridge installed less than five years before.

8) TMJ.

9) Bleaching.

10) Mouth guards.

Bereavement

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.

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

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

No payment shall be made for lost time following the date of the funeral unless the Member is required to travel for the purpose of attending the funeral. Bereavement pay for lost time on Saturday or Sunday shall only be paid if the Member was scheduled to work on such day and this requirement is verified by the Member's employer.

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

Claim forms 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.

HEALTH CARE SPENDING ACCOUNT

Effective January 1, 2019 eligible members and their dependents have a Health Care Spending Account (HCSA) to a maximum of $250 per family each calendar year.

The Health Care Spending Account is designed to cover out-of-pocket medical and dental expenses that exceed your plan maximum coverage. Amounts of the HCSA not spent in a calendar year may be carried forward into the next calendar year but not thereafter. There is a maximum of $500 that can be in your Health Care Spending Account at any one time.

The HCSA provides Supplemental Coverage for:

Eligible medical and dental expenses under the Plan where the maximum coverage has already been reached.

The HCSA cannot be used to pay for the following:

(a) Medical and dental expenses that are not covered by the Plan; and

(b) Medical and dental expenses that are covered by provincial health care plan.

To utilize the Health Care Spending Account funds, you must complete the appropriate claim form. This form is available from the Administrator.

MEMBERS HEALTH – VIRTUAL DOCTORS

Effective June 1, 2020 Members Health was introduced to your plan of benefits for eligible Active and Retired Members and their dependents.

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.

Members Health offers the following services:

- 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 surgeons referrals

To book a video call appointment with a Doctor:

Call: 1 800-484-0152

Visit: www.MembersHealth.com

Email: LMLteam@membershealth.com

Note: Be advised that this is an enhanced service in addition to the services of your family doctor and will not in any way affect your services or access to your family doctor. Also, upon request, any medical records from this service can be provided to your family doctor.

RETIREE BENEFIT PLAN

Qualification

Effective April 1, 2019 retirees of the Labourers' Multi-Local Welfare Trust of Ontario may apply for optional Life Insurance, Supplementary Health and Dental benefits within 30 days of retirement for which there is a monthly charge.

The following conditions must be met to be eligible for this coverage:

- You are a member in good standing with the Labourers' Multi-Local when you retired; and
- You have maintained your union membership continuously since you retired.

Please contact the Administrator for the monthly cost of this benefit which is determined by the Trustees and amended from time to time.

Summary of Benefits

The Retiree Benefit Plan provides benefits as included under the Active Plan with the following **exceptions**:

Life Insurance

Member	$10,000
Spouse/Dependents	Not Provided

Supplementary Health Benefits

Drugs	$5,000 per calendar year per individual

Dental Benefits

Orthodontic Treatment
or procedures .....Not Provided

Health Care Spending Account .....Not Provided
Accidental Death and
Dismemberment .....Not Provided
Long Term Disability.....Not Provided
Weekly Sick Pay .....Not Provided
Out of Country Coverage .....Not Provided

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 CLAIM FOR BENEFITS

General

All claims should be submitted within 90 days from the date charges are incurred.

Online Access

The Plan now provides for online claims submission. We encourage you to register on the Administrator's website at www.globalben.com for online access to submit and review claims and more. For your convenience, you may also submit and review claims on the Global Benefits app available on the App Store and Google Play.

Direct Deposit

In addition to the online claims submission, you can get your money back faster with electronic payment of claims directly into your bank account. You may sign up for this service on the Global Benefits website or on the app. The direct deposit form is also available by contacting the Administrator.

Electronic Dental Claims Submission

Effective August 4, 2020 your Dental Office can electronically submit claims via the Telus/Assure network for you and your eligible dependents covered under your Plan by using your existing Global Benefits/Trust Prescription Drug Card. If your dental office accepts assignment of benefits and you are eligible for the expenses incurred, payment will be sent directly to your dental office and you will receive a notice of payment.

Paper Claims

You may continue to submit paper claims by mail. All forms are available by contacting the Administrator.

Member Life/Dependent Life/Member Accidental Death and Dismemberment

Ensure to acquaint your beneficiary with the fact that one of the first duties to be performed, in the event of your death, is to immediately contact the Administrator. Claim forms may be obtained from the Administrator with specific instructions as to how they are to be completed.

Member Weekly Sick Pay

A claim must be submitted to the office of the Administrator within 90 days of the disability date to be eligible for benefit. Claim forms may obtained from the Administrator and completed by yourself and your doctor, in accordance with the instructions given with the form.

Member Long Term Disability

Contact the Disability department of the Administrator.

Member and Dependent Supplementary Health/Dental

When submitting a Supplementary Health or Dental claims please ensure that each bill indicates the following information (see drugs and vision care below):

i) Patient's full name;

ii) Date(s) the service(s) was rendered or purchase was made;

iii) Nature of the sickness or injury;

iv) Type of service or supply furnished;

v) Itemized charges.

Drug Bill must indicate:

i) Patient's full name;

ii) Prescription number and name of medication;

iii) Date of purchase and the charge for each item.

Original prescription receipt is required (this is different from the cash register receipt) – if you've lost the original prescription receipt, the pharmacist can reprint it for you.

Vision Care Bill must indicate:

i) Patient's full name;

ii) Charge for lenses;

iii) Charge for frames (receipt of purchase must be attached).

Please note that being in possession of a claim form does not constitute benefit entitlement.

All claims must be marked "Labourers' Multi-Local Welfare Trust of Ontario" and indicate the number of your Local Union.

Please submit your claims to the Administrator, as set out below:

Global Benefits
901-191 The West Mall
Toronto, Ontario
M9C 5K8
Telephone: 416-635-6000
Toll Free: 1-800-663-4500
Fax: 416-635-6464
Website: www.globalben.com
App: Global Benefits
(App Store and Google Play)

INSURANCE COMPANY

The Manufacturers Life Insurance Company underwrites the Life Benefit and the Accidental Death and Dismemberment Benefit. All other benefits are provided on a self-insured basis by the Labourers' Multi-Local Welfare Trust of Ontario.

THE LABOURERS'
MULTI-LOCAL GROUP
LEGAL TRUST OF ONTARIO

GROUP LEGAL PLAN

GROUP LEGAL PLAN
TABLE OF CONTENTS

PLAN INTRODUCTION

The Group Legal Plan provides eligible Plan Members and their eligible 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 up to the maximum amounts indicated and specifically for those legal services described in this benefit booklet. Charges beyond the maximum payable by the Plan or for non-legal services such as disbursements, taxes, registration and government fees are the responsibility of the Plan Member. 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, as circumstances may warrant and in order to protect the Trust, the Trustees have the authority to change eligibility rules and Plan's benefits, monetary or otherwise, as they apply to all current and future Plan Members.

Should you have any questions or require assistance with your claim, please do not hesitate to contact the Plan Administrator, Global Benefits at (416) 635 6000. The Plan Member's social insurance number is required when making inquiries.

Sincerely,

Board of Trustees

ELIGIBILITY

Members of the Labourers' Multi-Local Welfare Trust of Ontario are entitled to benefit coverage under the Group Legal Plan provided they are:

- employed by a participating employer who is making contributions to the Group Legal Plan on their behalf;
- eligible for benefit coverage under the Labourers' Multi-Local Welfare Trust of Ontario excluding when benefit coverage is extended by fund assistance;
- retired and continuing benefit coverage by paying direct.

Effective April 1, 2019 Retired Members of the Labourers' Multi-Local Welfare Trust of Ontario may continue benefit coverage on a pay direct basis provided you have maintained your union membership continuously since you retired.

Termination of coverage under the Group Legal Plan takes place on the same date that the Plan Member ceases to be eligible for coverage under the Welfare Trust. Legal services commencing following that date will be ineligible for reimbursement.

CLAIMS PROCEDURES

Plan Members and their eligible dependents are entitled to the use of a service provider of their own choice. Alternatively, the Law Society of Upper Canada provides a referral service that may be of assistance. For their contact information please refer to page 81.

Group Legal claims must be submitted within 24 of the date of service or the date of offence for

Highway Traffic Act claims. The Plan Member must be eligible for benefit coverage on the date of service or the date of offence.

Group Legal Benefits are a taxable benefit and Plan Members will receive a T4A for benefits paid on their behalf.

HOW TO CLAIM FOR GROUP LEGAL BENEFITS

Online Access

The Plan now provides for online claims submission. We encourage you to register on the Administrator's website at www.globalben.com for online access to submit and review claims and more. For your convenience, you may also submit and review claims on the Global Benefits app available on the App Store and Google Play.

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.

Direct Deposit

You can get your money back faster with electronic payment of claims directly into your bank account. If you have not already done so, you may sign up for this service on the Global Benefits website or on the app. The direct deposit form is also available by contacting the Administrator.

Paper Claims

You may continue to submit paper claims by mail. Group Legal claims forms are available by contacting the Administrator.

All paper claims should be submitted to the Plan Administrator:

Global Benefits
901-191 The West Mall
Toronto, Ontario
M9C 5K8

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 reimbursable 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.

“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. The required transfer of title on a property is included in the maximum amount of $550 payable for purchase and sale claims. Code “A6 Mortgage New or Renewal” is only payable for mortgages unrelated to a purchase.

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

For paper claims please ensure to complete the real estate section of the claim form when claiming for a purchase or sale of the Plan Member’s principal family residence.

Codes		Maximum Amount
A1	Purchase Family Dwelling	$550
A2	Sale Family Dwelling	$550
A3	Purchase Lot for Family Dwelling	$550
A4	Purchase/Sale Vacation Property	$550
A5	Transfer of Title	$300
A6	Mortgage New or Renewal	$400

A7	Mortgage Incidental to Purchase	$200
A8	Discharge of Mortgage	$150

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. For mortgage services provided by a financial institution, a formula will be applied to the total administration fee 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 includes the preparation of a separation agreement, filing a petition of divorce or separation, establishing custody and access of children, support payments, 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 consultation, refer to section "C".

Cheques for **divorce and domestic proceedings** for legal services provided to a Plan Member's dependent spouse may be mailed directly to the spouse or the lawyer upon request. If applicable, please provide the spouse's mailing address and phone number.

Codes		Maximum Amount
B1	Divorce Member	$850
B2	Divorce Spouse	$850
B3	Property and Custody Support Member	$850
B4	Property and Custody Support Spouse	$850
B5	Separation Agreement Member	$850
B6	Separation Agreement Spouse	$850
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 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 Separation Agreement is prepared, you shall be entitled to a reimbursement up to $850. You would not be entitled to an additional payment under "Property and Custody Support" although issues of custody and access of children, support payments and distribution of property are

addressed 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. It is essential that the statement of account from the service provider clearly indicates the date and fee charged for the initial consultation.

Code		Maximum Amount
C1	Preventive Law	$300

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

"E" - Wills

A Plan Member and the dependent spouse shall be entitled to have prepared what is commonly regarded as a simple will which does not include the creation of any trust or other estate. A Plan Member and the dependent spouse shall be entitled to the periodic review and amendment of all testamentary instruments. 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, refer to section "D". Probation of a will and estate matters are excluded from coverage under the Plan.

Codes		Maximum Amount
E1	Simple Will Member	$300
E2	Simple Will Spouse	$300
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, disputes or controversies arising out of a lessor-lessee relationship in respect to 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 and 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 nonmeritorious, calculated to be vexatious only, of a non-material or of a non-consequential nature or would be contrary to public policy.

In the event that any damages are recovered or some form of monetary claim effected, the first $4,000 excluding damages for property replacement and/or medical expenses of any such recovery shall be free of any assessment by the

Plan for legal costs expended on the Plan Member's behalf. **If the monetary settlement is in excess of the $4,000, the Plan Member is not entitled to reimbursement under the Plan.** 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.

Proceedings brought before the Small Claims court are not reimbursable under this section and 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 Labourers' Multi-Local Benefit Trusts or 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 incidents.

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 conviction, 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 multiple 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.

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 consultation, refer to section "C".

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.

Codes		Maximum Amount
M1	Highway Traffic Act	$400
M2	Provincial Offences Act or Offences under Municipal By-laws	$500
M3	Criminal Code of Canada	$950
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 are the maximum amounts 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 per court decision 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 $150 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 Plan Administrator and completed by the Plan Member and the employer. Completed claim forms must be accompanied by a proof of attendance outlining the days attended, proof of the per diem allowance paid by the court or the Sheriff's letter.

Codes		Maximum Amount
O1	Jury Duty	$150/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 disputes 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 disputes involving the Plan of Benefits or Trust provided by a Contributing Employer to this Plan of Benefits or by the Labourers' Multi-Local 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 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 where a Plan Member omitted to perform giving rise to tort, negligence, criminal claims, or charges, where 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.
24. Legal services incurred outside of Canada.

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

PLAN RULES

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

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

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

(1) Plan Member's spouse in respect of whom the contributions are being made for coverage under the Plan, see "Spouse";

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

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

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

"Plan Member" means a member of the Labourers' Multi-Local Benefit Trusts who is employed by a contributing Employer and who is eligible to receive benefits under the Plan.

"Plan" means the Labourers' Multi-Local Group Legal Benefit Plan.

"Spouse" means a person who:

(l) is married to the Plan Member;

(2) although not legally married to the Plan Member, cohabits with the Plan Member for at least one year in a spousal relationship.

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

"Trust" means the Labourers' Multi-Local Group Legal Trust of Ontario 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.

LAW SOCIETY REFERRAL SERVICE

Plan Members and their dependents are entitled to the use of a service provider of their own choice. Alternatively, the Law Society Referral Service connects residents of Ontario looking for legal assistance with a lawyer or paralegal who practices in the area of law required. The service will help to find a legal professional who will provide up to a 30 minute free consultation to help you determine your rights, options and to meet a specific requirement, such as communicating in a certain language. To access the service please visit:

www.lawsocietyreferralservice.ca

Licensed Paralegal Coverage

Legal services provided by a licensed paralegal are covered for the following:

- Litigation in Small Claims Court
- Offences under the Provincial Offences Act and Highway Traffic Act
- Minor criminal charges in Ontario Court of Justice

- Hearings before the Immigration and Refugee Board
- Matters before Tribunals

IMPORTANT INFORMATION FOR SERVICE PROVIDERS

In order to assist in the efficient processing of a Group Legal claim, it is crucial that the supporting documen- tation 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 incurred by 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 provided. For instance, **Real Estate Matters** often include preparation or discharge of a mortgage but rarely is it itemized in 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”.

Statements of account for **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 Separation Agreement is prepared, you shall be entitled to a reimbursement up to $850. You would not be entitled to an additional

payment under “Property and Custody Support” although issues of custody and access of children, support payments and distribution of property are addressed 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 the **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 the date of 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. 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 up to the maximum amounts indicated and specifically for those legal services described in this benefit booklet.

All claims are subject to the rules and exclusions applicable to the Plan of Benefits on pages 76-80.

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