2025 BENEFITS

RETIRED MEMBERS

Local 183 Retiree Benefit Fund

LiUNA! care
LOCAL 183
BUILDING HEALTHY FUTURES

LOCAL 183
RETIREE BENEFIT FUND

RETIRED MEMBERS

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

EFFECTIVE
JANUARY 1, 2025

WELCOME

This booklet describes the conditions of eligibility, coverage and claims procedures under the Local 183 Retiree Benefit Fund, which for descriptive ease is referred to in this booklet as the Trust Fund.

Effort has been made to ensure that the coverage descriptions in this booklet are consistent with the group insurance policies issued by the Insurance Companies and with related government Health coverages. However, this booklet is not, in itself, a legal contract, so it follows that the terms of the insurance policies, and of the governing legislation, take precedence in case of dispute. As well, in an effort to treat all members fairly and to guard the Trust Fund assets against abuse, the Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund.

The Trustees intend that the benefit coverage, provided by the Trust Fund, is of real value to you and your eligible dependents. Should you require additional information, please contact your plan's Administrative Agent.

Please read this booklet carefully and keep it for future reference.

The Board of Trustees

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HOW THE TRUST FUND WORKS

The benefits provided by the Trust Fund are purchased from insurance companies with contributions remitted to the Trust Fund.

The booklet describes benefits available under the Trust Fund.

The Trustees are responsible for the design of the benefit package provided by the Trust Fund and for the allocation of the contributions made to the Trust Fund. To help carry out their duties, the Trustees have appointed various people such as accountants, consultants and lawyers to provide them with professional advice. The Trustees meet with these advisors from time to time to review matters that arise in the running of the Trust Fund. The Trustees make all decisions that are necessary at these meetings by taking a vote amongst themselves. The plan's Administrative Agent performs the daily administrative functions of the Trust Fund.

It is hoped that the Trust Fund will be continued indefinitely, but as is customary in group insurance plans, the right of change or discontinuance at any time must be reserved. Please note that any benefit that is provided at a particular time cannot be guaranteed for any specific period of time, unless required by legislation. The Trustees reserve the right to amend, suspend, delete or terminate any benefit at any time as in their discretion they deem appropriate.

The Trustees have the power to disentitle any person to past, present or future benefits and to take any further action they deem appropriate, including denying membership in a Plan, to any person where the member or persons claiming through the member are found by the Trustees to be abusing the Plan or making false or improper claims under the Plan.

PROTECTING THE PLAN

The benefits provided by the Trust Fund are designed to its maximum for Retirees and eligible dependents of the Local 183 Retiree Benefit Fund. Inflating drug costs and therapies affect the Plan and its purpose. Retirees can help maintain the Plan with the following steps to ensure the Plan is able to continue to offer quality benefits:

- Coordination of coverage with your spouse can ensure that each plan is maximized to its full potential. Please ensure to advise the Administrative Agent of other coverage available to you.
- The Plan has been designed to help Retirees and their eligible dependents and to ensure suitable health care access. Please remember to use it when you need it and to use it prudently.
- Prior to sending a claim under the plan for items and services, take some time to shop and compare to help keep a limit on costs.

THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete an Application/Enrollment Card, which you can obtain from your Administrative Agent. On this card, you name the beneficiary/beneficiaries, to whom your Life Insurance should be paid, in the event of your death. Members should list all dependents that are eligible for insurance.

If you have already completed an Application/Enrollment Card and you have no desire to change your beneficiary/beneficiaries, it is not necessary for you to complete another card. You may change your named beneficiary/beneficiaries, subject to Provincial Law, by written request, filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the Plan for any payment(s) made before such request is received by the Administrative Agent.

Please be sure to fully complete and sign the Application/Enrollment Card, and return it to the Administrative Agent. It is extremely important that a completed Application/Enrollment Card be on file, since claims cannot be paid on behalf of you, or your eligible dependents.

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

CHANGE OF YOUR DEPENDENT OR MARITAL STATUS

You must complete a new Application/Enrollment Card to update your status. For example, if you were a single member when your insurance commenced and you get married at a later date, or you were married at the time insurance commenced and sometime later your family includes a child.

You must advise the Administrative Agent within 31 days of a change in your dependent status. Failure to do so could jeopardize the coverage of a newly acquired dependent.

This information is important to ensure uninterrupted coverage and avoidance of any delays in the assessment of claims.

PERSONAL INFORMATION

Any personal information collected by the Trustees and the Administrative Agent is used only to the extent required by law. To authorize an individual to have access to your personal information, you must complete an Authorization to Release Personal Information Form and return it to the Administrative Agent. Only authorized persons have access to your personal information when required for coverage purposes.

RETIREE ELIGIBILITY

WHO MAY BE INSURED

This Plan is for Retirees:

- in Good Standing with LiUNA Local 183 or BMIUC Local 1.
- who are at least 55 years of age at the date of their retirement.
- who have been a member in good standing with LiUNA Local 183 or B.M.I.U.C. Local 1 for a minimum of 5 consecutive years immediately prior to the date of retirement.
- who are in the process of successfully applying for a monthly retirement pension from the LiUNA Labourers' Pension Fund.
- who are receiving or have received a lump sum pension with LiUNA Labourers' Pension Fund and Retirees in the Industrial Sector who are eligible for a pension under the LiUNA Labourers' Pension Fund or a pension under the Canada Pension Plan.
- and their eligible dependents who are insured under a Provincial Health Insurance Plan at the date of their retirement.
- Retirees who are deemed to have in excess of 50+ years of continues membership with Local 183 will be eligible for benefits on a complementary basis.

INITIAL BENEFIT COVERAGE

Retirees must apply for coverage under the Plan within 45 days from the retirement date or upon the exhaustion of any hour banks under the Local 183 Members Benefit Fund and will become eligible for benefits provided by the Plan as follows:

- On the first day of the next month you cease to be eligible as an Active Member of the Local 183 Members Benefit Fund or Local 183 Industrial Benefit Fund provided you remit the required monthly contribution, on an uninterrupted basis.
- If you have hours in your hour bank account with the Local 183 Members Benefit Fund, you can enroll once you have exhausted these hours and your coverage terminates under the Local 183 Members Benefit Fund up to a maximum of 24 months. You will receive an enrolment package 60 days before your hours will exhaust.
- Coverage continues automatically for each month for which you make your required monthly contribution, uninterrupted, paid to the Local 183 Retiree Benefit Fund and submitted to the Administrative Agent.
- Continue to maintain a Good Standing membership with LiUNA Local 183 or B.M.I.U.C. Local 1, uninterrupted from the date of retirement.

If you do not elect Retiree benefit coverage within 45 days of your retirement date or upon the exhaustion of any hours in your Hour Bank Account, you will not be eligible to enroll or participate at a later date.

COVERAGE COST

Retirees are required to submit the following monthly contribution for benefit coverage as at May 1, 2024:

RETIREE COST
$ 45.00 / Month *The above rate is inclusive of the Provincial 8% Retails Sales Tax. Retiree's costs may change from time to time as defined by the Board of Trustees.*

CHANGES IN PLAN ELIGIBILITY

The requirements under the Retiree eligibility and coverage costs may be amended by the Board of Trustees at any time without prior notice to individuals affected, including current Retired members and those not yet eligible as of the effective date of any amendment.

The Board of Trustees reserve the right to change or terminate any or all of the benefit coverages under the Plan and amend the monthly contribution from time to time.

TERMINATION OF COVERAGE

Coverage for you and your dependents will terminate on the earliest of, the date:

- On the last day of the month that you stop making premium payments or are not eligible to make future premium payments;
- If you cease to be a member in Good Standing of LiUNA Local 183 or B.M.I.U.C. Local 1;
- Coverage for your eligible dependents will terminate on the date such dependents, ceases to be eligible;
- You enter Military Service;
- The date the Plan is discontinued.

RE-EMPLOYMENT OF A PENSIONER

If you are a Retiree covered under the Local 183 Retiree Benefit Fund who is receiving a monthly pension from the LiUNA Labourers' Pension Fund and you return to work with a participating employer, your coverage under the Local 183 Retiree Benefit Plan will pause and you will begin to generate eligibility under Local 183 Members Benefit Fund and will be classed as an Active Member.

Once you accumulate enough hours in your hour bank under the Local 183 Members Benefit Fund, you will be considered to be an Active Member under the Local 183 Members Benefit Fund and not a Retiree. You cannot have active benefit coverage as an Active Member and a Retiree at the same time.

Coverage will terminate if a Retiree enters into an active working relationship with an entity **contrary** to the interests of LiUNA Local 183. Coverage under the Local 183 Retiree Benefit Fund will reactivate once you are no longer employed/working in the industry and benefits exhaust under the Local 183 Members Benefit Fund.

CONTINUATION OF EXTENDED HEALTH CARE, VISION CARE, DENTAL CARE, EMERGENCY OUT OF PROVINCE MEDICAL, AND HOSPITAL CASH COVERAGE UPON YOUR DEATH - DEPENDENTS

Extended Health Care, Vision Care, Dental Care, and Emergency Out of Province Medical Coverage benefits will continue on a complimentary basis beyond the date of your death for your eligible spouse and eligible dependents provided you were eligible for benefits at the date of death, but not beyond the earliest of:

- The date such dependents cease to be eligible.
- The date your surviving spouse remarries (children will continue to be covered).
- The date of your surviving spouse's death.
- The date coverage for your dependents terminates as per the definition of dependent or for any other reason.
- The date your child attains the age of 21 or the age of 25 provided they are attending an accredited school, college, or university as a full time student.

CONTINUATION OF EXTENDED HEALTH CARE, VISION CARE, DENTAL CARE, EMERGENCY OUT OF PROVINCE MEDICAL, AND HOSPITAL CASH COVERAGE FOR INCAPACITATED CHILDREN

Extended Health Care, Vision Care, Dental Care, and Emergency Out of Province Medical Coverage benefits will continue beyond the date an unmarried child attains the limiting age of 21 or 25 provided they are attending an accredited school, college or university as a full-time student, provided proof is submitted to the Administrative Agent within 31 days after such date that such child:

- Is incapable of supporting themselves due to a physical or psychiatric disorder.
- Became so incapacitated prior to attainment of the limiting age.
- Is chiefly dependent upon you for support and maintenance.
- Thereafter such proof must be submitted to the Administrative Agent as required, but not more often than yearly.

DEPENDENT ELIGIBILITY

Your dependents become eligible for coverage when you become eligible or, if acquired later, upon becoming your dependent provided they are covered under a Provincial Health Insurance Plan. If your spouse also has coverage through their employer, you must co-ordinate your benefits through this plan with your spouse's plan. You must advise the Administrative Agent if you or your dependents are covered under another plan, such as your spouse's plan.

Your eligible dependents include your spouse and dependent children as identified below.

SPOUSE

- Spouse means a husband or wife by virtue of a valid civil or religious ceremony.
- Common Law Spouse means a person living with the member for a minimum of 12 consecutive months and will be deemed to be the member's spouse if such person is publicly represented as the member's spouse.
- Same-sex spouses are eligible provided that the relationship includes continuous cohabitation of a minimum of 12 consecutive months and public representation of married status.
- Divorced spouses are not eligible for coverage.

DEPENDENT CHILDREN

- Dependent child means a natural or legally adopted child; or a stepchild or other child who is dependent upon the member for support and lives with the member in a regular parent/child relationship.
- Dependent children must be 20 years of age or younger (children from 21 years of age but under age 25 will be covered provided they are attending an accredited school, college or university as a full time student. Annual proof of student registration (original) **must** be provided to the Administrative Agent).
- Dependent children must be dependent on you for support, unmarried and not employed at a regular full-time job.

SUMMARY OF PLAN BENEFITS

Following is a summary of your benefit coverages. The booklet provides further details.

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
LIFE INSURANCE (page 23)	**Benefit Maximum (Principal Sum):** • Retiree - $ 25,000* • Spouse - $ 10,000* Life Advance Benefit payable within 48 hours: • Retiree - $ 10,000* **Terminal Illness Advance (24-month life expectancy):** • Retiree - $ 12,500* • Spouse - $ 5,000* ** Total Life Insurance benefit payable not to exceed principal sum. Life Advance applicable to Retirees only.*	✓ Retirees and eligible spouse
CHILD DISABILITY BENEFIT (page 25)	**Benefit Maximum:** • Up to a maximum of $50,000 per dependent child. • Family maximum of up to $100,000	✓ Retirees and eligible dependents
MEMBER HEALTH MANAGEMENT SERVICES (page 27)	• Confidential in-house one-stop destination for support on all matters relating to disability and other medical benefits and services to get you back to health.	✓ Retirees Only ✓ Coverage Terminates at The Attainment of Age 65

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 28)	Any dollar amount shown as a "limit" in this summary refers to a maximum eligible charge, and not a maximum benefit **Lifetime Maximum:** • Unlimited per insured family member **Coinsurance Levels:** • 50% Custom made Orthotics • 100% Other Covered Charges **Prescription Drugs**: • Member Advantage Benefit Card • 100% Reimbursement • Opioids - $50,000 Lifetime Maximum • Smoking Cessation – One (1) course treatment up to a maximum of $350 per lifetime. • Vaccinations / Immunizations coverage up to a maximum of $500 per calendar year. • Medical Cannabis - $2,000 per calendar year. • Medical Exams / Test coverage to a maximum of $200 payable per calendar year to offset any fees charged for medical exams/tests. • Medical Claim Form reimbursement fee up to a combined maximum of $100 payable per calendar year to offset any claim form completion fees charged by the attending physician and/or medical provider.	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 28)	**Ontario Drug Benefit (ODB) Deductible**: • Annual $100 ODB deductible is eligible for reimbursement. • $6.11 maximum ODB dispensing fee reimbursement. **Paramedical Services Limits**: • Clinical Psychologist, Psychoanalyst, Psychotherapist or Social Worker up to a maximum of $105 per visit up to an overall combined behavioral therapy maximum of $2,000 per calendar year. • Chiropractor, Podiatrist/Chiropodist, Occupational Therapist, Athletic Therapy, Acupuncture, Osteopath, Naturopath and Massage Therapy* up to a maximum of $85 per visit. Physiotherapist* up to a maximum of $90 per visit. Up to an overall combined health practitioner maximum of $2,000 per calendar year. • Speech Therapist* up to a maximum of $200 per visit up to a lifetime maximum of $10,000 for dependent children only. ** MD Referral Required for Massage Therapy, Physiotherapist and Speech Therapist.*	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 28)	**Medical Services and Supplies:** • Orthopedic Shoes: 1 pair every 24 months to an overall maximum of $500 (must be custom made by a Foot Care Specialist and prescribed by licensed physician (M.D.) or specialist). • Orthotics: 1 pair reimbursed at 50% up to a maximum of $250 per calendar year (must be custom made by a Foot Care Specialist and prescribed by licensed physician (M.D.) or specialist). • Hearing Aids: $3,500 every 36 months for one set (including replacement, repairs and batteries). • Nursing Services: $5,000 lifetime maximum. • Ambulance services: outpatient services. • Limb braces, crutches, prosthesis services, wheelchair, hospital bed or oxygen equipment. • Platelet-Rich Plasma (PRP) Injections or nStride Injections up to $2,000 every 36 months to be accompanied by a M.D. Referral and not to be used for cosmetic purposes. • Vision Care: Maximum combined benefit of $450 once every 24 months for one (1) set of eyeglasses (lenses/frames combined) **or** Contact Lenses including one (1) eye exam. Eye exam prescriptions will be valid for 24 months from the date of exam unless different from prescription.	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXTENDED HEALTH CARE BENEFITS (page 28)	• $100 Replacement Lenses (one set) only if as a result of a prescription change or damage to lenses within the same 24 months under Vision Care. • Corrective Laser Eye Surgery: $2,000 / once per lifetime • Cataract Surgery: Intra-ocular lens (IOL) single focal to a maximum of $250 per eye per lifetime; multi-focal to a maximum of $600 per eye per lifetime. • Cataract Surgery: Intra-ocular lens (IOL), preparation exam of $450 per eye, per lifetime.	✓ Retirees and eligible dependents
DENTAL CARE BENEFITS (page 39)	**Co-Insurance Levels:** • Routine Care - 100% • Dentures - 100% • Crowns, Bridgework, and Implants – 100% • Orthodontics – 60% (dependent children under the age of 21 only) **Benefit Maximums:** • $3,000 for routine care, dentures, crowns, and bridgework (per individual, per calendar year) • $7,500 for implants (per individual, every 5 years) **Orthodontic Lifetime Maximum**: • $2,500 per lifetime (dependent children under the age of 21)	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
DENTAL CARE BENEFITS (page 39)	**Dental Ontario Dental Association (ODA) Fee Guide (Insured Plan):** • Current ODA Fee Guide *(resetting every January 1)*	✓ Retirees and eligible dependents
LONG TERM CARE (page 45)	**Benefit Maximum:** • $50 per day indemnity benefit • $100 per day for eligible expenses • Lifetime Maximum $300,000 • Hospice – Up to $10,000	✓ Retirees and eligible spouse
HOSPITAL CASH (page 48)	**Daily Benefit Maximum**: • Maximum of $200 per day **Benefits are payable after:** • 3 consecutive days of hospitalization **Benefit Duration**: • Maximum of 120 consecutive days	✓ Retirees and eligible dependents
EMERGENCY OUT-OF-PROVINCE MEDICAL (page 50)	**Benefit Maximum**: • $5,000,000 Per Trip Maximum up to age 80 • $2,500,000 Per Trip Maximum age 80 to age 99 **Trip Duration:** • Trips are limited to a maximum of 90 consecutive days to age 99.	✓ Retirees and eligible dependents ✓ Coverage terminates at the attainment of age 99

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
EXPEDITED HEALTHCARE (page 54)	**Benefit**: • Immediate access to diagnostic scans such as MRI, CT Scans, Ultrasound, Endoscopy, and Colonoscopy. • Specialist consultations for expediated access to a total of 20 different specialists. • Expediated low priority Orthopedic and General surgeries for Members only.	✓ Retirees and eligible dependents
MENTAL HEALTH - mHEALTH (page 55)	**Benefit**: • Confidential Online Platform for virtual real-time Cognitive Behavioral Therapy (CBT) sessions with a psychologist. • Sessions up to 12 weeks from home via computer or handheld device. • Access to educational materials. • Assessments can be shared confidentiality & securely with primary care physicians or counsellors.	✓ Retirees and eligible dependents
MENTAL HEALTH – LIVE VIDEO THERAPY (page 56)	**Benefit**: • Confidential one-on-one counselling via live video call. • Choice of therapist and day / time of treatment. • Up to 6 sessions.	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
MENTAL HEALTH – INTENSIVE OUTPATIENT PROGRAM (page 57)	**Benefit**: • Comprehensive mental health program offered in-person or virtually • Eight (8) weeks of treatment • Nine (9) hours of individual and group treatment per week • Ten (10) months of aftercare	✓ Retirees and eligible dependents
VIRTUAL HEALTH (page 58)	**Benefit**: • Confidential Online Platform for virtual 24/7 non-emergency personalized medical support through the mobile application. • Instant access to connect with healthcare provider for primary health questions & concerns. • Fill and refill prescriptions. • Initiate specialist referrals and lab requisitions. • Unlimited virtual consultations via text or chat. • Updates sent securely and confidentiality to primary care physicians with consent.	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
HEALTHCARE NAVIGATION (page 59)	**Benefit**: • Health coaching platform with nurse navigator to aid navigating current healthcare system for serious and chronic diseases. • Single point of contact throughout the diagnosis, treatment, and rehabilitation process.	✓ Retirees and eligible dependents
CANCER ASSISTANCE (page 60)	**Benefit**: • Specialized cancer care for immediate access to highly trained oncologists and experienced oncology nurses who work with patients and family to ensure right treatment is received.	✓ Retirees and eligible dependents
SECOND OPINION MEDICAL - MYCONSULT (page 61)	**Benefit**: • Online secured web platform to a medical second opinion program from the expertise of top Cleveland Clinic global specialists for prolonged or chronic illnesses without the time and expense of travel.	✓ Retirees and eligible dependents
HEALTH COACHING (page 62)	**Benefit**: • Confidential one-on-one telephone access to dedicated professional for coaching support. • Health goals include diabetes, heart health and mindful eating. • Nutritional Assessments available.	✓ Retirees and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
SELF HELP WORKS (page 62)	**Benefit**: • Online training program with video-based workshops to help with: ▪ smoking cessation ▪ weight loss ▪ alcohol consumption ▪ exercise motivation ▪ stress relief ▪ diabetes ▪ sleep restoration and more.	✓ Retirees and eligible dependents
VIRTUAL HOME DELIVERY PHARMACY (page 62)	**Benefit**: • Convenience of home delivery for prescription medications sorted into daily packets to ensure correct daily dosage and auto renewing or prescriptions.	✓ Retirees and eligible dependents
FINANCIAL WELLNESS (page 62)	**Benefit**: • Convenience of a virtual portal with access to tools and information to assist in educating and providing guidance for financial goals and alleviate stress from financial uncertainty.	✓ Members and eligible dependents

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
SUBSTANCE & RECOVERY PROGRAM – SMART (page 63)	**Benefit**: • The Substance Management Abuse & Recovery Treatment (SMART) program is a confidential 24-hour, 7-day virtual online substance management and recovery program to assist with all forms of substance abuse.	✓ Retirees and eligible dependents
OPIOID OUPATIENT PROGRAM (page 63)	**Benefit**: • The Canadian Addiction Treatment Centre Opioid Program is an Outpatient Treatment Service for those looking for confidential opioid therapy and treatment.	✓ Retirees and eligible dependents
SUBSTANCE USE AND ADDICTION TREATMENT – RESIDENTIAL INPATIENT PROGRAM (page 64)	**Benefit**: • Expedited access to substance use and addiction recovery inpatient program • Six (6) week residential program • On-site mental health clinicians and physicians specialized in addiction medicine • Individual and group therapy • Aftercare and family support	✓ Retirees Only

BENEFITS	BENEFIT COVERAGE	WHO IS COVERED
SUBSTANCE USE AND ADDICTION TREATMENT – INTENSIVE OUTPATIENT PROGRAM (page 65)	**Benefit**: • Expedited access to substance use and addiction recovery outpatient program • Offered in-person or virtually • Individual and group therapy • Aftercare	✓ Retirees Only
PARENTING AND CAREGIVING (page 65)	**Benefit**: • Online platform for one-on-one parenting and caregiving advice • Expert resources and tools	✓ Retirees and eligible dependents
MEMBER FAMILY ASSISTANCE PROGRAM - LIFEJOURNEY (page 66)	**Services:** • Confidential Counseling Services	✓ Retirees and eligible dependents
GROUP LEGAL AND PAID LEAVE BENEFITS	**Benefit:** • Assistance with Wills, Power of Attorney, Real Estate, Separation Agreements, Divorce, Highway Traffic Act, etc.	✓ Retirees and eligible spouses ✓ Coverage is under the LiUNA Local 183 Members Group Legal & Paid Leave Trust Fund

LIFE INSURANCE

BENEFITS

You and your eligible spouse are covered for life insurance as follows:

LIFE INSURANCE	
Member Category	**Coverage**
Life Insurance:	
- Retirees (Principal Sum)	
- Life Advance Benefit payable within 48 hours	$ 25,000*
- Terminal Illness Life Advance (24-month life expectancy)	$ 10,000
	$ 12,500
** The total maximum Retiree Life Insurance benefit payable above to be $25,000. Life Advance applicable to Members Only.*	
- Spouse (Principal Sum)	$ 10,000*
- Terminal Illness Advance (24-month life expectancy)	$ 5,000
** The total maximum Spousal Life Insurance benefit payable above to be $10,000.*	

In the event of your death at any time while covered, the amount above will be paid to your named beneficiary, if living, otherwise to your estate. You may change your beneficiary whenever you like (subject to any legal restrictions) by giving written notice to LiUNAcare Local 183.

CONVERSION OPTION

If coverage for you or your eligible spouse terminates, you or your spouse may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required within 31 days of the date coverage terminates. Contact LiUNAcare Local 183 for details.

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

BENEFICIARY

For member death benefits, you may name a beneficiary (ies) and, from time to time, change such named beneficiary (ies), subject to Provincial Law, by written request filed at the office of LiUNAcare Local 183, to take effect as of the date such request was executed, but without prejudice to the Plan for any payments made before such request is received.

LIFE ADVANCE BENEFIT

In the event of your death, a one-time Life Advance Benefit of $10,000 from the principal sum will be paid to your named beneficiary at the time of death within 48 hours, in advance of the Life Insurance Benefit to cover any burial expenses incurred. A death certificate from the funeral home must be submitted. You may change your beneficiary whenever you like (subject to any legal restrictions) by giving written notice to LiUNAcare Local 183. Total Retiree Life Insurance benefit payable not to exceed $25,000 and is applicable to Retirees only.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

CHILD DISABILITY BENEFIT

If your dependent child is diagnosed with a condition, disease, disorder, or injury which leads to significant disability while covered, you may be entitled to the Child Disability Benefit.

ELIGIBILITY

To be eligible for this benefit, your **dependent child** must:

- Meet one or more of the Insured Conditions, and
- The dependent child's diagnosis must be made on or after the benefit's effective date of coverage of November 1, 2024.

INSURED CONDITIONS

- In order to qualify for the Child Disability Benefit, one or more of the following Child Disability Benefit Types must be met:

(1) LISTED CONDITION
The dependent child is diagnosed with one or more of the over one hundred fifty (150) Listed Conditions specified by name.
(2) LONG-TERM HOSPITALIZATION
The dependent child is hospitalized for a continuous period of thirty (30) overnight stays or more.
(3) SEVERE MEDICAL COMPLEXITY OR DISABILITY
The dependent child has a high degree of medical complexity or caregiving needs, or severe functional limitations in mobility, activities of daily living, or social and cognitive function compared to children of the same age that has lasted, or is expected to last, a continuous period of at least ninety (90) days or is expected to result in death within ninety (90) days.

- Each Child Disability Benefit Type is assigned a Severity Level score between 1 to 5 based the nature of the condition and level of disability.
- The severity level score increases as caregiving and healthcare demands increase and the child's independence and ability to participate in activities of daily living decreases.
- The Child Disability Benefit amount payable is dependent on the severity level and expected duration.

BENEFITS

If your **dependent child** meets the eligibility requirements, **you** may be eligible for the following benefits:

- A maximum benefit of up to $50,000 per dependent child
- Up to a $100,000 family lifetime maximum.

The Child Disability Benefit amount payable is shown below by severity level and expected duration:

SEVERITY LEVEL	SEVERITY LEVEL LIFETIME MAXIMUM	LONG DURATION CONDITION (permanent or 8+ months expected) LUMP SUM	SHORT DURATION CONDITIONS (less than 8 months expected) MONTHLY BENEFIT
1	$10,000	$10,000	$1,250
2	$20,000	$20,000	$2,500
3	$30,000	$30,000	$3,750
4	$40,000	$40,000	$5,000
5	$50,000	$50,000	$6,250

- Long Duration Conditions (permanent conditions or conditions expected to last 8 or more months) are paid as a lump-sum at the severity level maximum.
- Short Duration Conditions (conditions expected to last less than 8 months) are paid monthly up to the severity level maximum.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Any disabilities caused by conditions, diseases, disorders, or injuries diagnosed prior to the coverage start date are not eligible. This includes any conditions caused by or resulting from any conditions diagnosed or known prior to November 1, 2024.

MEMBER HEALTH MANAGEMENT SERVICES

If **you or an eligible dependent** is struggling with health issues or need assistance during times of disability, Member Health Management Services is your in-house one-stop destination for support on all matters relating to disability and other medical benefits and services to get you back to health.

Member Health Management Services is comprised of disability management specialists and health professionals trained to ensure members receive medical care focused on recovery and return to work. Member Health Management Services staff work with members in developing a personalized plan and coordinating appropriate plan benefits and services on an expedited basis.

Member Health Management Services is here to promote a return to health by offering:

- Expediting diagnostic and specialist assessments
- Treatment coordination
- Healthcare navigation and second opinions
- Coordinating mental health wellness strategies and counselling
- Accessing medically related plan benefits and services for you and your eligible dependents such as hospital cash, long term care, and other benefits.

Whether waiting for a specialist appointment or diagnostic test, struggling to complete activities of daily living due to medical or mental health issues, or simply looking to connect with someone regarding your health and wellbeing, contact the Member Health Management Services at 416-240-2104, toll-free at 1-866-315-6011, or email **memberhealthservices@liunacare183.com.**

EXTENDED HEALTH CARE

If **you or your eligible dependents** incur reasonable and customary expenses for any of the services and supplies listed below, you will be reimbursed for the eligible expenses as described. These services and supplies must be recommended by a legally qualified physician in Canada, where indicated, and received while you are insured for either an illness, including pregnancy, or injury that is non-occupational.

MAXIMUM LIFETIME BENEFIT

The maximum amount payable under this benefit is unlimited per eligible dependent. This amount applies separately to you and each eligible dependent.

PERCENTAGE PAYABLE

This is the percentage of covered charges that are paid.

- 50% for custom made orthotics.
- 100% for all other eligible covered expenses.

PRESCRIPTION DRUG BENEFIT

You and your eligible dependents are covered for prescription drug charges as follows:

- Prescription drugs must be medically necessary and used to treat a bona fide, serious medical condition.
- Prescription drugs must be prescribed by a licensed physician (M.D.) or dentist or other professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or licensed physician (M.D.) legally authorized to dispense such drugs in Canada.
- Prescription drugs must be approved and used for the purpose identified by Health Canada and certain controlled drugs are subject to the amount and dosages that may be dispensed, i.e. – narcotics may be subject to a 30-day supply at any given time.
- Prescriptions drugs are limited to a maximum of a 3-month supply at any one time.
- Eligible opioids medication will be covered up to a lifetime maximum benefit of $50,000.
- Vaccines / Immunizations covered up to a maximum of $500 per calendar year.
- Smoking Cessation coverage for one (1) course treatment up to a maximum of $350 per lifetime.
- You and your eligible spouse will be provided a **Member Advantage Benefit Card** that you **must present to your pharmacist** when purchasing your prescription drugs for you and your eligible dependents.

WHAT PRESCRIPTION DRUGS/MEDICATIONS ARE NOT ELIGIBLE

The prescription drug plan does not reimburse the following:

- Drugs that can be purchased as over the counter medication or without a prescription.
- Drugs that are associated with dietary, anti-obesity, health foods, nutritional products, anabolic steroids, experimental drugs, vitamins, supplements, homeopathic medications, injectables, fertility, and erectile dysfunction.
- Drugs that are used for non-medically necessary purposes and provided directly by a physician or hospital.
- Prescribed drugs for sale in Canada not approved by Health Canada will not be reimbursed by the benefit plan if purchased outside of Canada.
- Prescribed drugs must be approved and used for the purpose identified by Health Canada.
- Lost, damaged, stolen or spoiled prescription drugs **will not** be covered by the drug plan.
- Any drugs purchased outside of Canada.

MEMBER ADVANTAGE BENEFIT CARD

Once you satisfy the eligibility requirements, you and your eligible spouse will be provided with a Member Advantage Benefit Card to be used as follows:

- For the purchase of all your eligible prescription drug expenses, dental expenses, & healthcare expenses.
- It is critical that LiUNAcare Local 183 have complete, accurate and up-to-date information on you and your dependents.
- In the event your Member Advantage Benefit Card does not work at the pharmacy, dental office or practitioner office due to incomplete information, please contact the Member Services Department **Toll Free at 1-888-790-3534**.
- If you are **not** in benefit at the date of your purchase, your Member Advantage Benefit Card will not work and you will be required to make the purchase directly at the office.
- Should your Member Advantage Benefit Card not function and you are in benefit, you may purchase the medication/supplies or pay for the service and submit the paid receipt along with a completed claim form for assessment to LiUNAcare Local 183.
- Should you choose not to use your Member Advantage Benefit Card and purchase eligible drugs/services with cash, debit or credit card, the pharmacist/practitioner may charge you in excess of what is eligible through your Member Advantage Benefit Card and you will be responsible for these excess charges. It is imperative you use your Member Advantage Benefit Card to assist in controlling the costs the pharmacy / pharmacists / practitioner levies.

- Certain drugs that are medically necessary and appropriate for the plan to cover need to be pre-approved prior to purchase. Please contact LiUNAcare Local 183 at 1-888-790-3534 for more information.

GENERIC SUBSTITUTION

Many brand name drugs on the market have a generic equivalent. In Canada, a generic drug has the same active ingredients as the brand name drug.

It is recommended that you ask your physician to prescribe a less expensive generic equivalent drug if one is available. This does not mean that your health care will be negatively impacted because, in Canada, the generic drug has the same active chemical ingredients as a brand name drug.

Generic substitution is the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your physician and is the normal practice of many pharmacists for a limited number of drugs.

DISPENSING FEES

Dispensing fees are a significant cost to the retiree and the benefit plan. Retirees can help keep costs down by shopping around, as some drug stores can charge more than twice as much as others.

TRILLIUM DRUG PROGRAM

The Trillium Drug Program helps to cover the cost of drugs if your drug costs are high compared to income level for retirees between the ages of 55-65. Serious illnesses can have higher than normal drug costs; therefore, a retiree can combine benefits from the Program and their benefit plan to cover up to 100% of costs along with a deductible. The Trillium Drug Program covers drugs that are approved under the Ontario Drug Program (ODB).

The following criteria are to be met in order to qualify:

- The Local 183 Retiree Benefit Fund Drug Plan does not cover 100% of the prescription drug costs;
- Must have valid coverage through the Ontario Health Insurance Plan (OHIP);
- Must not be covered under the Ontario Drug Benefit (ODB) Program.

For more information on the Trillium Drug Program, please call 1-800-575-5386.

ONTARIO DRUG BENEFIT (ODB) PROGRAM

Prescription drug expenses for retirees age 65 and older are reimbursed by the Ontario Drug Benefit Program. Retirees and eligible spouses are responsible for an annual $100 deductible. The Retiree Plan will reimburse retirees and eligible spouses the $100 Ontario Drug Benefit deductible and up to a maximum of $6.11 per prescription for ODB dispensing fee charges.

Pharmacies will coordinate reimbursement directly with the Ontario Drug Benefit Program. For more information on the Ontario Drug Benefit (ODB) Program, please call 1-866-811-9893.

MEDICAL CANNABIS

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

- Up to a calendar year maximum of $2,000 per insured individual.
- For medical purposes when obtained from a licensed producer pursuant to a medical document issued by an authorized healthcare practitioner and has been assigned a product identification number as defined under the Cannabis Act and Regulations.
- Must be accompanied with a Prior Authorization Approval and purchased through a Licensed Producer.
- For the treatment of one of the six eligible pre-determined conditions:
    - Neuropathic Pain (Chronic)
    - Spasticity
    - Palliative Care
    - Spinal Cord Injury
    - Nausea / Vomiting from Chemotherapy
    - Anorexia

MEDICAL EXAMS

You and your eligible dependents are covered for Medical Examinations and Tests to offset any fees charged for any medical exam or test in Canada as follows:

- Up to a calendar year maximum of $200 per insured individual.

MEDICAL CLAIM FORM REIMBURSEMENT

You and your eligible dependents are covered for a medical claim form reimbursement fee to offset any fees charged any claim form completion fees charged by the attending physician and/or medical provider in Canada as follows:

- Up to a combined maximum of $100 payable per calendar year per insured individual.

HEALTH PRACTITIONERS

You and your eligible dependents are covered for charges by the following health practitioners:

- Chiropractor, Massage Therapist, Athletic Therapist, Occupational Therapist, Podiatrist / Chiropodist, Naturopath, Osteopath, and Acupuncturist up to a maximum of $85 per visit. Physiotherapist up to a maximum of $90 per visit. Up to an overall combined health practitioner maximum of $2,000 per calendar year.

- Clinical Psychologist, Psychoanalyst, Psychotherapist or Social Worker up to a maximum of $105 per visit up to an overall combined maximum of $2,000 per calendar year.
- Speech Therapist up to a maximum of $200 per visit up to a lifetime maximum of $10,000 for dependent children only. Must be prescribed by a licensed physician (M.D.) or a nurse practitioner in Canada as to duration and type and claims must be accompanied by the referral.
- Psychoanalyst who is a licensed physician (M.D.) if the insured person is not hospitalized (for Quebec residents only).
- Treatments by a Physiotherapist, Massage Therapist and Speech Therapist must be prescribed by a licensed physician (M.D.) in Canada as to duration and type and claims must be accompanied by a M.D. referral. If the treatment is required for more than 1 year, a M.D. referral is required on an annual basis.
- M.D. referral required for Massage Therapy, Physiotherapist, and Speech Therapist.

AMBULANCE

You and your eligible dependents are covered for transportation by a licensed ambulance. Covered charges are in excess of the amount payable under your Provincial Health Plan, excluding air or rail ambulance service. Ambulance transportation coverage is as follows:

- From the place of injury (or where illness struck) to the nearest hospital where treatment is available.
- Directly from the first hospital where treatment is given to the nearest hospital for needed specialized treatment not available at the first hospital.
- From a hospital to a convalescent hospital / rehabilitation hospital.

DENTAL CARE FOR ACCIDENTAL INJURY

You and your eligible dependents are covered for services by a legally qualified Dentist for prompt repair of sound natural teeth when required because of a non-occupational injury or loss caused solely by external and accidental means within Canada.

Accidental Dental services must be commenced within 90 days of the accident causing the injury or loss and be completed within 12 months from the date of the accident.

ORTHOPEDIC SHOES

You and your eligible dependents are covered for custom made orthopedic shoes as follows:

- One (1) pair every 24 months up to a maximum reimbursement of $500.
- Custom made Orthopedic shoes must be prescribed by a licensed Physician (M.D.) or specialist and dispensed by a Pedorthist, Orthotist, Podiatrist or Chiropodist in Canada.
- Custom made Orthopedic shoes (including repairs) must be specially designed and molded to correct a diagnosed physical impairment, provided that the following information is supplied:
    - A diagnosis, including a list of symptoms and the primary complaint;
    - A description of the physical findings from the clinical examination;
    - A brief description of the abnormal walking pattern associated with the diagnosis (a gait analysis); and
    - Confirmation that the product has been custom made.

ORTHOTICS

You and your eligible dependents are covered for custom made Orthotics as follows:

- One (1) pair up to 50% of their purchase price to an overall maximum benefit of $250 per calendar year.
- Custom made Orthotics must be prescribed by a licensed Physician (M.D.) or specialist in Canada and dispensed by a Pedorthist, Orthotist, Podiatrist or Chiropodist and must be specially designed and molded to correct a diagnosed physical impairment, provided that the following information is supplied:
    - A diagnosis, including a list of symptoms and the primary complaint;
    - A description of the physical findings from the clinical examination;
    - A brief description of the abnormal walking pattern associated with the diagnosis (a gait analysis); and
    - Confirmation that the product has been custom made.

HEARING AIDS

You and your eligible dependents are covered for Hearing Aids as follows:

- To a maximum benefit of $3,500 every 36 months for one set of hearing aids when provided by a certified clinical audiologist in Canada including any replacement, repair charges and batteries.

VISION CARE

You and your eligible dependents are covered for Vision care services as follows:

- Maximum combined benefit of $450 once every 24 months includes one (1) set of eyeglasses (lenses and frame combined) or contact lenses in lieu of eyeglasses. Included in the vision care benefit is one (1) eye exam. Remaining balances cannot be applied to future claims.
- One (1) eye exam within the same 24 months up to a maximum benefit of $100. Retirees/Spouses over age 65 will have eye exams covered under OHIP while dependents are continued to be covered under the benefit plan. Eye exam prescriptions will be valid for 24 months from the date of exam unless different from prescription.
- One (1) set of replacement lenses up to a maximum of $100 only if your prescription changes or lenses become damaged within the same 24 month period covered under Vision Care, as per above.
- Corrective Laser Eye surgery up to a lifetime maximum reimbursement of $2,000.

- Prior to Cataract Surgery, Intra-ocular lens (IOL) preparation exams are covered up to $450 per eye, per lifetime.
- Following Cataract Surgery, Intra-ocular lens (IOL) is covered up to a lifetime maximum of $250 for single focal lens per eye and $600 for multi-focal lens per eye.
- All lenses must be prescribed by a legally qualified optometrist or ophthalmologist in Canada and must be for the correction of vision defects.
- A completed claim form must be submitted with the original paid receipts including final payment date and a copy of the original prescription.
- Eyeglasses or contact lenses must be purchased in Canada, Laser Eye surgery and Cataract Surgery must be performed in Canada.

You will not be reimbursed for the following:

- Nonprescription reading glasses, sunglasses, tinted other than (type 1 or 2) glasses, anti-reflective coatings or safety glasses.

OUT OF HOSPITAL NURSING

You and your eligible dependents are covered for Nursing care services as follows:

- Home nursing care performed by a legally qualified Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.), Registered Practical Nurse (R.P.N.) or Victorian Order Nurse (V.O.N.) in Canada.
- Your nurse cannot be related to you by blood or marriage or a member of your family and not normally a resident in your home.
- Services must be ordered by a licensed physician (M.D.) in Canada as medically necessary for a disability that requires the specialized training of a nurse.
- Home Nursing care will be eligible up to a maximum lifetime benefit of $5,000.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Prior to incurring any major expenses you should submit details to LiUNAcare Local 183 to determine payable benefits. In any event, a letter will be required by a licensed physician (M.D.) describing the nature of the disability and type, medical need and estimated duration of any required durable medical equipment.

You and your eligible dependents are covered for the rental of or at the Insurers discretion, the purchase of Durable Medical Equipment and Supplies as follows:

- Medical Braces for Wrist, Elbow, Finger, and Ankle up to a maximum of $250 per limb, once every 3 years.

- Platelet-Rich Plasma (PRP) Injections or nStride Injections up to $2,000 every 36 months to be accompanied by a M.D. Referral and not to be used for cosmetic purposes.
- Respiratory equipment, kidney dialysis equipment, oxygen, hypodermic needles and catheters.
- Wheelchairs, Hospital Beds, Iron Lungs or similar mechanical equipment.
- Splints, Canes, Crutches, Walkers, Trusses, Casts and Dennis Browne splints.
- Rigid or Semi-Rigid Back, Neck, Arm or Leg Braces once (1) every five (5) years per limb.
- Non-dental prosthesis such as artificial limbs and eyes, including replacement if required due to a change in physical condition.
- Injectables, needles, syringes, diabetic testing agents, insulin, glucometers and infusion pumps when patient is insulin dependent.
- Apnea monitors.
- One (1) external breast prosthesis to a maximum of $500 per breast once every 24 months.
- Two pairs of surgical brassieres, per calendar year.
- Two pairs of custom graduated compression stockings with a minimum compression factor of 20mmgh or higher per calendar year.
- Wigs up to a lifetime maximum of $500.
- Sclerotherapy (Vein Injections) is limited to $20.00 per visit up to a maximum of $2,500 per calendar year.

The Durable Medical Equipment and Supplies benefit does not cover the following:

- Items for personal comfort, convenience, exercise, safety, self-help or environmental control.
- Items which may be used for non-medical reasons, such as but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, whirlpool baths or saunas.

ONTARIO ASSISTIVE DEVICES PROGRAM (ADP)

The Ontario Assistive Devices Program (ADP) may provide reimbursement for certain expenses up to 75% of the cost. Eligible items are breast, limb and eye prosthesis, respiratory equipment, communication aids, ostomy supplies, visual aids, wheelchairs, etc. Claims for these types of services must be forwarded to ADP with the balance being submitted to the Plan for consideration. For more information on the Ontario Assistive Devices Program (ADP) call 1-800-268-6021.

INSULIN PUMPS

The Ontario Assistive Devices Program (ADP) provides funding assistance to eligible Ontario residents of all ages with type 1 diabetes. The program covers 100% of the cost of an insulin pump (up to a maximum of $6,300) paid directly to the supplier on behalf of the recipient. The program will also cover $2,400 ($600 every three months) per year for supplies paid directly to the recipient. Retirees and eligible dependents that do not qualify for Adult Insulin Program should submit their claim for an insulin pump for pre-approval under the Local 183 Retiree Benefit Fund.

OSTOMY SUPPLIES

The Ontario Assistive Devices Program (ADP) provides funding assistance to eligible Ontario residents that have a permanent colostomy, ileostomy, urostomy, ileal conduit or continent pouch/reservoir. The program does not pay for supplies for persons with a temporary ostomy.

The program will pay $600 ($300 every six months) per year directly to the recipient for supplies if eligible. Any additional costs should be submitted to the Local 183 Retiree Benefit Fund for consideration.

For more information on the Ontario Assistive Devices Program (ADP), please call 1-800-268-6021.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- For drugs, sera or injectible drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis.
- Any expenses incurred and submitted for cosmetic/lifestyle purposes.
- If the payment is prohibited by law.
- That a covered person may obtain as a benefit under any governmental plan or law.
- For which no charge would have been made in the absence of this coverage.
- For dental work, except as provided under Dental Care for Accidental Injury.
- Expenses submitted more than 18 months after the date of service are not covered.
- Expenses incurred outside of Canada are not eligible for reimbursement.

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

- War, whether declared or not.
- Insurrection, rebellion or participation in a riot or civil commotion.
- Purposely self-inflicted injury.
- The commission or, attempt to commit, an assault or a criminal offence.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

DENTAL CARE

You or your eligible dependents may incur reasonable and customary charges for services and supplies provided by or under the supervision of a licensed, certified or registered oral surgeon or dentist in Canada. Eligible services are those that are recommended as necessary by a physician or dentist. Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of his/her license.

Members may choose to either have their dental care provided by the Insured Dental Plan or by enrolling in the LiUNA Local 183 Dental Clinic. LiUNA Local 183 Dental Clinic Members and their eligible dependents must use the Dental Clinic for their Dental Care needs. Members and eligible dependents enrolled in the LiUNA Local 183 Dental Clinic that incur services outside of the LiUNA Local 183 Dental Clinic, while enrolled in the Clinic, will **not** be eligible for reimbursement.

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

Summary of Dental Care Benefits		
Dental Clinic / Insured Plan	Calendar Year Maximum	$3,000 per person/year
	Dental Fee Guide Reimbursement	Current O.D.A. Fee Guide
	Diagnostics: exams, x-rays	100%
	Endodontics: root canals	100%
	Periodontics: root planing and surgery	100%
	Preventative: polishing, scaling, fluoride	100%
	Dentures: Partial	100%
	Dentures: Complete	100%
	Crowns/Bridgework	100%
	Implants	100%
	Restorative: fillings, crowns	100%
	Surgical: extractions, oral surgery	100%
	Orthodontics: (dependent children 21 years of age or younger)	60% *(max of $2,500 per lifetime)*

BENEFITS

The total benefits payable are subject to the following maximums:
Calendar Year Maximum (per individual)

Dental Clinic / Insured Plan	-	$3,000 per Calendar Year
Implants	-	$7,500 every 5 Years
Orthodontics	-	$2,500 Lifetime Maximum

Lifetime Maximum (Dependent Children Only – 21 years of age or younger)

PERCENTAGE PAYABLE

This is the percentage of covered charges that are paid. Covered Charges are charges up to the amount shown in the Fee Guide for needed Dental Care, services or supplies, while you are covered for either a disease or injury that is non-occupational.

DENTAL FEE GUIDE

Payments under the **Insured Dental Plan** will be based on the **Current Ontario Dental Fee Guide**. *(The ODA Dental Fee Guide will adjust each January 1 and remain on the current year)*.

ROUTINE DENTAL CARE SERVICES

You and your eligible dependents are covered for charges up to the benefit maximum as follows:

- Oral examinations, prophylaxis (light scaling and polishing of teeth) and bite-wing X-rays, up to once every 6 months.
- Scaling, root planing or occlusal equilibration (limited to 8 units per calendar year for all procedures combined).
- Fluoride treatment for the maintenance of sound natural teeth (dependent children age 16 or younger).
- Dental X-rays (full mouth series of X-rays or Panoramic X-ray once every 24 months).
- Complete exams covered once in every 24 months.
- Fillings, including porcelain fillings on all teeth and surfaces.
- Oral surgery and extractions for the removal of teeth, including the excision of impacted wisdom teeth.
- Anesthesia and its administration when made necessary due to a dental procedure.

- Space maintainers and pre-fabricated full coverage restorations for primary teeth.
- Repair, relining or rebasing of dentures.
- Repair or re-cementing of crowns, inlays, onlays or bridges.
- Periodontal treatment for disease of the bone and gums of the mouth, including tissue grafts, bone grafts and occlusal guards, but not athletic guards.
- Endodontic treatment, including initial root canal therapy and pulp conservation and root resection.
- Root canal once per lifetime per tooth.
- Scaling and cleaning of teeth may be done by a licensed dental hygienist.
- Fee for the root canal has been reduced by ½ of the fee paid for pulpectomy.

MAJOR RESTORATIVE SERVICES

You and your eligible dependents are covered for charges up to the benefit maximum as follows:

DENTURES

- First installation, including adjustments, of partial, permanent or complete temporary or permanent removable dentures to replace 1 or more natural teeth extracted while you are covered if you are covered for less than 12 consecutive months.
- Denture adjustments that occur more than 3 months after installation.
- Replacement of an existing partial or full removable denture, if it was installed at least 5 years before and cannot be made serviceable or is a temporary full denture which replaces one or more natural teeth extracted while the person is covered if the person has been covered for less than 12 months, and for which replacement by a permanent denture is required and takes place within 1 year from the date the temporary denture was installed. The cost of a temporary denture will be deducted from the cost of a permanent denture.
- Addition of teeth to an existing partial denture, if required to replace 1 or more natural teeth extracted while the person is covered.
- Installation, adjustment, repair, relining or rebasing of dentures may be done by a denturist, denture therapist, technician or mechanic, who is registered and practicing within the scope of his/her license.
- Denture Relines/Rebases are covered once every 24 months per arch.
- Denture repairs/adjustments are not eligible within 3 months of the date the denture was inserted.
- Cost of denture may apply towards Initial Bridge when missing 3 or more teeth within the same arch.

CROWNS, INLAYS, ONLAYS

- Inlays, onlays, gold fillings and crowns.
- First installation of inlays or onlays, and crown are covered when a natural tooth has extensive loss.
- Replacement of an existing inlays, onlays, and crown, but only if it was installed at least 5 years before and cannot be made serviceable.

BRIDGEWORK

- First installation of a fixed bridge is covered when 2 or less natural teeth have been extracted while insured under the Local 183 Retiree Benefit Fund or Local 183 Members Benefit Fund.
- Replacement of an existing bridge, but only if it was installed at least 5 years before and cannot be made serviceable.

IMPLANTS

- First installation of an implant is covered if the natural tooth (teeth) have been extracted while insured under the Local 183 Retiree Benefit Fund or Local 183 Members' Benefit Fund.
- Replacement of an existing implant crown, but only if it was installed at least 5 years before and cannot be made serviceable.
- Implant claims are reimbursed in two portions of the approved amount. 50% is reimbursed when the surgical stage is completed, and the remaining 50% will be paid when the restorative crown is placed.
- Implants up to a maximum of $3,000 per calendar year, per individual, exclusive of all other dental care services (Routine Dental Care Services and Major Restorative Services).

ORTHODONTICS

Your dependent children 21 years of age or younger are covered for charges as follows:

- Orthodontic treatments are reimbursed at 60% of the total submission, up to an overall maximum of $2,500 per lifetime.
- An estimate must be submitted prior to any incurred orthodontic treatments.
- Initial treatment cannot exceed 35% of the total cost of orthodontic treatment.
- Treatment must commence prior to the dependent reaching 22 years of age.
- Services will only be eligible if rendered in Canada.
- Reimbursement of orthodontic benefits will only be made if the Retiree is in benefit at the time the service is rendered.
- Diagnostic procedures, initial fee, monthly, and quarterly fees will be reimbursed as services are rendered.
- Orthodontic reimbursements are limited to a monthly fee, therefore, no lump sums will be reimbursed. Should you choose to pay your orthodontist the entire treatment fee up front, you will only be reimbursed for the services as they are actually rendered. Prepayments are not reimbursable under this plan.

ALTERNATE BENEFITS CLAUSE

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

PREDETERMINATION OF BENEFITS

If charges for a planned Course of Treatment by a licensed dentist in Canada will exceed $300, proposed details and x-rays should be submitted to LiUNAcare Local 183 for pre-approval.

Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

Course of Treatment means one or more services rendered by one or more dentist for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Dental care or appliances that are deemed to be for cosmetic purposes.
- Replacement of tooth structure lost due to incisal wear.
- Fillings are limited to once every 12 months per tooth, per surface.
- Expenses submitted more than 18 months after the date of service are not covered.
- Perio-Splinting is not eligible unless performed in conjunction with periodontal surgery.
- Crowns, Abutments and Pontics on molar teeth will be limited to the cost of metal appliance.
- Fees associated with travel, completion of claim forms and or missed appointment fees.
- Services that are not performed by a licensed dentist.
- Services incurred outside of Canada.
- Dental care covered under a medical plan provided by an Employer or Government.
- Space maintainers and pre-fabricated full coverage restorations for permanent teeth.
- Oral hygiene instruction or nutritional counseling.
- Protective athletic appliances.
- A full mouth reconstruction for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.
- Replacement of a lost or stolen prosthesis.
- Prosthesis, including crowns and bridgework, and the fitting there of which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this benefit is discontinued or more than 90 days after termination of coverage for any other reason.

GENERAL INFORMATION

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LONG TERM CARE

If you or your eligible spouse suffers from a prolonged or chronic illness and are over the age of 18, **you or your eligible spouse** may be eligible for Long Term Care Benefits as follows:

ELIGIBILITY

To be eligible for this benefit, **you or your eligible spouse** must be:

- Over the age of 18.
- Not needing Long Term Care at the time you become eligible for Long Term Care coverage.
- Not be able to perform at least 2 of the 6 "activities of daily living" without assistance due to a loss of functional capacity.
- Require "substantial supervision" to protect your health and safety due to a cognitive impairment.
- Surviving Spouse remains eligible for coverage for a period of 2 years following the death of the Retired member while in benefit.

BENEFITS

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

- A maximum basic daily indemnity benefit of up to **$50 per day** if you qualify as needing long term care.
- A maximum additional daily reimbursement benefit of up to **$100 per day** toward the cost of eligible long term care expenses such as home care services or home health care services provided by a licensed agency, hospice or long-term care facility (provided supporting documentation is submitted to substantiate the expenses).
- A maximum respite care basic benefit of up to **$100 per day** if receiving the basic daily indemnity benefit for a maximum of 14 days in each 12-month period following the date of the claim for actual costs incurred for additional home care or home health care services provided by a licensed agency when the insured persons primary unpaid caregiver requires relief from providing such care. Unused portions of this benefit cannot be carried forward.
- A maximum home modification benefit of up to **$1,000 per period** of care for actual costs incurred within 60 days of the date of eligibility for primary home modifications.
- A maximum grief counselling benefit of up to **$2,000 per period** of care for actual costs incurred within 365 days of the death of the insured for surviving

spouse/caregiver and/or dependent children provided by a licensed, registered or certified therapist or counsellor.

- A hospice care benefit of up to a maximum benefit of **$10,000** if you or your eligible spouse become eligible for claim under the Basic Daily Benefit and subsequently die within 31 days following the elimination period. Any basic Daily Benefit and/or Additional Daily Benefit amount already paid will reduce the flat benefit amount payable.
- The lifetime maximum benefit is $300,000 per person.

ELIMINATION PERIOD

For each period during which you or your spouse needs long term care, no benefit is payable for the first 90 days. This waiting period, or "elimination period", begins on the first documented date that the person is considered to need long term care. After this 90-day period, benefits will be payable for the rest of the qualifying period of care.

If the person who needs long term care recovers and then needs care once again, the second period of care will be considered a continuation of the first one if the two periods are less than 180 days apart and are due to related causes. For periods of care that do not meet these conditions, a new elimination period will apply each time.

ACTIVITIES OF DAILY LIVING

- **Bathing:** washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** the ability to maintain control of bladder function, or when unable to maintain control of the bowel or bladder function, the ability to perform associated personal hygiene (including care for catheter or colostomy bag).
- **Dressing:** putting on and taking off all necessary items of clothing and any necessary braces, fasteners or artificial limbs.
- **Eating:** feeding oneself by getting food, already prepared and made available, into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- **Toileting:** getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
- **Transferring:** moving into or out of a bed, chair or wheelchair with or without the use of equipment.
- **Substantial Supervision:** continual supervision which may include cueing by verbal the chronically ill person form threats to health or safety (such as may be a result from wandering).

EXCLUSIONS AND LIMITATIONS

The Plan does not cover or pay benefits for any claim, care or treatment directly or indirectly related to:

- Home care services and home health care services provided by an immediate family member (e.g., spouse, daughter or son), who may or may not be a nurse, unless provided through an agency;
- Confinement, services or care received while in a hospital that is not a long-term care facility (charges that exceed what the provincial health plan covers, such as private duty nursing, may be covered by this Plan);
- Neurosis, psychoneurosis, psychopathy, psychosis or any other mental or nervous disorder without demonstrable organic disease. Note: Brain disorders with demonstrable organic cause (such as Alzheimer's Disease and related dementia) are covered if symptoms are exhibited or a diagnosis is made;
- Any portion of any expenses incurred for home care services or home health care services which are reimbursable under any Canadian federal, provincial and territorial government plans or under any private insurance plan will not be reimbursed;
- Alcoholism, drug addiction or other chemical dependence; however, this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment by a physician in the course of treatment for an injury or sickness;
- Confinement, services or care for which no charge is normally made in the absence of insurance;
- Care or treatment provided outside of Canada or the United States;
- Any charges for the comfort and convenience of the chronically ill person such as, but not limited to televisions, telephones, beauty care and entertainment. Also excluded are any charges for medications;
- War or act of war (whether declared or undeclared);
- Participation in a felony, riot or insurrection;
- Service in the armed forces or units auxiliary thereto;
- Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
- Commission of any attempt to commit a criminal act; or
- An injury sustained because of involvement in an illegal occupation.

GENERAL INFORMATION

The eligibility and benefit provisions set out in this booklet are general and for information only. The booklet is not, in itself, a legal contract. The terms and conditions of the insurance policies take precedence in case of dispute. Should you require further information on eligibility or benefits, please contact the Administrative Agent.

HOSPITAL CASH

If **you or your eligible dependents** become hospitalized, you may be eligible to receive a daily cash benefit for the duration of your hospital stay.

ELIGIBILITY

To be eligible for this benefit, **you or your eligible dependents** must be:

- Present themself at a recognized hospital anywhere for a minimum of 3 consecutive days, including time spent in the Emergency Room immediately preceding admission to the hospital.
- Hospital stays of less than 3 days do not qualify for this benefit. Once you have been confined to a recognized hospital for more than 3 consecutive days, your benefit will include the first 3 consecutive days.
- Hospital confinements associated with the admission and birth of a child will begin after 1 day (24 hours).

BENEFITS

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

- A maximum daily benefit of $200.
- A maximum benefit period of 120 consecutive days.

DEFINITION OF HOSPITAL

"**HOSPITAL**" means an incorporated or licensed hospital having accommodation for resident bed patients, a laboratory, a registered graduate nurse always on duty and an operating room where surgical operations are performed by a legally qualified physician or surgeon. The term "Hospital" shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness. The term "Hospital" shall also include a rehabilitation hospital when recommended by a physician, and if you are transferred directly from a hospital to a rehabilitation hospital. Only in the event where a concurrent transfer from a hospital to a rehabilitation hospital is not feasible will a grace period of 14 days be provided for the admittance to a rehabilitation hospital.

The Hospital Cash Benefit is available for claims incurred outside of Canada so long as the standard definition of "hospital" is met and the valid discharge papers are submitted to LiUNAcare Local 183.

SUBSEQUENT HOSPITALIZATION

If under the unfortunate circumstance you require further hospital confinement, or your situation requires more than one period of hospitalization for the accident or illness, then the full benefit will be reinstated provided that at least 61 days has elapsed from your last paid hospitalized day.

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, while sane or insane.
- Declared or undeclared war, or any act of declared or undeclared war.
- Flying in an aircraft, vehicle or device for aerial navigation:
    - For test or experimental purpose that you are operating, learning to operate or serving as a crew member;
    - That is operated by or under the direction of any military authority (this does not include transport type aircraft which is operated by the Canadian Air Transport Command or any other countries similar type of air transport service).
- Losses occurring while the insured person is serving on full-time active duty in the Armed Forces of any country or international authority.
- Any injury or illness that is the result of non-accidental means.

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EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE

Each Canadian Province and Territory provides a Medicare Plan with comprehensive benefits for hospital confinement, the service of medical physicians and other health practitioners, ambulance services, etc.

When you are outside your province of residence or Canada and require these services, your Provincial Medicare Plan will usually make a payment towards your expenses but that payment is usually limited to the amount that would have been paid for the same service in the Province in which you reside.

This benefit provides extensive coverage for many services rendered outside of Canada. It would be important to note that such expenses are covered provided that they were unexpected and of an emergency nature. This benefit does not provide benefits for medical treatment if the purpose of your trip is to obtain medical treatment.

ELIGIBILITY

To be eligible for this benefit, **you and your eligible dependents** must be:

- Under the age of 99.

PERIOD OF COVERAGE

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

- 90 consecutive days per trip if under age 80
- 90 consecutive days per trip ages 80 to 99

Travel medical insurance covers member and eligible dependents for trips of up to the consecutive days above. Travelers must return home for at least one day before being eligible for a new set of consecutive days for another trip.

BENEFIT MAXIMUMS

When injuries or sickness result in a claim, benefits will not exceed a per trip maximum of $5,000,000 for persons under age 70 for the actual expenses incurred outside of Province that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical plan in Canada. Persons aged 70 to under age 80 are subject to a maximum of $5,000,000 per trip maximum and persons aged 80 to 99 are subject to a maximum of $2,500,000 per trip maximum.

BENEFITS

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

	Benefit Maximums	
• Hospital, Medical and Therapeutic Services	$5,000,000	
• Hospital Confinement	$5,000,000	
• Emergency Evacuation Benefit	$ 500,000	
• Emergency Dental Treatment	$ 2,500	
• Repatriation Benefit	$ 15,000	
• Identification Benefit	$ 5,000	
• Auto Return Benefit	$ 10,000	
• Family Transportation Benefit	$ 15,000	
• Return Transportation for Travelling Companion	$ 5,000	
• Return and Escort of Dependent Children Under Age	$ 5,000	
• Trip Interruption Benefit	*Airfare*	$ 500
	Hotel and Meal Expenses (5 day max)	$ 1,500
	Combined Maximum	$ 2,000

EXCLUSIONS AND LIMITATIONS

No benefit will be paid for:

- Injuries received while the insured person is participating in any maneuvers or training exercises of the armed forces.
- Pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder.
- Sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury.
- Dental surgery or cosmetic surgery unless such surgery is a result of a covered injury.
- Treatment or services that contravene any government hospital or medical care plan in Canada.
- Sickness or injury due to participation in professional sports.
- Anticipated medical treatment required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure.
- Emotional or mental disorders unless the insured person is hospitalized.
- Expenses incurred on an elective (non-emergency) basis.
- Loss or injury as a result of suicide or any attempted threat or self-inflicted injuries, while sane or insane.

- An act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority.
- Any services or supplies provided by an insured person.
- Any treatment or surgery not required for the immediate relief of acute pain or suffering.
- Any treatment or surgery, which reasonably could be delayed until the insured person returns to Ontario; or anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the insured person prior to departure.
- Any sickness, injury or medical condition that was not stable in the 180 days prior to the departure date if you are 85 years of age or above.

GENERAL INFORMATION

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IN AN EMERGENCY, HERE'S WHAT TO DO:

You or someone acting on your behalf should call AXA Assistance Canada (AXA) immediately, before you get medical assistance in the event of a serious medical emergency. If you can't call right away, contact AXA as soon as you are able to do so. Their operators are backed by a team of emergency care professional physicians and nurses who work closely with the physician looking after you and, if necessary, your family or company physician, to help ensure that you receive the medical care you need.

NOTE: If you contact AXA right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

Telephone AXA Assistance Canada (AXA) at the numbers listed below:

- Canada & U. S. A. - **1-877-490-7228**
- Elsewhere (Collect Call) - **647-258-7274**

An operator will ask you the following:

- Your name, location and the details of your emergency
- Your AIG Policy No: **SRG 9025410**

EMERGENCY OUT OF PROVINCE MEDICAL WALLET CARD

Emergency Out of Province Medical Coverage Wallet Cards to carry while traveling, are available from LiUNAcare Local 183.

EXPEDITED HEALTHCARE

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

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

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

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

ELIGIBLE DIAGNOSTIC SCANS AND SPECIALISTS AVAILABLE TO RETIREES AND ELIGIBLE DEPENDENTS:	
Magnetic Resonance Imaging (MRI)	General Surgeon
Computed Tomography Scan (CT Scan)	Gynecologist
Ultrasounds	Neurologist
Endoscopy	Neurosurgeon
Colonoscopy	Ophthalmologist
Cardiologist	Orthopedic
Dermatologist	Podiatrist
Ear, Nose, Throat (ENT)	Respirologist
Endocrinologist	Rheumatologist
Gastroenterologist	Urologist

ELIGIBLE SURGERIES AVAILABLE TO RETIREES ONLY:	
Orthopedic Surgery *(ACL / elbow / foot / ankle / toe / hand / wrist / hip / knee / shoulder)*	General Surgery *(Cataract / ear / nose and throat / gallbladder / hernia)*

ADDICTION TREATMENT AVAILABLE TO RETIREES ONLY:
Inpatient substance use and addiction treatment.

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

MENTAL HEALTH

MENTAL HEALTH - mHEALTH

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

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

Retirees and eligible dependents get effective psychological treatment that will improve and sustain their overall health by ensuring rapid access to Cognitive Behavioural Therapy (CBT) as a short-term therapy that offers long term benefits. The program offers virtual CBT therapy sessions with a psychologist for a range of psychological conditions in the comfort and privacy of the members' own home for up to 12 weeks.

INCLUDED PSYCHOLOGICAL CONDITIONS	
Anxiety	Stress
Addiction	Substance Abuse
Depression	Alcohol Abuse

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

Retirees and dependents can download and share results of the assessment tool with their primary care physician or their mental health counsellors, securely and confidentially, from the comfort of home via computer or a handheld device.

Please visit www.liunacare183.com and simply click on the mHealth link at the top of the website to download and register or you can contact the Confidential Helpline 24/7 at 1-844-900-8357.

MENTAL HEALTH - LIVE VIDEO THERAPY

If you or your eligible dependents need assistance in tackling any mental health issues, you may be eligible for the Live Video Therapy as follows.

Live Video Therapy is ideal for retirees and eligible dependents who want the convenience and privacy of at-home mental health care and feel more comfortable seeing and interacting with their therapist face-to-face.

This program offers up to six (6) sessions with a licensed mental health therapist live via video call, accessible through your phone, tablet, or computer.

Retirees and eligible dependents can select a therapist from the roster of mental health professionals and schedule a convenient time for therapy sessions.

MENTAL HEALTH LIVE VIDEO THERAPY IS APPROPRIATE FOR:	
Alcohol use	Procrastination
Substance use	Relationships
Depression	Self-esteem
Grief	Sleep problems
Health anxiety	Social Anxiety
Mood concerns	Stress
Panic attacks	Trauma
Phobias	Anxiety/worry

Contact the confidential helpline at 1-844-900-8357 to access the program and schedule your first session.

MENTAL HEALTH - INTENSIVE OUTPATIENT PROGRAM

If you or your eligible dependents need help in addressing mental health issues you may be eligible for the Intensive Outpatient Program as follows.

The Intensive Outpatient Program is best suited for retirees and eligible dependents who experience symptoms of anxiety, depression, or bipolar disorder and find that their symptoms interfere with their daily tasks and obligations. It is also intended for those who previously completed other forms of treatment and are looking for a more comprehensive treatment program.

The Intensive Outpatient Program offers nine (9) hours of group and individual treatment over a period of eight (8) weeks. This is followed by ten (10) months of weekly aftercare to help maintain healthy habits.

TREATMENT MODALITIES INCLUDE:
Cognitive Behavioural Therapy (CBT)
Dialectical Behavioural Therapy (DBT)
Acceptance and Commitment Therapy (ACT)

Retirees and eligible dependents can access treatment in-person or virtually.

Contact the confidential helpline at 1-844-900-8357 to enroll in the program.

VIRTUAL HEALTH

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

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

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

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

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

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

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

HEALTHCARE NAVIGATION

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

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

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

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

CANCER ASSISTANCE

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

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

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

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

SECOND OPINION MEDICAL - MyCONSULT

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

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

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

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

The Cleveland Clinic is a global health care leader specializing in heart care. For more information, please contact MyConsult at1-866-883-5956..

WELLNESS BENEFITS

HEALTH COACHING

Retirees and eligible dependents can now take back their health with the new Health Coaching program. The Health Coaching program is a confidential program which gives Retirees and eligible dependents telephone access to a dedicated professional who will provide one-on-one coaching support in achieving health goals around diabetes, heart health and mindful eating. To complete your nutritional assessment, sign up for the program online at enroll.e-coaching.ca/liuna/183 to start achieving all your health goals.

SELF HELP WORKS

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

VIRTUAL HOME DELIVERY PHARMACY

The Virtual Home Delivery Pharmacy was added to the Plan to provide Retirees and eligible dependents the convenience of home delivery for their prescription medication sorted into daily packets to ensure the correct dose daily, also ensuring auto-renewing of prescriptions, while taking advantage of lower dispensing fees and same day delivery within the Greater Toronto Area. Home delivery pharmacy is available online or by using the app on your device, simply visit app.pocketpills.com/liunalocal183 to sign up and have access to all your prescription information.

FINANCIAL WELLNESS

Retirees and eligible dependents now have the convenience of a secure and confidential digital platform with 24-hour access to tools and information designed to educate and build financial confidence. The website includes articles, bulletins, videos, and a variety of methods to help members navigate through current circumstances, life changes and alleviate stress from financial uncertainty. Simply visit financialresources.liunacare.ca to sign up using registration code: **LiUNA22** to start your journey towards better financial health.

SUBSTANCE & RECOVERY PROGRAM – SMART PROGRAM

If you or your eligible dependents suffer from any form of substance abuse, you and your eligible dependents may be eligible for the SMART Substance & Recovery Program as follows.

The Substance Management Abuse & Recovery Treatment (SMART) program is a 24-hour, 7-day virtual online substance management and recovery program for Retirees and eligible dependents to assist with all forms of substance abuse including opioids, alcohol, prescription drugs and other drug abuse. The SMART program provides secure access to coaches, therapists, and physicians through a secure mobile and web platform to get on demand assistance when needed.

For more information, please visit https://try.alavida.co/liuna183/.

OPIOID OUTPATIENT PROGRAM

If you or your eligible dependents suffer from opioid abuse, you and your eligible dependents may be eligible for the Opioid Treatment Program as follows.

The Opioid Treatment Program is an Outpatient Treatment Service for Retirees and eligible dependents who are looking for confidential opioid therapy and treatment. Retirees and dependents can confidentially call 1-877-937-2282 to begin the process in a same or next day appointment at one of the treatment centres or to obtain virtual care for those who are unable to attend in person.

SUBSTANCE USE AND ADDICTION TREATMENT RESIDENTIAL INPATIENT PROGRAM

If you need help in addressing substance use and addiction, you may be eligible for the Residential Inpatient Program as follows.

Expedited retiree access to a residential inpatient program for alcohol, substance, and prescription medication addiction.

The Inpatient Program is a six (6) week residential program offering multi-faceted treatment approaches customized for each patient according to clinical preadmission assessment. Treatment is overseen by mental health clinicians and physicians specialized in addiction medicine.

TREATMENT MODALITIES INCLUDE:
Cognitive Behavioural Therapy (CBT)
Dialectical Behavioural Therapy (DBT)
Acceptance and Commitment Therapy (ACT)
Individual psychotherapy
Group therapy
Family support
Relapse Prevention
Aftercare

Retirees can confidentially call 1-844-900-8357 to begin the expedited admission process with case management support to obtain required documentation and assist through every step.

SUBSTANCE USE AND ADDICTION TREATMENT INTENSIVE OUTPATIENT PROGRAM

If you need help in addressing substance-use and addiction you may be eligible for the Intensive Outpatient Program as follows.

The Intensive Outpatient Program is a multi-week treatment program for those struggling with substance-use or addiction. The program is best suited for members who need expedited access to comprehensive treatment but cannot take time away from family or work.

TREATMENT MODALITIES INCLUDE:
Cognitive Behavioural Therapy (CBT)
Dialectical Behavioural Therapy (DBT)
Relapse Prevention
Aftercare

Retirees can access treatment in-person or virtually.

Retirees can confidentially call 1-844-900-8357 to begin the expedited program enrollment.

PARENTING AND CAREGIVING

If you or your spouse are looking for assistance or strategies to help you approach parenting and caregiving you may be eligible for this benefit.

The Parenting and Caregiving online platform is an easy to access digital platform with educational materials, resources, and access to one-on-one guidance. Retirees and their spouse have access to curated resources and tools, expert Q&A library, on-demand videos, and live webinars.

Please visit local183.torchlight.care to create an account.

MEMBER FAMILY ASSISTANCE PROGRAM - LIFEJOURNEY

If **you or your eligible dependents** need family assistance during times of stress, the Member Family Assistance Plan provides access to professional confidential counselling services.

LifeJourney provides an access to additional resources to help with a wide range of challenges. Care advocates have specialized expertise, are fluent in different languages and are available to help develop solutions for your problems or concerns.

Counselling is available in person, by phone or online. There is no cost to you. Offices are local and appointments are made quickly, with your convenience in mind. The counselling is intended to be short-term and focused on providing you with the tools and resources to address the cause of your stress.

If you wish to access the Member Family Assistance Program service, please call Toll Free 1-800-254-7223 or visit online at www.liunacare183.com/vcare. The Member Family Assistance Program helps you take practical and effective steps to improve your well-being and be the best you can be. Within a supportive, confidential and caring environment you can receive counselling for any challenge including:

COUNSELING SERVICES ASSIST WITH:	
Nutrition	Financial Stress
Lifestyle Changes	Addictions
Weight Management	Anxiety
Smoking Cessation	Depression
Family and Elder Care	Life Transitions
Relationships	Grief / Bereavement

GENERAL PROVISIONS

COORDINATION OF BENEFITS (EXTENDED HEALTH CARE AND DENTAL CARE)

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

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

The plan that does not have a Coordination of Benefits provision pays before the plan that does (most, if not all, plans have such a provision).

The plan that covers the person as:

- Other than a dependent pays before the plan that covers such person as a dependent; or
- A dependent child of the parent, covered as an employee or member, whose birthday occurs first during the calendar year, pays first.

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

To implement this provision, the Administrative Agent may:

- Subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed; or
- Pay to or recover from any other person, corporation or organization any excess payment, any payment so made will be deemed to be benefits paid and, to the extent of such payment, will fully discharge the Administrative Agent from all liability under this Plan.

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

Retiree	*Spouse*
For Retirees whose spousal's plans do not have rules on claiming from more than one plan, should, claim first to the spouse's plan then submit unpaid remaining claims to the Local 183 Retiree Benefit Fund when treatment is received.	If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Local 183 Retiree Benefit Fund.

Spousal Plan with Coordination of Benefits Provisions

Retiree	*Spouse*
Reitrees are to claim to the Local 183 Retiree Benefit Fund first then submit unpaid remaining claims to their spouse's plan when treatment is received.	If your spouse receives treatment, they should claim to his/her plan first then submit unpaid remaining claims to the Local 183 Retiree Benefit Fund.

Dependent Children

Determination of Coverage	*What to do?*
A dependent child's primary coverage is determined by the parent/guardian whose birthday comes earlier in the calendar year.	A member living with their child's other parent should first claim to the primary coverage then submit unpaid remaining claim to the remaining plan.
If you are separated or divorced, claims for each dependent child should be made in the following order: 1. To the plan of the parent in custody 2. To the plan of the spouse of the parent in custody 3. To the plan of the parent not having custody 4. To the plan of the spouse of the parent not having custody	

HOW ARE BENEFITS CALCULATED?

The group plan that determines benefits first will calculate its benefits as though duplicate coverage does not exist. The group plan that determines benefits second, limits its benefits for each individual item of expense listed on the claim, to the lesser of:

1. The amount that would have been payable had it been the group plan that determines benefits first, or;

2. 100% of the eligible expense (not the submitted expense) reduced by all other benefits payable by the group plan that determines benefits first for the same expense.

The combined payment from all group plans for a particular service/item cannot exceed 100% of the eligible expense. In some cases, the combined payment from all group plans on a particular service/item may be less than the actual expense incurred.

All dental expenses are based on the active fee guide for the plan at the time the expense is incurred.

As such, where a visit or expense is paid in part by a group plan, the visit will count as one (1) visit, or the expense will accumulate towards any cumulative maximums applicable to that expense.

Where the eligible expense for a submitted claim is paid in full by the group plan that determines benefits first, submission to the group plan that determines benefits second is not required unless the covered individual wishes to count that expense towards any applicable deductions or maximums.

DEFINITIONS

Allowable expense means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When the plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

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

ONTARIO HEALTH INSURANCE PLAN (OHIP)

The Ontario Health Insurance Plan (OHIP) pays most medical and surgical services required by residents of Ontario and their eligible dependents. It also pays for standard ward hospital charges. Regulations for the Ontario Health Insurance Plan are made under the Ontario Health Insurance Act and will change from time to time.

Should you have any questions relating to the commencement date or termination procedures of your OHIP coverage, you should contact OHIP directly.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted for each Benefit to the Administrative Agent within:

- 6 months after the date of death for Life Insurance Benefits.
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Extended Health Care and Dental Care benefits.
- Legal action to recover benefits under this plan must begin within 3 years (6 years for Life Insurance) of the date of loss.
- 90 days after the date of loss for Emergency Out of Province and Long Term Care Benefits.

LiUNAcare Local 183 shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably be required during the pendency and payment period, if any of such claim.

OVERPAYMENT OF BENEFITS

In the event where the Plan has paid more benefits to a Retiree than entitled to, the following measures apply:

- The Retiree will be notified of the overpayment by LiUNAcare Local 183 and asked to repay the Plan.
- If the Retiree doesn’t make the repayment within 30 days, the Trustees may decide the overpayment be treated as a lien against any future benefit claimed by the Retiree and deducted from any future payments paid to the Retiree.

HOW TO SUBMIT A CLAIM

Claim forms are available from LiUNAcare Local 183. Please be sure to complete them fully, attach necessary original paid in full invoices along with any other original documentation where applicable and keep a copy for your records to substantiate your claims, and submit to the following mailing address:

LiUNAcare Local 183
200 Labourers Way, Suite 2100
Vaughan, ON L4H 5H9

Dental & Extended Health Care Claims can be submitted online via the LiUNAcare Local 183 eClaims app from the App Store or Google Play.

INSURANCE PROVIDERS

The benefits described under this plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the policies may be obtained from LiUNAcare Local 183.

The Group Insurance Benefits described in this booklet are insured as follows:

CANADA LIFE ASSURANCE COMPANY - POLICY NO. 158400

- Member Life Insurance
- Dependent Life Insurance
- Extended Health Care
- Vision Care
- Dental Care

AIG INSURANCE COMPANY OF CANADA

- Emergency Out of Province Medical – Policy No. **SRG 9025410**

CHUBB INSURANCE COMPANY OF CANADA

- Hospital Cash – Policy No. **SG 10395006**

CONTACT INFORMATION

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

LiUNAcare Local 183
200 Labourers Way, Suite 2100
Vaughan, ON L4H 5H9

Telephone Directory:

Toll Free	**1-888-790-3534**
Member Services Department	**416-240-7487**
Reception	**416-240-7480**
General Fax	**416-240-7488**

Additional Phone Numbers:

Ontario Assistive Devices (ADP) Program	**1-800-268-6021**
Trillium Drug Program	**1-800-575-5386**
Ontario Drug Benefit (ODB) Program	**1-866-811-9893**
AIG – Emergency Out of Province Coverage	
Canada & U.S.A.	**1-877-490-7228**
Elsewhere (Collect Call)	**647-258-7274**
Expedited Healthcare	**1-844-900-8357**
Mental Healthcare - mHealth	**1-844-900-8357**
Virtual Healthcare – vCare	**1-800-254-7223**
Healthcare Navigation	**1-866-883-5956**
Cancer Assistance	**1-866-599-2720**
Second Opinion Medical - MyConsult	**1-866-883-5956**
Canadian Addiction Treatment Centres	**1-877-937-2282**
Addiction Inpatient Services	**1-844-900-8357**
Member Family Assistance Program (MFAP) LifeJourney	**1-800-254-7223**
Workplace Safety Insurance Board (WSIB)	**1-800-387-0750**
Employment Insurance (EI)	**1-800-206-7218**
Canada Pension Plan (CPP)	**1-800-277-9914**
Suicide Crisis Line	**9-8-8**

LiUNA!care LOCAL 183

LiUNA! LOCAL 183
Feel the Power

LiUNAcare Local 183 | 200 Labourers Way, Suite 2100, Vaughan, ON L4H 5H9
Phone (416-240-7487) | Email: info@liunacare183.com | liunacare183.com