LiUNA! LOCAL 493

2018 Benefits Booklet

Laborers' International Union of North America

LiUNA!

Feel the Power

Submit your signed claim forms with receipts for processing to:

Labourers' Local 493 Welfare Trust Fund
584 Clinton Ave
Sudbury ON P3B 2T2

Claim forms available on our website

www.local493.com/benefits

For assistance or inquiries regarding your plan contact:

705-805-5601 855-942-9937

benefits493@liunalocal493.ca

LiUNA! LOCAL 493

2018 Benefits Booklet

Table of Contents

INTRODUCTION

This information booklet has been prepared to give you an informal summary of the main features of your group coverage program.

Plan description outlined in this booklet includes all the changes and/or additions to the plan up to and including February 1, 2015.

This booklet is not an insurance policy, and does not grant or confer any contractual rights. All rights under this program shall be governed by:

- Group Life, Long Term Disability Insurance; Sunlife Policy #102606
- Short Term Disability Insurance; Sunlife Policy #151606
- Group Critical Illness; Chubb Canada Policy #CI10519101
- Health and Dental Group Benefits; NexgenRX Policy #3037 and by applicable law.

The Weekly Disability Income, Supplementary Health and Dental Expense benefits described in this booklet are not insured but are payable from the funds of the Labourers' Local 493 Welfare Trust Fund. NexgenRX, however, will administer all benefit payments.
SunLife will adjudicate all disability claims.

This booklet is for your reference.
Please read it carefully and keep it for future use.

GENERAL INFORMATION

The Labourer's Local 493 Welfare Trust Fund was established in April 1987, for the purpose of providing Benefits for members of Local 493 in good standing as per the Uniform Local Constitution (article III-membership) and their dependents who:

- are employed under the terms of a collective agreement with Local 493;
- are Unemployed Members with Local 493 who have insufficient funds in their Dollar Bank Account to maintain coverage (Member Life Insurance coverage only for a period of up to one year) and who are actively seeking employment through Local 493 by remaining registered on the out of work list; or
- are retired and meet all eligibility requirements under the Retired Members plan.

The Welfare Trust Fund is managed by three trustees all of whom are elected or appointed by LIUNA Local 493. In accordance with the trust agreement establishing the Welfare Trust Fund, these Trustees have all the necessary powers to receive contributions and convert them into the best possible Welfare plan that prudence will allow. The Trustees have appointed a Plan Administrator and Consultant to assist them in managing the Welfare Trust Fund and its Welfare Plan. An account is kept by the Administrator of the Fund for each member, which shows hours worked for a Contributing Employer for which contributions have been made for the purchase of group coverage. This account is called a Dollar Bank Account.

Each month, an amount equal to one month's of coverage cost will be deducted from your Dollar Bank Account. The number of dollars in your Dollar Bank Account may never exceed enough to provide 12 months of coverage. Any funds in excess will be credited to the general reserves of the Fund. After 12 months of no contributions, any excess will be credited to the general reserves of the fund.

Future Collective Agreements may change the rate of contribution.

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund

Active Members Welfare Plan

ACTIVE MEMBER ELIGIBILITY

Who May Be Covered

This Plan is for members in good standing as per the Uniform Local Constitution (article III – membership), who are resident in Canada and:

- working for Contributing Employers; or are
- Unemployed Members* who have insufficient funds in their Dollar Bank Account to maintain coverage.

*Unemployed Members have Member Life Insurance only in the amount of $10,000. There is no cost to the Member for this benefit as it is being paid by the Trust Fund. To be entitled to this benefit the Member must meet the following requirements:

- Immediately prior to unemployment, you must have been previously covered as an Active Member;
- be unemployed due to layoff;
- be, and remain, a Member in good standing as per the Uniform Local Constitution (article III – membership), and actively seeking work through LIUNA Local 493 by being registered on the out-of-work list of the Union.

When You Become Covered Initially

You and your eligible dependents will become covered on the first day of the month following accumulation of 1 months of coverage costs in your Dollar Bank Account (currently $220). The plan administrator will keep you covered by the Welfare Plan during periods of unemployment or underemployment, as long as you have at least one months of coverage costs in your Dollar Bank Account and you remain a member in good standing.

The above Dollar Bank eligibility rules are those that were in effect when this booklet was printed. These rules are subject to change in the future, and in that event, you will be notified. Frequently, changes will occur because there has been a change in the contribution rate to fund the cost of enhanced benefits, in which case it is likely that any amounts previously mentioned will increase to reflect the cost of a new and improved Welfare Plan.

If your dependent is confined, the effective date of coverage is the first date the dependent is no longer confined.

Confinement shall include both home and hospital confinement. If the dependent is confined at home, confinement shall mean the dependent is unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and sex. This shall not postpone the effective date for a child born while the employee's dependents are covered under this policy.

Eligibility Continuance

If your dollar bank is exhausting, you may elect to continue your eligibility by contributing to the Local 493 Welfare Trust Fund the dollar amount equal to the monthly amount required to maintain your eligibility bank ($220.00 plus taxes at time of print).

- You must be active in benefits at the time of contribution and the payment must be received by the Welfare Trust Fund by the 20th of the month prior to the month in which benefits are to remain active
- There is a 3-month maximum on eligibility continuance per calendar year.

It is the MEMBERS RESPONSIBILITY to be aware of your eligibility status. You can contact our office at any time to check on your eligibility bank and it is strongly advised at time of layoff.

Reinstatement

If your coverage has previously terminated because of insufficient funds in your Dollar Bank Account, or due to administrative suspension for not meeting the requirements of a member in good standing as per the Uniform Local Constitution (article III- membership), you will again become covered on the first day of the month following the accumulation of 1 month of coverage costs in your Dollar Bank Account or reinstatement as a member in good standing.

Termination of Coverage for Active Members

The coverage for you and your eligible dependents will terminate on the earliest of the following dates:

- The last day of the month in which you have less than one months of coverage cost in your Dollar Bank Account.
- On the day you cease to be a member in good standing as per the Uniform Local Constitution (article III – membership), including suspension for non-payment of dues.
- If you transfer to another Liuna Local, your group benefits will cease on the day of transfer. Any funds in your eligibility bank may be transferred to your new local by signing a reciprocal agreement, and will otherwise be held for a period of up to one year, at which time any funds will be credited to the general reserves of the fund.
- If you enter Military Service.
- If the Group Policy terminates.
- If you discontinue any required contributions.
- If you retire, and have insufficient funds in your Dollar Bank Account.
- The date outlined in the Summary of Benefits.
- A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Termination of Coverage for Unemployed Members who have insufficient funds in their Dollar Bank Account to maintain coverage.

Your coverage will terminate on the earliest of the following dates:

1. the date you are no longer actively seeking work through LIUNA Local 493 by being registered on the out-of-work list of the Union.
2. If you cease to be a member in good standing as per the Uniform Local Constitution (article III – membership).
3. If you enter Military Service.
4. If the Group Policy terminates.
5. If we do not receive any contributions for a period of one year.
6. The date outlined in the Summary of Benefits.

Extension of Coverage

If you are absent from work due to injury and are receiving Workers' Compensation benefits, your Welfare Plan dollars bank account will be frozen, and you and your eligible dependents will remain covered while you are in receipt of Workers' Compensation, up to a maximum of 12 months. Coverage ceases on the earlier of (i) one year following the date of injury; or (ii) the date you are no longer receiving Workers' Compensation Benefits. It is the responsibility of the member to notify the plan administrator directly within 30 days, and supply evidence that you are in receipt of WSIB benefits, the date of disability and, if known, the expected date of your recovery, to avoid being overlooked.

Eligible Dependents

Eligible dependents under this plan shall include:

- Unmarried children from live birth who are under age 22. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Coverage is continued while the child is under age 25 and attending an accredited college or university on a full-time basis. You must provide annual confirmation that the child is a full-time student and remains dependent on you for support and maintenance; and
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was covered as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act;

who are resident in Canada.

- A child of your spouse provided,
  - i. he/she is also your biological child; or
  - ii. your spouse is living with you and has custody of the child.

- Your spouse as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum of 24 consecutive months immediately prior to the date on which a claim arose and provided the existence of such continuous common-law relationship can be established by public representation, and ceases on the date the co-habitation ends.
  Separated spouses shall be removed only with written permission from spouse or by court order. Divorced spouses are not eligible for coverage.

No one will be eligible as a dependent while in military service.

nexgenRx

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund

Active Members Dental, Drug, and Extended Health Care Benefits - Class A

Policy / Contract #: NexgenRx 3037

Contract Effective Date: 01Jan18
Booklet Production Date: 07Nov17

CONTACT INFORMATION

NexgenRx Inc. administers your Dental, Drug, and Extended Health Care Benefits

Member Support is available from
8:30am to 10:00pm E.S.T.
866-424-0257

Pharmacy and Dental Office support for electronic submission is available from 8:30am to 10:00pm E.S.T.
866-394-3648

INTRODUCTION

Your Union, Labourers Local 493 Welfare Trust Fund and NexgenRx Inc. have worked together to develop a package of benefits to meet your needs. These benefits are an important part of your financial security provided by your Union.

The goal is to make it easy for you and your family to have your questions answered. If you have any questions about your benefits, you can ask your Union, or call NexgenRx Inc. on our toll-free at line 1-866-424-0257or if calling in the Toronto area 647-722-3046.

Why is this booklet important?
This booklet outlines the benefits that are available under your Union's contract with NexgenRx Inc. The section called "General Terms" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides and what you are not covered for.

Please remember that this booklet is a summary of your benefit details effective January 1, 2018.

If you have any questions about the details in this booklet or about your group health benefits please contact your local benefits administrator or call NexgenRx Inc.

If there are variations between the information contained in the booklet and the provisions of the contract and plan document, the contract and plan document will prevail.

DEFINITIONS

Here are definitions for some of the terms in this booklet. You will find more definitions included in each section.

Co-Insurance: Co-insurance is the rate at which benefits are payable.

Child: A child is your unmarried son or daughter. This includes a step-child, foster child and a common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance.

- A child must be under age 22 ,and dependent on you for support and maintenance
- Coverage is continued while the child is under age 25 and attending an accredited college or university on a full-time basis. Upon request you must provide confirmation that the child is a full-time student and remains dependent on you for support and maintenance
- Coverage is continued beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as the child became handicapped before reaching the applicable maximum age stated above, and you provide proof satisfactory to us that the child is not capable of self-support due to the handicap

Dependent: A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Emergency: An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Family: A family is you and all your dependents that are covered under the contract.

Covered Person: Covered person means you or any one of your dependents who is covered under the contract.

Spouse: A spouse is a person to whom you are legally married or with whom you have a common-law spouse relationship. Common-law spouse means a partner whom you have lived with for at least 24 months. The maximum number of spouses that can be covered at one time is 1.

Confirming Your Coverage

When your coverage begins, you will receive a NexgenRx Inc. Benefit Card outlining your coverage. Upon receipt, please check the card to make sure the information is correct.

What Changes To Report To Your Union / NexgenRx Inc.?

You must report the following changes immediately to your Union:

- changes in dependent coverage, including the birth of a child
- change of spouse. Separated spouses may be removed with the consent of the spouse or by court order (divorced spouses are NOT eligible for coverage). Separated common-law spouses are NOT eligible for coverage and coverage will cease on the date co-habitation ends
- change of name
- change from single or family status
- change of banking information (if NexgenRx Inc. is depositing your claim expenses directly into your bank account). You may also update your banking information on line.

You report these changes by advising your Union of any changes in your coverage needs such as a change from single to family status.

Legal Action

No legal action may be taken until 60 days after proof of claim is given to NexgenRx Inc. or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

SUBMITTING CLAIMS

All claims should be submitted immediately after the expense is incurred but not more than 12 months from the date of service.

Should the contract terminate with NexgenRx, you have 90 days from the termination date to submit any claims incurred during the period you were covered under the plan.

Co-ordination of Benefits with Your Spouse's Plan

Co-ordination with your spouse's plan is one of the advantages of group coverage. It may allow you to receive up to 100% of Health Care costs. First, you must have family coverage that includes Health Care coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage.

Claiming Your Spouse's Expenses

If you are claiming your spouse's expenses, a claim must be sent to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a completed claim form for the unpaid portion, to NexgenRx Inc.

Claiming Your Child's Expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

1. If you are separated or divorced, claims for your child's benefit must be co-ordinate based on the standard industry guidelines. Please refer to CLHIA – Co-ordination of Benefits guide… http://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_To_CoOrdinationBenefits_ENG.pdf

Claiming Your Expenses

If you are claiming your expenses, the claim must be sent to NexgenRx Inc. first. NexgenRx Inc. will pay for the portion of the claim that is covered by your plan and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim form for the unpaid portion, to his/her group carrier.

Should the contract terminate with NexgenRx, you have 90 days from the termination date to submit any claims incurred during the period you were covered under the plan.

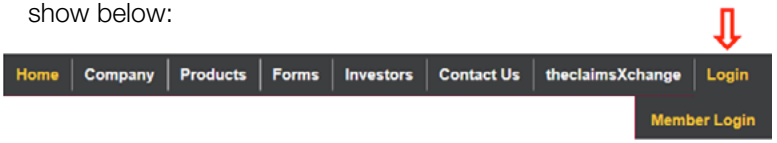
Submitting Your Claims on the Web

Members have the option to submit claims on our secure website. Please note when using the web claims submission, you must be set up on our system for Direct Deposit for your claims reimbursement. You must also keep the original copies of your receipts for 18 months from the time you submit your claim on line for audit purposes.

As a plan member, NexgenRx Inc. provides you with access to our claims processing website to look-up the status of your claims anytime you wish. In order to access our secure, online administration and information website please follow these instructions:

FIRST TIME USERS:

2. Go to the following Web address: www.nexgenrx.com
3. Click on **MEMBER LOGIN** at the top right-hand side of screen as show below:



Please note that **FIRST TIME USERS** must complete all steps in order to use their account and subsequently logon to the website.

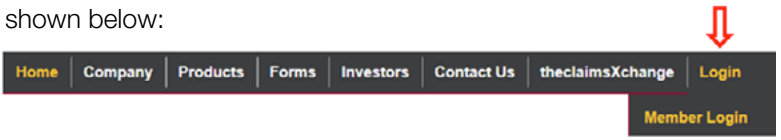
Your **USERNAME** and **TEMPORARY pass phrase** are automatically generated by our system and included in your welcome kit.

- After clicking on the **ACTIVATE ACCOUNT** button under the **Activate Your Account** section, the system will take you to the Account Activation Screen.
- Read the information and click **NEXT**.
- Review the Terms of use and click the checkbox at the bottom of the screen to accept the terms.
- Click **NEXT**
- This will take you to the **VERIFICATION OF IDENTITY** screen.
- Fill in the fields on this screen that are noted with an asterisk, i.e. **USER NAME** and temporary **PASS PHRASE**; click **NEXT.**
- The system will take you to the **ACCOUNT SETUP** screen.
- Complete all fields. Select a **NEW** password of your choosing **(it must be at least 8 characters in length)** and confirm your newly selected password by entering it again. Complete the challenge question, challenge answer section and enter your email address. Click **NEXT**.

- The system will now confirm that your account has been activated. **The next time you log in, enter your user name and pass phrase under the SIGN IN heading.**
- Click **FINISH**. This will take you back to the main login screen.
- You may now login using your username and the **NEW** password that you have selected.
- Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
- Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

EXISTING USERS

1. Go to the following Web address: www.nexgenrx.com
2. Click on **MEMBER LOGIN** at the top right-hand side of screen as shown below:



3. Enter your pre-assigned user name and personal secure pass phrase under the **SIGN IN** heading.
4. Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
5. Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

How to submit a paper claim

Complete the claim form that is available from our NexgenRx Inc.'s web site, www.nexgenrx.com

Make sure that your receipts include:

- the name of the person who received the service or supply (referred to as "the patient")
- the date the service or supply was received
- the type of service or supply received and
- the cost paid

Mail your claim to: Local 493 Benefit Services
584 Clinton Ave
Sudbury, ON P3B 2T2

YOUR HEALTH CARE COVERAGE

Your plan will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy and incurred in Canada by a recognized practitioner / provider.

It will cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care and the Canada Revenue Agency
- Services and supplies that private plans are legally allowed by the government to cover. The plan will not cover services or supplies that are covered by the government plan in your home province
- Charges for services and supplies that are incurred while the person is covered under this plan

YOUR HEALTH CARE COVERAGE (SUMMARY)

Extended Health Care	
Deductible	None
Maximum Dispensing Fee Allowed	$10 per prescription
Coinsurance	
Drugs	100% for Generic equivalent.drugs and certain Brand name drugs up to $10,000, then 80% up to $25,000 per person per calendar year. 75% for certain Brand name drugs up to $10,000, then 60% up to $25,000 per person per calendar year
Extended Health Care	75% for laser eye surgery, 80% for hearing aids and 100% for all other eligible services/supplies
Drug Annual Maximum	$25,000 per person per benefit year
Extended Health Care Annual Maximum	Unlimited overall maximum with inner limits on certain benefits; please refer to the Extended Health Care section of this booklet for details
Supplementary Medical	
Paramedical Practitioners	$750 per person per calendar year for all practitioners combined

Extended Health Care

Supplementary Medical	**(continued)**
Vision Care (Eyewear) Maximum	Combined maximum of $500 per person every 24 months toward eye exams, prescription eyeglasses &/or contact lenses, prescription sunglasses and safety glasses
Laser Eye Surgery Maximum	$1,000 per eye per person's lifetime
Nursing Care (at home) Maximum	$10,000 per person per calendar year
Dental Accident	$5,000 per accident
Convalescent/Rehabilitative/ Chronic Care	$25 per day for semi-private room to a maximum of 120 days
Orthopedic Shoes and Custom Made Orthotics Maximum	Combined benefit of $300 per person per calendar year (Must be prescribed by a Physician, Podiatrist or Chiropodist)
Hearing Aids Maximum	$500 per person every 36 months
Medical Supplies (medically necessary services and supplies)	Post cataract surgery frames/lens, contact lens or prosthetic lens (Once per lifetime per eye); Breast prostheses (one every 2 calendar years); Surgical bras (One every 3 months); Surgical/ support/compression hose (4 pairs per calendar year); Wigs ($200 per person's lifetime); CPAP machine and supplies (masks are limited to 2 per calendar year up to a maximum of $350)

Dental

Deductible	None
Coinsurance	
Basic	80%
Major Restorative	80%
Orthodontia	50%
Maximums	
Basic & Major Restorative	Combined maximum of $2,000 per person per calendar year
Orthodontia	$2,000 lifetime maximum
Recall Exams	Once every 6 months
Fee Guide	Current Provincial General Practitioners and Specialists

DRUG BENEFIT

What You Are Covered For and How Much the Plan Will Pay

The plan has no deductible.

The benefit year is August 1 to July 31 each year.

The plan pays as follows for eligible expenses:

- Eligible single-source brand name drugs, generic drugs, and any prescriptions where the prescribing physician states 'no substitution' on a multi-sourced brand name drug, are payable at 100% up to $10,000; the plan will then pay 80% from $10,000 to $25,000
- All other eligible brand name drugs are payable at 75% up to $10,000 and then 60% from $10,000 to $25,000

The annual maximum is $25,000 per person per benefit year.

The plan has the following inner limits:

- Prescribed smoking cessation products are covered at 2 courses of treatment per person every 3 benefit years to a maximum of $1,000
- Oral contraceptives are covered to a maximum of $400 per person per benefit year
- Oxycotin (and drugs containing Oxycotin) are covered to $500 per person per benefit year
- Sclerotherapy related drugs are covered to a maximum of $20 per person per treatment
- Methadone (and any drug containing any form of methadone) is payable at 100% to a maximum of $2,000 per person per benefit year. Once $2,000 is reached, the plan will cover 50% of the eligible cost
- Immunizations and Vaccines (oral or injected) require a physician's referral

Covered expenses under the drug plan include both the ingredient cost and the dispensing fee. The plan covers up to $10 of the dispensing fee. Pharmacies charge varying levels of dispensing fees and it is in your own best interest to find a pharmacy that will accept this amount as full payment.

The plan pays for most drugs that legally require a written prescription and some life sustaining Over-The-Counter drugs (OTCs). Examples of these OTC items include insulin, diabetic test strips, disposable insulin needles and syringes, oral potassium supplements, Epi-Pen, nitroglycerin, low dose aspirin for blood thinning, niacin for cholesterol lowering, vitamin B12 for certain types of anemia.

The plan covers up to a 34-day supply of acute drugs, and up to a 100-day supply for maintenance drugs.

You and your Dependents can use the NexgenRx Inc. drug card to purchase eligible drugs. Use of the NexgenRx Inc. drug card authorizes NexgenRx Inc. or their authorized agent, to inform pharmacists and physicians on patient safety issues for you and your dependents. NexgenRx Inc. and its authorized agents are not legally liable for this information

You and your Dependents may not be able to use the NexgenRx Inc. drug card to purchase drugs from a physician, dentist, clinic, hospital, or some pharmacies, but you can make a claim for the cost of eligible medicines by using a claim form and attaching the original receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN)

If your NexgenRx Inc. drug card is lost or stolen, it must be reported immediately to your Union.

You and your Dependents cannot use the drug card to purchase the following items:

- alcohol swabs
- appliances
- atomizers
- certain equipment
- ostomy supplies
- devices for giving inhaled medications (for example, an aero chamber), blood glucose monitor and prosthetic devices

We will not pay for the following:

- fertility drugs
- hair growth stimulants
- alcohol
- bandages
- contraceptives, other than birth control pills
- cosmetic items
- sunscreens
- cotton
- vitamins (except some injectable items), minerals, dietary supplements food substitutes, infant food or formula
- disinfectants
- homeopathic medicines
- non-disposable insulin injectors
- products which can be bought without a prescription, other than some life supporting products
- spring loaded devices used to hold lancets
- over-the-counter medications, vitamins and supplements, even if prescribed by a medical practitioner
- prescription drugs and medications acquired unlawfully for use or prescribed by a non-medical practitioner

EXTENDED HEALTH CARE (EHC) BENEFIT

The plan has no deductible.

The benefit year is January 1 to December 31 each year.

The plan pays 75% toward laser eye surgery, 80% for hearing aids and 100% for all other eligible expenses.

Although the plan has an overall unlimited annual maximum, maximums do apply to some benefits. Please refer to each benefit section.

Hospital Accommodation
For "in province" hospital services, the plan will cover the difference between the cost of a ward and a semi-private room in a hospital for a maximum of 120 days. Room charges for outpatient treatment will not be covered.

The hospital stay must be because of illness, injury or pregnancy and the patient must be confined on an in-patient basis.

Vision Care
The plan will cover eye examinations, prescription eyeglasses, contact lenses, prescription sunglasses and safety glasses to a combined maximum of $500 per person every 24 months.

Laser eye surgery is covered to a maximum of $1,000 per eye per person's lifetime.

Paramedical Practitioner Services
The plan will pay an overall annual maximum of $750 per person per practitioner. The plan will pay for the following:

- Chiropractors
- Osteopaths
- Podiatrists/Chiropodists
- Acupuncturists
- Naturopaths
- Physiotherapists
- Speech Therapists
- Massage Therapists *Limit of $75/visit. Physician's referral is required*
- Psychologists
- Correactologists

These practitioners must be registered in the province where the service is given, be performing a service for which their registration applies and cannot be a person who normally lives with you nor be a person related to nor a member of your immediate family.

The plan will cover up to $20 per person per calendar year toward the cost of x-rays by a Chiropractor.

Registered Nurses
The plan will cover these services to a maximum of $10,000 per calendar year.

Services provided by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse must be approved by NexgenRx in advance. These services must be provided in the insured person's home by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

The plan will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a Registered Nurse, Registered Nursing Assistant, or Registered Practical Nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

Ambulance Services
The plan will cover the cost of a licensed ambulance or other emergency service, (including air ambulance), that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals.

The plan will cover up to $200 per person per calendar year toward local ambulance service. There is no limit on emergency air ambulance service.

Convalescent Care
The plan will pay for active treatment or convalescent care in a Rehabilitative, Convalescent or Chronic Care Institute when prescribed by a physician, up to $25 per day for semi-private accommodation for a maximum of 120 days per calendar year.

Miscellaneous Services
The plan will pay for out-patient services from a licensed hospital and for certain diagnostic tests, radium treatments and x-rays from a licensed facility in your home province.

Medical Equipment
The plan covers the cost of out-patient supplies obtained from a hospital or surgical supply company in your home province. It will also cover the cost of rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that NexgenRx approves. It may cover the cost of purchasing this equipment if NexgenRx &/or LiUNA Local 493 determines

that it is more economical than renting. NexgenRx &/or LiUNA Local 493 must approve the purchase before it is made. The plan will pay a reasonable and customary fee for the least expensive device that is medically adequate.

The following is a list of eligible items that the plan will cover if prescribed by a physician and approved by NexgenRx &/or LiUNA Local 493:

- Artificial limbs and eyes and other approved prosthetic devices
- Bathroom Aids (including grab bars)
- Bed Wetting Device
- Blood Glucose monitors
- Blood Pressure Kit
- Braces, rigid or semi-rigid
- Breast prostheses after a mastectomy, including replacement(s), one every 2 calendar years and one surgical bra every 3 months
- Burn Garments
- Casts
- Caster Cart
- Casto Kit
- Custom made orthopedic shoes and custom-made orthotics prescribed by a Physician, Podiatrist or Chiropodist, providing the diagnosis and deemed necessary for everyday living and not just for sports and recreation, and dispensed by a Podiatrist/Chiropodist, Orthotist, or Pedorthist. The plan covers up to a combined maximum of $300 every calendar year, from the last date of purchase, for the member and his/her dependents. Proof of a biomechanical assessment/ gait analysis performed by a licensed practitioner is required. The cost of adjustments/ modifications are also covered and such costs are included in the combined annual maximum stated
  - Note: supporting documentation is required. Please contact your Benefits Coordinator or NexgenRx Inc. to find out how to submit orthotic claims
  - Orthopedic shoes or Orthotics prescribed or dispensed by a Chiropractor or Physiotherapist are not eligible under the plan
- Custom supplies for cystic fibrosis, parkinsonism, diabetes and heart disease
- Electro Magnetic Bone Healing System
- Femtens
- Gastrotomy
- G-Button
- Hearing aids and repairs (excluding batteries) up to a maximum of $500 every 36 months
- Hospital beds, wheelchairs and other temporary therapeutic

equipment that is deemed medically necessary. Rental only unless it is more economical to purchase such equipment
- Home/Car Modifications
- Humidifier
- Initial pair of frames and one corrective lens, contact lens or prosthetic lens prescribed after cataract surgery for the eye that had the surgery, once per lifetime per eye
- Intra Uterine devices (IUDs) and Diaphragms
- Jobst Sleeves
- Jobst Extremity Pump
- Laryngeal Speaking Aids
- Lymph Press
- Maclaren Buggy/Convaid Cruisers
- Medix
- Mini Standy
- Mobile Aids (including walkers, crutches and canes)
- Mobile Aid Supplies
- Muslab II
- Ortho-Kinetics
- Orthopaedic pillows
- Ostomy/Ileostomy/Colostomy supplies
- Palco Alarm
- PEP Therapy
- Pessary
- Prosthetic Supplies
- Prosthetic Repairs
- PSA tests
- Punctal and Punctum Plugs
- Respiratory equipment & supplies such as Aero Chambers, Apnea Monitors, CPAP machine & supplies, Compressors, Nebulizers to administer asthma medication and Oxygen & Oxygen equipment
- Titanium
- Heel Lifts
- Extremity Pump for Lymphedema
- Trapeze bar
- Seating Device
- Spatula
- Speech Aids
- Splints
- Sphygometer
- Synvisc or Neovisc
- Suction Unit
- Surgical or support stockings or compression hose up to 4 pairs every calendar year
- T.E.N.S. machine (for chronic pain)
- Wigs following chemotherapy or radiation up to $200 per person's lifetime

DENTAL ACCIDENT

The plan will cover eligible services to a maximum of $5,000 per accident.

If healthy, natural teeth are damaged or lost due to a sudden impact, the plan will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while you or your dependent are covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount payable will pay is based on the least expensive treatment that is adequate to correct the damage. No more than the fee stated in the current Dental Association General Practitioner's Fee Guide will be covered. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, NexgenRx must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing cross bites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

What You Are Not Covered For

The plan will not pay for the cost of:

- health care services or supplies that you or your Dependents are eligible to claim under Workers' Compensation legislation in your province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the you or your Dependent is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, your employer, a school or anyone other than your physician (for example, your employer requiring a doctor's note or a court requiring that you receive psychological services)
- treatment on temporomandibular joint (the hinge joint of the jaw)

- any service and supplies for which the you or your Dependent would not normally be charged
- cosmetic treatments
- any service that we are legally prohibited from paying

When Your Dental Treatment Will Cost More Than $600

If the cost of any dental treatment will be more than $600, NexgenRx Inc. recommends that you submit a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. NexgenRx Inc. will determine how much of the treatment is covered before the treatment begins and give you a written estimate of how much you will be responsible to pay before the treatment begins.

If you do not submit a pre-determination prior to the treatment being performed and submit the claim post treatment, your claim may be delayed in processing. In order to assess whether the treatment will be allowed, NexgenRx Inc. may need to obtain x-rays and/or study models from your dentist. This process may also delay your claim assessment.

What You Are Covered For and How Much the Plan Will Pay

The plan has no deductible.

The benefit year is January 1 to December 31 each year.

The plan does have co-insurance as described in the following section. Note that the amount payable is a percentage (as outlined below) of the current Dental Association Suggested Schedule of Fees for General Practitioners and Specialists of the province in which the treatment is performed.

Orthodontics are covered to a lifetime maximum of $2,000 per person for dependent children to age 25.

The plan has an annual combined maximum of $2,000 per person per calendar year for eligible basic and major services. This maximum applies to the following:

- Diagnostic services
- Preventative services
- Basic Restorative services
- Endodontic services
- Periodontic services
- Basic Surgical services
- Major Restorative Services
- Major Surgical Services

Diagnostic Coverage (covered at 80%)
Diagnostic services include items such as oral exams and x-rays

Preventive Coverage (covered at 80%)
Preventive services include items such as scaling and polishing

Basic Restorative Coverage (covered at 80%)
Basic Restorative services include items such as fillings

Endodontic Coverage (covered at 80%)
Endodontic services include items such as root canal therapy

Periodontic Coverage (covered at 80%)
Periodontic services include items such as treatment of the gums

Basic Surgical Coverage (covered at 80%)
Basic Surgical services include items such as tooth extractions

Major Restorative Coverage (covered at 80%)
Major Restorative services include items such as crowns, dentures and bridges

Major Surgical Coverage (covered at 80%)
Major Surgical services include items such as extensive surgical procedures

Orthodontic Coverage (covered at 50%)
Orthodontic services such as braces

Alternate Benefit Clause
Coverage is based on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, the plan will only cover the cost of the least expensive treatment. This rule does not apply to basic restorative fillings.

Limitations

- Oral hygiene instruction is covered once per person's lifetime
- Fluoride treatments are limited to once every 6 months
- Recall exams, scaling and polishing are limited to once every 6 months
- Bitewing x-rays are limited to once every 6 months
- Full Mouth Series X-rays or a Panoramic X-ray are limited to once every 36 months
- Scaling (root planning) are payable up to 6 units every calendar year
- White (composite) fillings are covered on all teeth (except for molars)

- Space maintainers and habit breaking appliances are covered for dependent children to age 25
- Replacement of removable dentures and bridgework are eligible only:
  - if a natural tooth is extracted and the existing appliance cannot be made serviceable
  - when it is 5 years old and cannot be made serviceable
  - if the existing appliance is temporary and is replaced with the permanent denture within 12 months of its installation

What You Are Not Covered For

The plan will not pay for:

- Dental services or supplies that the insured person is eligible to claim under the Workers' Compensation legislation
- Any dental charges not included in the current Dental Association Suggested Schedule of Fees for General Practitioners, Dental Specialists, Denturists or Hygienists.
- Cosmetic procedures
- Charges for appointments that are not kept
- Charges for completing claim forms
- Treatment to correct temporomandibular joint dysfunction (the hinge joint of the jaw is called the temporomandibular joint)
- Any endodontic treatment which was started before the effective date of coverage
- The replacement of dental appliances that are lost, misplaced or stolen
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw)

Sun Life Financial

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund

Active Member Short-term Disability Long Term Disability and Group Life Insurance

Policy / Contract # 102606 and 151606
Effective: January 1, 2018
Issued: January 3, 2018

CONTACT INFORMATION

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-800-361-6212.

For faster service, have your group contract number and member ID ready to enter into our automated telephone system.

All other inquiries
Call 1-877-SUN-LIFE (1-877-786-5433).

BENEFIT SUMMARY

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

GENERAL INFORMATION

We, our and us	Throughout this booklet, we, our and us mean Sun Life Assurance Company of Canada
Waiting period	The first day of the month following the month in which there is an accumulation of one month of coverage cost in the member's Dollar Bank Account. Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the General Information section of this booklet.

SHORT-TERM DISABILITY - CONTRACT NUMBER 151606

Maximum amount	$400 The maximum amount may be reduced by benefits and payments provided from other sources as described in the Short-Term Disability section of this booklet
Elimination period	Accident – none Illness – 7 days of uninterrupted total disability or the period up to the day you are hospitalized, whichever is shorter. To be considered hospitalized, you must have either: • been admitted in a hospital overnight as an in-patient • been admitted in a hospital as an outpatient and have undergone a surgical intervention • undergone a procedure under general or epidural anaesthesia in either a hospital, medical clinic or doctor's office
Maximum benefit period	26 weeks However, payments will not be made from the 2nd week up to the 16th week of total disability when employment insurance benefits are payable Benefits may also end on an earlier date as specified in the Short-Term Disability section of this booklet
Termination	When you retire
Tax status	Since your employer is paying all or a portion of the cost of this disability plan, the benefit payments are taxable income

LONG-TERM DISABILITY - CONTRACT NUMBER 102606

Maximum amount	$1,000 The maximum amount may be reduced by benefits and payments provided from other sources as described in the Long-Term Disability section of this booklet
Elimination period	26 weeks
Maximum benefit period	The period ending on the last day of the month in which you reach age 65. Benefits may also end on an earlier date as specified in the Long-Term Disability section of this booklet
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier
Tax status	Your employer has indicated that it is paying all or a portion of the premium for this disability plan. Therefore, the benefit payments are taxable income.

LIFE - CONTRACT NUMBER 102606

Employee Life

Amount	$100,000
Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

Dependent Life

Amount	Spouse – $10,000 Child – $5,000
Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

ACCIDENTAL DEATH AND DISMEMBERMENT - CONTRACT NUMBER 102606

Employee Accidental Death and Dismemberment

Amount	Equal to Employee Life coverage
Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

EMPLOYEE ASSISTANCE PROGRAM

included

MAKING CLAIMS

There are time limits for making claims. You can find more on these time limits in the following chart. If you fail to meet these time limits, you may not be entitled to some or all benefit payments.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Short-Term Disability	Ask your employer for the claim forms, and ensure that the following people complete them: • you, • your attending doctor, and • your employer	Up to 30 days after your total disability begins. We will assess the claim and send you or your employer a letter that outlines our decision. From time to time, we can require that you provide us with proof of your continued total disability. We must be provided with this information within 90 days of the request.
Long-Term Disability	Ask your employer for the claim forms, and ensure that the following people complete them: • you, • your attending doctor, and • your employer. The submission of these forms is your proof of claim.	You should submit your proof of claim at least 8 weeks prior to the completion of your elimination period, but in no event later than 90 days after the end of your elimination period. If your Long-Term Disability coverage terminates, you must advise us of the claim within 30 days of the date the coverage terminates. We will assess the claim and send you or your employer a letter outlining our decision. From time to time, we can require that you provide us with proof of your continued total disability. We must be provided with this information within 90 days of the request.

Type of claim	Starting the claims process	Limits and special instructions
Life and Accidental Death and Dismemberment coverage	Ask your employer for the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred. **For any loss other than death:** We must receive the claim form within 12 months after the loss. **For coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

GENERAL INFORMATION

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies.

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to your employer.

Your Group Benefits

The contract holder, Labourers' Local 493 Welfare Trust Fund, self-insures the Short-Term Disability benefit. This means Labourers' Local 493 Welfare Trust Fund has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.

Legal actions for insured benefits
Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

Limitation period for any other province:
Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation of your province or territory.

Legal actions for self-insured benefits
Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms or within one year of the date we stop paying disability benefits. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Proof of disability
From time to time, Sun Life can require that you provide us with proof of your continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Medical examination
We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

Recovering overpayments
If we have overpaid any amount of benefit, we have the right to recover this money. We will:
- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments
For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

DEFINITIONS

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

Accident - An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

Appropriate treatment - Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Doctor - A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

Illness An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Retirement date - If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Sun Life Financial

Short-Term Disability Insurance

Sunlife Financial Policy / Contract #151606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE COVERAGE

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

Short-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you present proof of claim acceptable to Sun Life that confirms both of the following:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since it started.

For the purposes of your Short-Term Disability coverage, we will consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with your employer or with another employer. The availability of work with any employer does not affect the determination of total disability.

We will base your benefits on your coverage on the date you became totally disabled. We pay benefits at the end of each week for which you are entitled to payments.
See the table Instructions and Time Limits for Sending Us Your Claims at the beginning of this booklet for information about when and how to make a claim.

When disability payments begin

If you become totally disabled because of an accident or illness, you will be eligible for Short-Term Disability payments on the later of the following:

- after you have been totally disabled for the number of days indicated in the Benefit Summary (elimination period), or

- the first day you consult a doctor.

If benefits are payable for part of any week, we will pay 1/7 of the weekly benefit for each day you are entitled to a payment.

What we will pay

Here is how we calculate your Short-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions.

Step 1:

We take the maximum amount indicated in the Benefit Summary.

Step 2:

We subtract any benefits or payments provided:

- under a motor vehicle insurance plan.
- under a group plan, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan.
- as part of a salary continuance received from your employer during your disability.
- under the Québec Parental Insurance Plan.

After the first 17 weeks of total disability, when the maximum benefit period is more than 17 weeks, we also subtract any benefits or payments provided:

- under any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding all benefits or payments on behalf of a dependent, for the same or a subsequent disability.
- under a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- under any coverage resulting from your membership in an association but excluding any benefits or payments provided under a Critical Illness plan.

The result from Step 2 is the amount you will normally receive.

However, if this amount plus the above sources of benefits and payments is more than 85% of your basic earnings when your disability began, we will reduce your Short-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Important to remember:

- If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Short-Term Disability payments.

- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Short-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous total disability as long as the disability reoccurs within 2 weeks of the end of your previous disability. We will base these benefits on your coverage as it existed on the original date of total disability and will pay them for no longer than the rest of the maximum benefit period.

Rehabilitation program

Sun Life may require you to participate in a rehabilitation program that we have approved in writing.

This may include one or more of the following:

- consulting our rehabilitation specialist,
- part-time work,
- working in another occupation or vocational training to help you become capable of full-time employment.

During your rehabilitation program, you may receive Short-Term Disability payments plus income, benefits and payments from other sources.

However, if during any week the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, your Short-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

When payments end

Your Short-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the date you retire on pension.
- the date you die.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks due to any reason.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay if benefits are payable to you under any Workers' Compensation Act or similar legislation.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

Sun Life Financial

Long-Term Disability Insurance

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE COVERAGE

Long-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that confirms both of the following:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since it started.

For the purposes of your Long-Term Disability coverage:

- during the elimination period and the following 24 months (this period is known as the own occupation period), we consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with your employer or with another employer, and
- afterwards, we will consider you to be totally disabled while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are or may become reasonably qualified by education, training or experience.

The availability of work with any employer does not affect the determination of total disability.

We pay these benefits at the end of each month. We base them on your coverage on the date you became totally disabled.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

When disability payments begin

Your Long-Term Disability payments begin on the later of the following dates:

- after you have been totally disabled for the uninterrupted period indicated in the Benefit Summary.
- after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan.

This period, which must be completed before disability benefits become payable is called the elimination period.

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions.

Step 1:
We take the maximum amount indicated in the Benefit Summary.

Step 2:
We subtract any benefits or payments provided under:

- any Workers' Compensation Act or similar law for the same or a subsequent disability.

The result from Step 2 is the amount you will normally receive.

Take the result you got in Step 2, add the above sources of benefits and payments plus the other sources of benefits and payments listed below and check the total you get. If it's more than 85% of your basic earnings when your disability began, we will reduce your Long-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Other sources of benefits and payments:

- any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding any benefits or payments on behalf of a dependent, for the same or a subsequent disability.
- a motor vehicle insurance plan.
- a group plan, including any coverage you have because you are a member of an association but excluding any benefits or payments provided under a Critical Illness plan.
- a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- the Québec Parental Insurance Plan.
- any Criminal Injuries Compensation Act or similar law.

Important to remember:

- If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Long-Term Disability payments.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Long-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date you become totally disabled.

Rehabilitation / Partial disability program

Sun Life may require you to participate in a partial disability or rehabilitation program that we have approved in writing.
This may include one or more of the following:

- consulting our rehabilitation specialist,
- part-time work,
- working in another occupation or vocational training to help you become capable of full-time employment.

During your rehabilitation program, you may receive Long-Term Disability payments plus income, benefits and payments from other sources.

However, if during any month the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, indexed for inflation, your Long-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

You should consider participating in a partial disability or rehabilitation program as soon as possible after becoming disabled. If you enter a partial disability or rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Your participation in a partial disability program will be limited to the own occupation period.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

For disability benefits paid or payable prior to the date of judgment or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a judgment or settlement, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits.

Refer to your group contract for more information.

What you are responsible to do

During your total disability, you must make reasonable efforts to do all of the following. If you do not, Sun Life may hold back or discontinue benefits.

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 24 months that benefits are payable.
- receive training to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to get work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

When payments end

Your Long-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off.
- you are absent from Canada longer than 4 months due to any reason.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

Waiver of premium

Long-Term Disability premiums will be waived while you are receiving Long-Term Disability benefits.

Sun Life Financial

Life Insurance

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE COVERAGE

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.
See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay

If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us.

If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

If a dependent dies, we will pay you the benefit for that dependent.

Fact

There are different rules for designating a minor beneficiary, please refer to your contract for specific information.

Coverage during total disability

Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is

earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Important *- There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact your employer for details.*

Converting Life coverage

If your Life coverage or your spouse's Life coverage ends or reduces for any reason other than your request, you or your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends because your Life coverage has ended, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days that the Life coverage reduces or ends.

Important *- There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.*

Sun Life Financial

Accidental Death and Dismemberment

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE COVERAGE

Accidental Death and Dismemberment coverage provides benefits if you die or suffer any of the losses listed in the table under What we will pay, and it is due to an accident that occurs while covered. Any death benefit we will pay under this coverage is in addition to any Life coverage.

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

What we will pay

We will pay this benefit if you are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage, in the table on the following page (p.47):

Remember…

- We only pay the largest percentage for injuries to the same limb resulting from the same accident.
- We will only pay up to 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay up to 200%.
- Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

Table of Losses			
Loss of life	100%	Loss of use of one arm or one leg	75%
Loss of both arms or both legs	100%	Loss of use of one hand or one foot	75%
Loss of both hands or both feet	100%	Loss of entire sight of both eyes	100%
Loss of one hand and one foot	100%	Loss of speech and loss of hearing in both ears	100%
Loss of one hand or one foot, and entire sight of one eye	100%	Loss of entire sight of one eye	75%
Loss of one arm or one leg	75%	Loss of speech	75%
Loss of one hand or one foot	75%	Loss of hearing in both ears	75%
Loss of four fingers on the same hand	33 1/3%	Loss of hearing in one ear	25%
Loss of thumb and index finger on the same hand	33 1/3%	Quadriplegia	200%
Loss of four toes on the same foot	25%	Paraplegia	200%
Loss of use of both arms or both legs	100%	Hemiplegia	200%
Loss of use of both hands or both feet	100%		

Limit on benefit amounts
If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of $3,000,000 for all claims related to the accident.

Additional benefits
In addition to your Accidental Death and Dismemberment payment, we also offer additional benefits if you die or suffer a loss as a result of an accident. **There are specific conditions that apply to each benefit and you can get more information about when these benefits apply from your employer or Sun Life.**

Repatriation benefit: Pays up to $10,000 for the return of your body if you die 100 kilometres or more away from your home.

Rehabilitation program: Pays up to $10,000 of your expenses in a rehabilitation program.

Spouse occupational training benefit: Pays up to $5,000 to your spouse for occupational training if you die.

Child education benefit: Pays 5% of the amount of coverage up to $5,000, each year up to a maximum of 4 years, to cover a dependent child's tuition fees in a post-secondary school if you die.

Family transportation benefit: Pays up to $5,000 for hotel accommodations and travel costs of an immediate family member if you are hospitalized 150 kilometres or more away from home.

Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, this coverage will continue without the payment of premiums, but not past age 65.

Any amount of continued coverage follows the terms of this group plan when your total disability began.

What is not covered

We will not pay for losses that result from one or more of the following actions:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft.
  - being flown for a parachute jump.
  - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

Converting coverage

If you apply to convert your group Life coverage to an individual Life policy with Sun Life, you may have an Accidental Death benefit attached to the individual Life policy.

Important *- There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.*

Sun Life Financial

Employee Assistance Program

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE PROGRAM

The Employee Assistance Program (EAP) available through your employer as part of your group benefits, gives you access to services performed by Morneau Shepell Ltd. (Shepell). The EAP is not insured by Sun Life. Sun Life only acts as administrator on behalf of the contract holder in providing access to the services available under the EAP.

In this section, you means the employee and all dependents as defined under the group plan.

Immediate, confidential help

Your EAP is a confidential and voluntary support service that can help you with:

- Family and social relationships
- Personal problems
- Dependency issues
- Workplace related issues
- Legal and financial advice*
- Wellness issues
- Crisis

**(does not include employment or workplace issues, criminal law, asset management or accounting services)*

When you call Shepell, your needs will be assessed and a personal support plan will be designed. Your EAP includes:

- Clinically appropriate number of telephone sessions per issue
- Access to e-counselling, First Chat (online secure messaging), MyMigo, video counselling, online group counselling
- Unlimited access to online tools and resources on the EAP website
- 3 in-person counselling sessions per issue

Assistance is available 24 hours a day, seven days a week. For immediate confidential help, you can call Shepell toll-free at 1-855-544-7722.

You can also access EAP services at www.workhealthlife.com/sunlife

Confidential service

Your EAP is completely confidential. Your employer will not be advised that you have used the service unless you choose to tell them.

Cost

There is no cost to use EAP and no claims to submit.

Liability of Sun Life or Shepell

Neither Sun Life nor Shepell will be held liable for any acts or omissions of any person or organization providing services in connection with this program.

Sun Life Financial

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit www.sunlife.ca/privacy.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1 877 SUN LIFE (1 877 786 5433).

CHUBB

LiUNA! LOCAL 493

Critical Illness Program

For the employees of:
Labourer's Local 493 Welfare Trust Fund

Policy Number: CI10519101

Underwritten by: Chubb Life Insurance Company of Canada

Effective Date: 01/01/2018

This information has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada ("Chubb Life"). For ease of reference it contains a brief description only and does not mention every provision of the contract issued.

For the exact provisions applicable, please consult your Employer.

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

ELIGIBILITY

You will be eligible for coverage as per the Eligibility Rules of the Labourers Local 493 Wefare Trust Fund.

INSURED CONDITIONS

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

ADDITIONAL BENEFITS

- Ductal Carcinoma in situ (DCIS) Benefit
- Early Stage Prostate Cancer (T1a or T1b) Treatment
- Hip or Knee Replacement Surgery
- Second Event Benefit

BENEFITS & COVERAGE

Mandatory Coverage

You are covered for a flat amount of $25,000.

BENEFIT PAYMENT

If an Insured is diagnosed with or meets the definition of an Insured Condition or a Partial Payment Benefit condition, after the effective date or latest reinstatement date of coverage, the insurer will pay the applicable benefit.

PARTIAL BENEFITS

Subject to the terms, conditions and other provisions of the policy, the insurer will pay the Partial Payment Benefit as set out below.

Please note that Partial Payment Benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit.

Payment of a Partial Payment Benefit does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

Ductal Carcinoma In Situ (DCIS)
"DCIS" means the diagnosis by a Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the insured is diagnosed with DCIS.

Early Stage Prostate Cancer Treatment
"Early Stage Prostate Cancer (T1a or T1b Treatment" means the diagnosis by a Physician certified as an oncologist of Early Stage Prostate Cancer with one of the following recommended treatments: Prostate Surgery, Radiation Therapy, Chemotherapy, or Hormone Therapy

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the Insured undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment.

No Partial Payment Benefit will be payable unless the Physician has recommended at least one of the above treatments.

Hip or Knee Replacement Surgery
The insurer will pay 10% of the Principal Sum up to a maximum of $10,000 if the insured has undergone surgery to replace either the hip or the entire knee through the procedures set out below:

- Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and biopolar)
- Knee replacement qualifies if all three compartments of the knee (medial, lateral and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.

Hip replacement or knee replacement surgeries must be performed by a Specialist.

Second Event Benefit
If an Insured Person is diagnosed with either of the following Category of Conditions:

- Cancer, or
- Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)

for which the Principal Sum has been paid and an Insured is thereafter considered (by the treating physician) fully recovered and

not actively receiving treatment and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event benefit payable will be equal to the Principal Sum.

In order to be considered an eligible Second Event condition the first event and the second event cannot fall into the same Category of Conditions, except as provided for under Cancer Recurrence.

The Second Event Benefit is payable only once. Payment of the Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit. Following Payment of the Second Event Benefit, coverage under the policy will terminate.

Critical Care Expense Allowance Benefit

If the Insured is diagnosed with, or meets the definition of an Insured Condition, Partial Payment Benefit, or Second Event Benefit, after the effective date or latest reinstatement date of coverage, which results in the Insured incurring any of the following expenses directly related to the diagnosis of an Insured Condition, the insurer will reimburse such expenses, subject to all policy terms and conditions, up to an overall policy maximum of $1,000.00.

1. Services from a registered graduate nurse who is not a family member of the Insured.
2. Transportation costs including; ambulatory fees, taxi, and public transportation to any medical treatments, Physician appointments, and post diagnostic testing appointment.
3. Rental costs of a wheel chair or other approved durable equipment for temporary therapeutic treatment.
4. Drugs or medicines dispensed by a licensed pharmacist, which requires the prescription from the attending Physician, including deductible amounts under other benefit plans.
5. Meals, in hospital, for Insured, plus one attending caregiver, on days where the hospital visit duration is three hours or more.
6. Parking costs at medical facilities such as; hospitals, physician's offices, diagnosis testing facilities.
7. Daycare costs for children at a licensed and registered daycare facility.
8. Pet care costs including day boarding, in home or dog walking, provided by a registered pet care operator.

The insurer may require proof of payment (original receipts) up to one year from the date of submission. Where a portion of reimbursement may be covered under another group health benefits plan an Explanation of Benefits (EOB) must be submitted with the claim.

Benefit Limitations

Benefits are subject to the following limitations and may not be covered under this Critical Care Expense Allowance Benefit:

1. Expenses covered by any governmental health insurance plan in the Insured's province or territory of residence.
2. Expenses covered under any other group health benefits plan; and
3. Expenses must be solely and directly as a result of the diagnosed Insured Condition and must occur within 365 days of the date of diagnosis.

DEFINITIONS OF INSURED CONDITIONS

Alzheimer's Disease: means the diagnosis of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Person exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the activities of daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A physician who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

Aorta Surgery: means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a physician certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign Brain Tumour: means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

Blindness: means the total and irrecoverable loss of sight in both eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A physician certified in ophthalmology, must clinically confirm the diagnosis in writing.

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma (or other AIDS related cancers) and cancer in the

presence of human immunodeficiency virus (HIV).
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth.
- Prostate cancer diagnosed as T1 N0M0 or equivalent staging.
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage, except as provided for under Cancer Recurrence.

A physician certified as an oncologist must confirm diagnosis in writing.

Cancer Recurrence means, if the insured person has already been diagnosed with Cancer and, while insured, a new diagnosis of Cancer is made, a benefit will be paid, subject to all the policy terms and provisions, if the following conditions have been met:
- More than 60 months have passed since the previous cancer diagnosis; &
- No Treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

Coma: means you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A physician who is certified as a neurologist must confirm diagnosis in writing.

Coronary Artery Bypass Surgery: means surgery performed by a physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered Critical Illness.

Deafness: means the diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A physician, who is certified as an otolaryngologist must confirm diagnosis in writing.

Dismemberment: means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Heart Attack: means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a. heart attack symptoms; or

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

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

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

a. elevated biochemical cardiac markers with a:
   ii. Troponin Level of less than 1
   iii. CK-Mb Level of less than 4, or
b. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement: means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist. Exclusion: No benefit will be payable under this condition for heart valve repair.

Loss of Speech: means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Loss of Independence: means the definitive diagnosis by a physician of either:
- Being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,
- Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of Independence must persist for a continuous period of 90 days from the date of the diagnosis with no reasonable chance of recovery as diagnosed by a physician.

Major Organ Failure: means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded) both lungs, both kidneys or bone marrow, in which the affected organ is unresponsive to any treatment and for which the Insured Person medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

Major Organ Transplant: means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure

as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease: means a definite diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: means the unequivocal written diagnosis by a physician who is certified as a neurologist confirming at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection: means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

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

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

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

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

- The Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- A licensed cure for HIV infection is available prior to the accidental injury; or,

HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent. A physician certified as a neurologist must confirm diagnosis in writing.

Parkinson's Disease: means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 activities of daily living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a physician who is certified as a neurologist.

Severe Burns: means the Insured Person has third degree burns covering at least 20% of the surface area of their body. A physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

Stroke: means that the Insured Person has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the stroke, confirmed in writing by a physician who is certified as a neurologist.

CONTINUANCE OF COVERAGE

If you are (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of 12 months following the beginning of any such event subject to continued payment of premium.

WAIVER OF PREMIUM

If you are, under age 65, and become totally disabled for 6 consecutive months, while coverage is in force and can provide evidence of total disability satisfactory to the insurer; the insurer will waive the payment of

each premium which falls due with respect to your coverage. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided for you, will continue until age 65 or earlier termination of the policy. If you cease to be disabled and return to employment with the Policyholder and is a member of an eligible class, your insurance may then be continued upon resumption of premium payments.

If after 120 days, you receive approval of any Long Term Disability claim provided under a policy of group insurance through your Employer, the insurer will then waive the payment of each Critical Illness insurance premium subject to the terms stated above.

Recurrent Disabilities: If you become totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and the insurer will waive the 6 month qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least 1 day.

Termination of Waiver of Premium: Waiver of Premiums will cease on the earliest of:

a. the date you cease to meet the policy's definition of totally disabled;
b. the date you do not supply the insurer with appropriate medical evidence as deemed necessary by the insurer;
c. the date you are no longer receiving regular, ongoing care and treatment of a physician appropriate for the disabling condition, as determined by The insurer;
d. the date you do not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by The insurer;
e. the date you reach 65 years of age;
f. the date the policy terminates; or
g. the date of your death.

Coverage During Waiver of Premium: While premiums are being waived, Critical Illness Insurance coverage provided under the policy will continue to be in force for all insured persons. The amount of such Critical Illness Insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to waiver of premium, means disability resulting from injury or sickness which prevents engagement in the Insured Person's regular occupation for 6 consecutive months.

CONVERSION

On the date of termination of employment or during the 31 day period following termination of employment, an Insured may convert his or her coverage under this policy to an individual insurance policy of the insurer. The individual policy will be effective either as of the date that the insurer receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured would ordinarily pay when applying for an individual policy at that time. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $25,000. The individual policy will cover the same conditions as those available under the group policy currently in force.

LIMITATIONS AND EXCLUSIONS

The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of the specified insured conditions, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse of medication or the abuse of drugs or intoxicants;

HOW TO CLAIM

You may obtain the required forms from your Plan Administrator.

Notice of claim must be given to the insurer within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or

proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the insurer accept notice of claim beyond one year.

GENERAL PROVISIONS

Beneficiary: You or your covered spouse have the right to name a beneficiary when applying for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under this policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured employee.

All other indemnities of the policy will be payable to the insured employee.

An insured person can change his beneficiary at any time, where permitted by law. The insurer assumes no responsibility for the validity of such designation or change of beneficiary. The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer: An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

LiUNA! LOCAL 493

Out of Province Travel Insurance

For the employees of:
Labourer's Local 493 Welfare Trust Fund

Policy Number: 220500043

Effective Date: 01/01/2018

The following information provides a summary of the group travel insurance coverage provided to you by the policyholder. In the event of a discrepancy between the details in this summary and the provisions of the Master Policy, the Master Policy will prevail.

For full plan details see the full booklet at **www.local493.com/benefits** or contact the office for a printed or digital copy.

In the event of an emergency or if you experience medical signs or symptoms or require medical treatment, you must contact the Assistance Company at:

1-844-460-8324 toll-free from Canada and the USA
+1-514-286-8324 collect where available
email: assistance@canassistance.ca

It is your responsibility to ensure that the Assistance Company has been contacted prior to receiving treatment. Benefits will be limited to 80% of eligible expenses to a maximum of $25,000 if you fail to do so, other than in extreme circumstances when treatment is required to resolve a life-threatening medical crisis.

GROUP OUT-OF-PROVINCE TRAVEL INSURANCE

Policy Schedule	
Policyholder Name	Labourers Local 493 Welfare Trust Fund
Policyholder Address	584 Clinton Avenue, Sudbury, ON, P3B 2T2
Berkley Policy Number	220500043
NexgenRx Policy Number	3037
Policy Effective Date	01/01/2018
Initial Policy Period	12 months
Trip Duration	Class A: 60 Days | Class B: N/A | Class C: N/A
Trip Cancellation Limit (Enhanced Plan Only)	$ N/A
Overall Maximum per Insured Person Per Trip	$5,000,000 CAD
Termination Age - Active Employees*	74 Years
Termination Age - Retirees	N/A
Termination Age - Dependent Children	22 Years or 25 Years if full-time student
Waiting Period	Class A: Based on hour bank | Class B: N/A | Class C: N/A
Policy Changes	None

All dates become effective at 12:01 a.m. Standard Time, at the address of the policyholder

Benefit Summary	
Hospital Accommodation	Reasonable & Customary Costs
Medical Services	Reasonable & Customary Costs
Diagnostic Services	Reasonable & Customary Costs
Prescriptions	30-day supply
Private Duty Nurse	Up to $10,000 per insured person
Paramedical Services	Up to $500 per practitioner
Dental Accident	Up to $2,500
Dental Pain	Up to $500
Medical Appliances	$10,000
Emergency Transportation	Ground: $10,000; Air: $250,000
Transportation to Bedside	Economy Airfare and up to $250 per day / max $5,000 for meals and accommodation
Repatriation of Remains	Up to $10,000
Meals & Accommodation	Up to $250 per day / max $5,000
Hospital Allowance	Up to $500
Return and Escort of Children	Up to $5,000
Return of Travel Companion	Economy Airfare
Vehicle Return	Up to $10,000
Excess Baggage Return	Up to $500

Important Notice - Please read Carefully

- Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your policy as your coverage may be subject to certain limitations or exclusions.
- Your policy may not cover medical conditions and/or symptoms that existed prior to your trip. Check to see how this applies in your policy and how it relates to your departure date.
- In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.
- Your policy provides travel assistance; you are required to notify the Assistance Company prior to medical treatment. Your policy may limit benefits should you not contact the Assistance Company before seeking medical treatment.

This policy may contain a clause which may limit the amount payable

INDIVIDUAL COVERAGE — ELIGIBILITY

Participant Coverage

To be covered under this policy as a participant, a person must meet the following eligibility requirements:

- be a Canadian resident covered under a government health insurance plan; and
- be younger than the termination age; and
- be a member in good standing of the policyholder
- be on the monthly list of members entitled to coverage provided to the insurer by the policyholder.

Dependent Coverage

To be covered eligible for coverage under this policy as a dependent, a person must:

- be covered under a government health insurance plan; and
- meet the definition of dependent in this policy.

INDIVIDUAL COVERAGE — EFFECTIVE DATE

Coverage will become effective on the later of the date:

- the date this policy becomes effective; or
- the date the participant becomes a member with the policyholder and eligible for coverage under this policy.

Coverage for each trip begins on the date and time you depart your province or territory of residence.

Note: If you are already on a trip on the effective date of the insurance, the coverage period for that trip will be reduced by the number of days you have been out of the province/Canada on the effective date of this insurance.

INDIVIDUAL COVERAGE — TERMINATION

Coverage will terminate immediately upon the earliest of the date:

- the participant ceases to meet the eligibility requirements for participant coverage; or
- the dependent ceases to meet the eligibility requirements for dependent coverage ; or
- the premium is due but not paid, except where this is the result of a clerical error; or
- this policy is terminated.

Coverage for each trip will terminate on the date you return to your province or territory of residence or the date you reach the maximum number of days allowed in the coverage period.

INTERNATIONAL ASSISTANCE SERVICE

The Assistance Company is available to take calls, 24 hours a day, 7 days a week. In the event of an emergency please contact the Assistance Company immediately at:

1-844-460-8324 toll-free from Canada and the USA
+ 1-514-286-8324 collect where available

Emergency Call Centre — No matter where you travel, professional assistance personnel are ready to take calls 24 hours a day, 7 days a week.

Referrals — The Assistance Company can refer you to the preferred medical providers (hospitals, clinics and physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out of pocket.

Benefit Information — Explanation of this policy is available to you and to the medical providers who are treating you.

Medical Consultants — The Assistance Company's team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious emergency. If necessary, the Assistance Company will help you return to Canada for the care required.

Urgent Message Relay — In the event of a medical emergency, the Assistance Company will contact your travel companion to advise on your medical situation and will help you exchange important messages with family.

Interpretation Service — The Assistance Company can connect you to a foreign language interpreter when required for emergency services in foreign countries.

Direct Billing — Whenever possible, the Assistance Company will instruct the hospital or clinic to bill the insurer directly.

Claims Information — The Assistance Company will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under this policy are administered.

The Assistance Company must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact the Assistance Company immediately on your behalf. It is your responsibility to ensure that the Assistance Company has been contacted prior to receiving medical treatment or as soon as reasonably possible.

The Assistance Company can be reached at the emergency telephone numbers listed on the medical assistance card provided to you.

CLAIMS

Claims must be submitted within 30 days of the first medical expense. You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

- complete and submit a claim form for each new sickness or injury;
- submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;
- provide original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;
- provide proof of your departure date(s) and return date(s);
- provide written proof of claim within 90 days of the date of receipt of services covered under this policy;
- provide additional information pertinent to your claim, as may be required by the Assistance Company after receipt of the claim;
- sign and return the authorization form, provided by the Assistance Company, allowing the insurer to recover payment from the Canadian provincial or territorial government health insurance plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial government health insurance plan on your behalf; and
- return the unused portion of your air ticket to the Assistance Company, if the Emergency Transportation benefit is used.

All pertinent documents should be sent to the Assistance Company.

IDENTIFICATION OF INSURER

Underwritten by:
Berkley Canada
(a Berkley Company)
145 King Street West
Suite 1000
Toronto, Ontario M5H 1J8

Claims Administered by:
CanAssistance
550 Sherbrook Street West
Suite B-9
Montreal, Quebec, H3A 3S3

Please contact CanAssistance for emergency assistance, medical management, coordination of benefits and to arrange direct billing with a healthcare provider.

1-844-460-8324 in Canada and the U.S.A.
+ 1-514-286-8324 collect where available

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund

Retired Members Welfare Plan

RETIRED MEMBERS PLAN ELIGIBILITY

Retired Members Welfare Plan

When you retire, you may be eligible for coverage in the Retired Members Welfare Plan, the cost of which is paid partly by you and the balance by the Welfare Trust Fund`s Surplus, an arrangement that will continue in effect as long as the surplus can sustain cost.

The following information sets out the eligibility requirements, who is covered, your required contribution, and the benefits of the plan:

Eligibility Requirements

In order to be covered by the Retired Members Welfare Plan, you must meet all of the following requirements:

1. You must be at least age 55. Members under age 55, who are Totally Disabled*, have the option of taking early retirement and being covered under the Retired Members Welfare Plan;
   *Totally Disabled shall mean you are incapacitated by an injury or disease to the extent that you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation;
2. You must be a resident in Canada;
3. During the 144 months immediately prior to your effective date of coverage in the Retired Members Welfare Plan, you had been covered for at least 60 months (in the aggregate, and not necessarily consecutively) by the Welfare Plan for Active Members of LIUNA Local 493; and
4. In the calendar month immediately preceding your effective date for coverage in the Retired Members Welfare Plan, you were covered by the Labourers Local 493 Welfare Plan for Active Members; and
5. You are a recognized pensioner with LIUNA having notified the Central and Eastern Pension Office that you have retired, and you continue to remain a member in good standing with Local 493 as per the Uniform Local Constitution (article III-membership), LIUNA Local 493, and you continue to maintain the status in accordance with the records of LIUNA Local 493.

If you become covered by the Labourers' Local 493 Retired Members Welfare Plan and you breach one or more of the above stated Eligibility Rules, your coverage will be terminated effective 12:01 a.m. of the first day of the calendar month first following receipt by the Plan Administrator, Labourers' Local 493 Welfare Plan, of written Notice of the breach under the hand and seal of any duly-appointed or elected Officer, LIUNA Local 493.

Please note that you cannot select the benefits you want. The plan is a "package", so that all benefits cover all eligible retired members.

Required Contribution
Since participation in the Retired Members Welfare Plan is voluntary, you alone decide whether you want coverage. If you are eligible and want coverage, you must contact the Plan Administrator within 30 days of your termination in the Active Members Plan, and pay the required contribution set from time to time by the Trustees.

Reenrollment is not permitted. You will not be allowed to rejoin the plan should you fail to make the required contributions to maintain your coverage. All Contributions must be made on a continuous basis.

When You Become Covered Initially
You and your eligible dependents will be become eligible for coverage on the first day of the month following retirement. Retired Members must be covered as Active Members immediately prior to Retirement.

If your dependent is confined, the effective date of coverage is the first date the dependent is no longer confined.

Confinement shall include both home and hospital confinement. If the dependent is confined at home, confinement shall mean the dependent is unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and sex. This shall not postpone the effective date for a child born while the employee's dependents are covered under this policy.

Termination of Coverage
The coverage for you and your eligible dependents will terminate on the earliest of the following dates:

1. The date you cease to be a member in good standing as per the Uniform Local Constitution (article III-membership), including non-payment of dues
2. The date you enter Military Service.
3. The date your Group Policy terminates.
4. The date you discontinue any required contributions.
5. The date outlined in the Summary of Benefits.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Eligible Dependents
Eligible dependents under this plan shall include:

- Unmarried children from live birth who are under age 22. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Coverage is continued while the child is under age 25 and attending an

accredited college or university on a full-time basis. You must provide annual confirmation that the child is a full-time student and remains dependent on you for support and maintenance; and

- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was covered as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act;

who are resident in Canada.

- A child of your spouse provided,
  i. he/she is also your biological child; or
  ii. your spouse is living with you and has custody of the child.
- Your spouse as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum of 24 consecutive months immediately prior to the date on which a claim arose and provided the existence of such continuous common-law relationship can be established by public representation, and ceases on the date the co-habitation ends.
  Separated spouses shall be removed only with written permission from spouse or by court order. Divorced spouses are not eligible for coverage.

No one will be eligible as a dependent while in military service.

nexgenRx

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund

Retired Members Dental, Drug, and Extended Health Care Benefits - Class C

Policy / Contract #: NexgenRx 3037

Contract Effective Date: 01Jan18
Booklet Production Date: 13Dec17

CONTACT INFORMATION

The following Benefits are provided by or administered by:

NexgenRx Inc. administers your Dental, Drug, and Extended Health Care Benefits
Member Support is available from 8:30am to 10:00pm E.S.T.
866-424-0257
Pharmacy and Dental Office support for electronic submission is available from 8:30am to 10:00pm E.S.T. 866-394-3648

DEFINITIONS

Co-Insurance: Co-insurance is the rate at which benefits are payable.

Child: A child is your unmarried son or daughter. This includes a step-child, foster child and a common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance.

- A child must be under age 22 ,and dependent on you for support and maintenance
- Coverage is continued while the child is under age 25 and attending an accredited college or university on a full-time basis. Upon request you must provide confirmation that the child is a full-time student and remains dependent on you for support and maintenance
- Coverage is continued beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as the child became handicapped before reaching the applicable maximum age stated above, and you provide proof satisfactory to us that the child is not capable of self-support due to the handicap

Dependent: A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Emergency: An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Family: A family is you and all your dependents that are covered under the contract.

Covered Person: Covered person means you or any one of your dependents who is covered under the contract.

Spouse: A spouse is a person to whom you are legally married or with whom you have a common-law spouse relationship. Common-law spouse means a partner whom you have lived with for at least 24 months. The maximum number of spouses that can be covered at one time is one.

Confirming Your Coverage

When your coverage begins, you will receive a NexgenRx Inc. Benefit Card outlining your coverage. Upon receipt, please check the card to make sure the information is correct.

What Changes To Report To Your Union?

You must report the following changes immediately to your Union:

- changes in dependent coverage, including the birth of a child
- change of spouse. Separated spouses may be removed with the consent of the spouse or by court order (divorced spouses are NOT eligible for coverage). Separated common-law spouses are NOT eligible for coverage and coverage will cease on the date co-habitation ends
- change of name
- change from single or family status
- change of banking information (if NexgenRx Inc. is depositing your claim expenses directly into your bank account). You may also update your banking information on line.

You report these changes by advising your Union of any changes in your coverage needs such as a change from single to family status.

Legal Action

No legal action may be taken until 60 days after proof of claim is given to NexgenRx Inc. or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

SUBMITTING CLAIMS

All claims should be submitted immediately after the expense is incurred but not more than 12 months from the date of service.

Should the contract terminate with NexgenRx, you have 90 days from the termination date to submit any claims incurred during the period you were covered under the plan.

Co-ordination of Benefits with Your Spouse's Plan
Co-ordination with your spouse's plan is one of the advantages of group coverage. It may allow you to receive up to 100% of Health Care costs. First, you must have family coverage that includes Health Care coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage.

Claiming Your Spouse's Expenses
If you are claiming your spouse's expenses, a claim must be sent to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a completed claim form for the unpaid portion, to NexgenRx Inc.

Claiming Your Child's Expenses
If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinate based on the standard industry guidelines. Please refer to CLHIA – Co-ordination of Benefits guide…
http://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_To_CoOrdinationBenefits_ENG.pdf

Claiming Your Expenses
If you are claiming your expenses, the claim must be sent to NexgenRx Inc. first. NexgenRx Inc. will pay for the portion of the claim that is covered by your plan and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim form for the unpaid portion, to his/her group carrier.

Should the contract terminate with NexgenRx, you have 90 days from the termination date to submit any claims incurred during the period you were covered under the plan.

Submitting Your Claims on the Web

Members have the option to submit claims on our secure website. Please note when using the web claims submission, you must be set up on our system for Direct Deposit for your claims reimbursement. You must also keep the original copies of your receipts for 18 months from the time you submit your claim on line for audit purposes.

As a plan member, NexgenRx Inc. provides you with access to our claims processing website to look-up the status of your claims anytime you wish. In order to access our secure, online administration and information website please follow these instructions:

FIRST TIME USERS:

1. Go to the following Web address: www.nexgenrx.com
2. Click on **MEMBER LOGIN** at the top right-hand side of screen as show below:

Please note that **FIRST TIME USERS** must complete all steps in order to use their account and subsequently logon to the website.

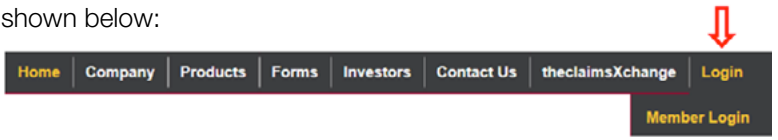
Your **USERNAME** and **TEMPORARY pass phrase** are automatically generated by our system and included in your welcome kit.

- After clicking on the **ACTIVATE ACCOUNT** button under the **Activate Your Account** section, the system will take you to the Account Activation Screen.
- Read the information and click **NEXT**.
- Review the Terms of use and click the checkbox at the bottom of the screen to accept the terms.
- Click **NEXT**
- This will take you to the **VERIFICATION OF IDENTITY** screen.
- Fill in the fields on this screen that are noted with an asterisk, i.e. **USER NAME** and temporary **PASS PHRASE**; click **NEXT.**
- The system will take you to the **ACCOUNT SETUP** screen.
- Complete all fields. Select a **NEW** password of your choosing **(it must be at least 8 characters in length)** and confirm your newly selected password by entering it again. Complete the challenge question, challenge answer section and enter your email address. Click **NEXT**.

- The system will now confirm that your account has been activated. **The next time you log in, enter your user name and pass phrase under the SIGN IN heading.**
- Click **FINISH**. This will take you back to the main login screen.
- You may now login using your username and the **NEW** password that you have selected.
- Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
- Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

EXISTING USERS

1. Go to the following Web address: www.nexgenrx.com
2. Click on **MEMBER LOGIN** at the top right-hand side of screen as shown below:



3. Enter your pre-assigned user name and personal secure pass phrase under the **SIGN IN** heading.
4. Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
5. Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

How to submit a paper claim

Complete the claim form that is available from our NexgenRx Inc.'s web site, www.nexgenrx.com

Make sure that your receipts include:

- the name of the person who received the service or supply (referred to as "the patient")
- the date the service or supply was received
- the type of service or supply received and
- the cost paid

Mail your claim to: Local 493 Benefit Services
584 Clinton Ave
Sudbury, ON P3B 2T2

YOUR HEALTH CARE COVERAGE

Your plan will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy and incurred in Canada by a recognized practitioner / provider.

It will cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care and the Canada Revenue Agency
- Services and supplies that private plans are legally allowed by the government to cover. The plan will not cover services or supplies that are covered by the government plan in your home province
- Charges for services and supplies that are incurred while the person is covered under this plan

YOUR HEALTH CARE COVERAGE (SUMMARY)

Extended Health Care	
Deductible	None
Maximum Dispensing Fee Allowed	$10 per prescription
Coinsurance	
Drugs	100% for Generic equivalent.drugs and certain Brand name drugs up to $10,000, then 80% up to $25,000 per person per calendar year. 75% for certain Brand name drugs up to $10,000, then 60% up to $25,000 per person per calendar year.
Extended Health Care	75% for laser eye surgery, 80% for hearing aids and 100% for all other eligible services/supplies
Drug Annual Maximum	$25,000 per person per benefit year
Extended Health Care Annual Maximum	Unlimited overall maximum with inner limits on certain benefits; please refer to the Extended Health Care section of this booklet for details

Extended Health Care

Supplementary Medical	
Paramedical Practitioners	$750 per certificate (family) per calendar year for all practitioners combined.
Vision Care (Eyewear) Maximum	Combined maximum of $500 per person every 24 months toward eye exams, prescription eyeglasses &/or contact lenses, prescription sunglasses and safety glasses
Laser Eye Surgery Maximum	$1,000 per eye per person's lifetime
Nursing Care Maximum (at home)	$10,000 per person per calendar year
Dental Accident	$5,000 per accident
Convalescent/Rehabilitative/Chronic Care	$25 per day for semi-private room to a maximum of 120 days
Hearing Aids Maximum	$500 per person every 36 months
Medical Supplies (medically necessary services and supplies)	Post cataract surgery frames/lens, contact lens or prosthetic lens (Once per lifetime per eye), Breast prostheses (one every 2 calendar years), Surgical bras (One every 3 months), Surgical/support/compression hose (4 pairs per calendar year), Wigs ($200 per person's lifetime), CPAP machine and supplies (masks are limited to 2 per calendar year up to a maximum of $350)

Dental

Deductible	None
Coinsurance	
Basic	80%
Major Restorative	80%
Maximums	
Basic & Major Restorative	Combined maximum of $1,000 per person per calendar year
Recall Exams	Once every 6 months
Fee Guide	Current Provincial General Practitioners and Specialists

What You Are Covered For and How Much the Plan Will Pay

The plan has no deductible. The benefit year is January 1 to December 31 each year.

The plan pays as follows for eligible expenses:

- Eligible single-source brand name drugs, generic drugs, and any prescriptions where the prescribing physician states 'no substitution' on a multi-sourced brand name drug, are payable at 100% up to $10,000; the plan will then pay 80% from $10,000 to $25,000
- All other eligible brand name drugs are payable at 75% up to $10,000 and then 60% from $10,000 to $25,000

The annual maximum is $25,000 per person per benefit year.

The plan has the following inner limits:

- Oxycotin (and drugs containing Oxycotin) are covered to $500 per person per calendar year
- Methadone (and any drug containing any form of methadone) is payable at 100% to a maximum of $2,000 per person per calendar year. Once $2,000 is reached, the plan will cover 50% of the eligible cost
- Immunizations and Vaccines (oral or injected) require a physician's referral

Covered expenses under the drug plan include both the ingredient cost and the dispensing fee. The plan covers up to $10 of the dispensing fee. Pharmacies charge varying levels of dispensing fees and it is in your own best interest to find a pharmacy that will accept this amount as full payment.

The plan pays for most drugs that legally require a written prescription and some life sustaining Over-The-Counter drugs (OTCs). Examples of these OTC items include insulin, diabetic test strips, disposable insulin needles and syringes, oral potassium supplements, Epi-Pen, nitroglycerin, low dose aspirin for blood thinning, niacin for cholesterol lowering, vitamin B12 for certain types of anemia.

The plan covers up to a 34-day supply of acute drugs, and up to a 100-day supply for maintenance drugs.

You and your Dependents can use the NexgenRx Inc. drug card to purchase eligible drugs. Use of the NexgenRx Inc. drug card authorizes NexgenRx Inc. or their authorized agent, to inform pharmacists and physicians on patient safety issues for you and your dependents.

NexgenRx Inc. and its authorized agents are not legally liable for this information

You and your Dependents may not be able to use the NexgenRx Inc. drug card to purchase drugs from a physician, dentist, clinic, hospital, or some pharmacies, but you can make a claim for the cost of eligible medicines by using a claim form and attaching the original receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN)

If your NexgenRx Inc. drug card is lost or stolen, it must be reported immediately to your Union.

You and your Dependents cannot use the drug card to purchase the following items:

- alcohol swabs
- appliances
- atomizers
- certain equipment
- ostomy supplies
- devices for giving inhaled medications (for example, an aero chamber), blood glucose monitor and prosthetic devices

We will not pay for the following:

- fertility drugs
- hair growth stimulants
- alcohol
- bandages
- contraceptives, other than birth control pills
- cosmetic items
- sunscreens
- cotton
- vitamins (except some injectable items), minerals, dietary supplements food substitutes, infant food or formula
- disinfectants
- homeopathic medicines
- non-disposable insulin injectors
- products which can be bought without a prescription, other than some life supporting products
- spring loaded devices used to hold lancets
- over-the-counter medications, vitamins and supplements, even if prescribed by a medical practitioner
- prescription drugs and medications acquired unlawfully for use or prescribed by a non-medical practitioner

EXTENDED HEALTH CARE (EHC) BENEFIT

The plan has no deductible. The benefit year is January 1 to December 31 each year. The plan pays 75% toward laser eye surgery, 80% for hearing aids and 100% for all other eligible expenses. Although the plan has an overall unlimited annual maximum, maximums do apply to some benefits. Please refer to each benefit section.

Hospital Accommodation

For "in province" hospital services, the plan will cover the difference between the cost of a ward and a semi-private room in a hospital for a maximum of 120 days. Room charges for outpatient treatment will not be covered. The hospital stay must be because of illness, injury or pregnancy and the patient must be confined on an in-patient basis.

Vision Care

The plan will cover eye examinations, prescription eyeglasses, contact lenses, prescription sunglasses and safety glasses to a combined maximum of $500 per person every 24 months. Laser eye surgery is covered to a maximum of $1,000 per eye per person's lifetime.

Paramedical Practitioner Services

The plan will pay an overall annual maximum of $750 per certificate (family) for all practitioners combined. The plan will pay for the following:

- Chiropractors
- Osteopaths
- Podiatrists/Chiropodists
- Acupuncturists
- Naturopaths
- Physiotherapists
- Speech Therapists
- Massage Therapists *Limit of $75/visit. Physician's referral is required*
- Psychologists
- Correactologists

These practitioners must be registered in the province where the service is given, be performing a service for which their registration applies and cannot be a person who normally lives with you nor be a person related to nor a member of your immediate family.

The plan will cover up to $20 per person per calendar year toward the cost of x-rays by a Chiropractor.

Registered Nurses

The plan will cover these services to a maximum of $10,000 per calendar year. Services provided by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse must be approved by NexgenRx in advance. These services must be provided in the insured person's home by a Registered Nurse, Registered Nursing Assistant or Registered Practical

Nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

The plan will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a Registered Nurse, Registered Nursing Assistant, or Registered Practical Nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

Ambulance Services
The plan will cover the cost of a licensed ambulance or other emergency service, (including air ambulance), that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals.

The plan will cover up to $200 per person per calendar year toward local ambulance service. There is no limit on emergency air ambulance service.

Convalescent Care
The plan will pay for active treatment or convalescent care in a Rehabilitative, Convalescent or Chronic Care Institute when prescribed by a physician, up to $25 per day for semi-private accommodation for a maximum of 120 days per calendar year.

Miscellaneous Services
The plan will pay for out-patient services from a licensed hospital and for certain diagnostic tests, radium treatments and x-rays from a licensed facility in your home province.

Medical Equipment
The plan covers the cost of out-patient supplies obtained from a hospital or surgical supply company in your home province. It will also cover the cost of rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that NexgenRx approves. It may cover the cost of purchasing this equipment if NexgenRx &/or LiUNA Local 493 determines that it is more economical than renting. NexgenRx &/or LiUNA Local 493 must approve the purchase before it is made. The plan will pay a reasonable and customary fee for the least expensive device that is medically adequate.

The following is a list of eligible items that the plan will cover if prescribed by a physician and approved by NexgenRx &/or LiUNA Local 493:

- Artificial limbs and eyes and other approved prosthetic devices
- Bathroom Aids (including grab bars)
- Bed Wetting Device
- Blood Glucose monitors
- Blood Pressure Kit
- Braces, rigid or semi-rigid
- Breast prostheses after a mastectomy, including replacement(s), one every 2 calendar years and one surgical bra every 3 months
- Burn Garments
- Casts
- Caster Cart
- Casto Kit
- Custom supplies for cystic fibrosis, parkinsonism, diabetes and heart disease
- Electro Magnetic Bone Healing System
- Femtens
- Gastrotomy
- G-Button
- Hearing aids and repairs (excluding batteries) up to a maximum of $500 every 36 months
- Hospital beds, wheelchairs and other temporary therapeutic equipment that is deemed medically necessary. Rental only unless it is more economical to purchase such equipment
- Home/Car Modifications
- Humidifier
- Initial pair of frames and one corrective lens, contact lens or prosthetic lens prescribed after cataract surgery for the eye that had the surgery, once per lifetime per eye
- Jobst Sleeves
- Jobst Extremity Pump
- Laryngeal Speaking Aids
- Lymph Press
- Maclaren Buggy/Convaid Cruisers
- Medix
- Mini Standy
- Mobile Aids (including walkers, crutches and canes)
- Mobile Aid Supplies
- Muslab II
- Ortho-Kinetics
- Orthopaedic pillows
- Ostomy/Ileostomy/Colostomy supplies
- Palco Alarm
- PEP Therapy
- Pessary
- Prosthetic Supplies
- Prosthetic Repairs
- PSA tests
- Punctal and Punctum Plugs
- Respiratory equipment & supplies such as Aero Chambers, Apnea Monitors, CPAP machine & supplies, Compressors, Nebulizers to administer asthma medication and Oxygen & Oxygen equipment
- Titanium
- Heel Lifts
- Extremity Pump for Lymphedema
- Trapeze bar
- Seating Device

- Spatula
- Speech Aids
- Splints
- Sphygometer
- Synvisc or Neovisc
- Suction Unit
- Surgical or support stockings or compression hose up to 4 pairs every calendar year
- T.E.N.S. machine (for chronic pain)
- Wigs following chemotherapy or radiation up to $200 per person's lifetime

DENTAL ACCIDENT

If healthy, natural teeth are damaged or lost due to a sudden impact, the plan will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while you or your dependent are covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount payable will pay is based on the least expensive treatment that is adequate to correct the damage. No more than the fee stated in the current Dental Association General Practitioner's Fee Guide will be covered. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, NexgenRx must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing cross bites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

What You Are Not Covered For

The plan will not pay for the cost of:

- health care services or supplies that you or your Dependents are eligible to claim under Workers' Compensation legislation in your province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the you or your Dependent is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, your employer, a school or anyone other than your physician (for example, your employer requiring a doctor's note or a court requiring that you receive psychological services)
- treatment on temporomandibular joint (the hinge joint of the jaw)
- any service and supplies for which the you or your Dependent would not normally be charged
- cosmetic treatments
- any service that we are legally prohibited from paying

When Your Dental Treatment Will Cost More Than $600
If the cost of any dental treatment will be more than $600, NexgenRx Inc. recommends that you submit a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. NexgenRx Inc. will determine how much of the treatment is covered before the treatment begins and give you a written estimate of how much you will be responsible to pay before the treatment begins.

If you do not submit a pre-determination prior to the treatment being performed and submit the claim post treatment, your claim may be delayed in processing. In order to assess whether the treatment will be allowed, NexgenRx Inc. may need to obtain x-rays and/or study models from your dentist. This process may also delay your claim assessment.

What You Are Covered For and How Much the Plan Will Pay
The plan has no deductible.

The benefit year is January 1 to December 31 each year.

The plan does have co-insurance as described in the following section. Note that the amount payable is a percentage (as outlined below) of the current Dental Association Suggested Schedule of Fees for General Practitioners and Specialists of the province in which the treatment is performed.

The plan has an annual combined maximum of $1,000 per person per calendar year for eligible basic and major services. This maximum applies to the following:

- Diagnostic services
- Preventative services
- Basic Restorative services
- Endodontic services
- Periodontic services
- Basic Surgical services
- Major Restorative Services
- Major Surgical Services

Diagnostic Coverage (covered at 80%)
Diagnostic services include items such as oral exams and x-rays

Preventive Coverage (covered at 80%)
Preventive services include items such as scaling and polishing

Basic Restorative Coverage (covered at 80%)
Basic Restorative services include items such as fillings

Endodontic Coverage (covered at 80%)
Endodontic services include items such as root canal therapy

Periodontic Coverage (covered at 80%)
Periodontic services include items such as treatment of the gums

Basic Surgical Coverage (covered at 80%)
Basic Surgical services include items such as tooth extractions

Major Restorative Coverage (covered at 80%)
Major Restorative services include items such as crowns, dentures and bridges

Major Surgical Coverage (covered at 50%)
Major Surgical services include items such as extensive surgical procedures

Orthodontic Coverage (covered at 50%)
Orthodontic services such as braces

Alternate Benefit Clause
Coverage is based on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, the plan will only cover the cost of the least expensive treatment. This rule does not apply to basic restorative fillings.

Limitations

- Oral hygiene instruction is covered once per person's lifetime
- Fluoride treatments are limited to once every 6 months
- Recall exams, scaling and polishing are limited to once every 6 months
- Bitewing x-rays are limited to once every 6 months
- Full Mouth Series X-rays or a Panoramic X-ray are limited to once every 36 months
- Scaling (root planning) are payable up to 6 units every calendar year
- White (composite) fillings are covered on all teeth (except for molars)
- Space maintainers and habit breaking appliances are covered for dependent children to age 25
- Replacement of removable dentures and bridgework are eligible only:
  - if a natural tooth is extracted and the existing appliance cannot be made serviceable
  - when it is 5 years old and cannot be made serviceable
  - if the existing appliance is temporary and is replaced with the permanent denture within 12 months of its installation

What You Are Not Covered For

The plan will not pay for:

- Dental services or supplies that the insured person is eligible to claim under the Workers' Compensation legislation
- Any dental charges not included in the current Dental Association Suggested Schedule of Fees for General Practitioners, Dental Specialists, Denturists or Hygienists.
- Cosmetic procedures
- Charges for appointments that are not kept
- Charges for completing claim forms
- Treatment to correct temporomandibular joint dysfunction (the hinge joint of the jaw is called the temporomandibular joint)
- Any endodontic treatment which was started before the effective date of coverage
- The replacement of dental appliances that are lost, misplaced or stolen
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw)
- Orthodontia

Sun Life Financial

LiUNA! LOCAL 493

LiUNA Local 493 Welfare Trust Fund
Retired Member
Group Life Insurance

Policy / Contract # 102606
Effective: January 1, 2018
Issued: January 3, 2018

CONTACT INFORMATION

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-800-361-6212.

For faster service, have your group contract number and member ID ready to enter into our automated telephone system.

All other inquiries
Call 1-877-SUN-LIFE (1-877-786-5433).

BENEFIT SUMMARY

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, we, our and us mean Sun Life Assurance Company of Canada
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the General Information section of this booklet.

Life - Contract Number 102606

Employee Life

Amount	$10,000

Dependent Life

Amount	Spouse – $6,000	Child – $2,000

Employee Assistance Program

included

MAKING CLAIMS

There are time limits for making claims. You can find more on these time limits in the following chart. If you fail to meet these time limits, you may not be entitled to some or all benefit payments.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Life coverage	Ask your employer for the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred.

GENERAL INFORMATION

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies.

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to your employer.

Legal actions:
Limitation period for Ontario: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

Limitation period for any other province: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation of your province or territory.

Recovering overpayments
If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments
You may not assign any rights or interests to anyone.

Definitions
Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

Illness - An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Sun Life Financial

Life Insurance

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE COVERAGE

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay

If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us.

If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

If a dependent dies, we will pay you the benefit for that dependent.

Fact: There are different rules for designating a minor beneficiary, please refer to your contract for specific information.

The request must be made within 31 days that the Life coverage reduces or ends.

Important *- There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.*

Sun Life Financial

Employee Assistance Program

Sunlife Financial Policy / Contract #102606
Effective: January 1, 2018
Issued: January 3, 2018

GENERAL DESCRIPTION OF THE PROGRAM

The Employee Assistance Program (EAP) available through your employer as part of your group benefits, gives you access to services performed by Morneau Shepell Ltd. (Shepell). The EAP is not insured by Sun Life. Sun Life only acts as administrator on behalf of the contract holder in providing access to the services available under the EAP.

In this section, you means the employee and all dependents as defined under the group plan.

Immediate, confidential help

Your EAP is a confidential and voluntary support service that can help you with:

- Family and social relationships
- Personal problems
- Dependency issues
- Workplace related issues
- Legal and financial advice*
- Wellness issues
- Crisis

**(does not include employment or workplace issues, criminal law, asset management or accounting services)*

When you call Shepell, your needs will be assessed and a personal support plan will be designed. Your EAP includes:

- Clinically appropriate number of telephone sessions per issue
- Access to e-counselling, First Chat (online secure messaging), MyMigo, video counselling, online group counselling
- Unlimited access to online tools and resources on the EAP website
- 3 in-person counselling sessions per issue

Assistance is available 24 hours a day, seven days a week. For immediate confidential help, you can call Shepell toll-free at 1-855-544-7722.

You can also access EAP services at www.workhealthlife.com/sunlife

Confidential service
Your EAP is completely confidential. Your employer will not be advised that you have used the service unless you choose to tell them.

Cost
There is no cost to use EAP and no claims to submit.

Liability of Sun Life or Shepell
Neither Sun Life nor Shepell will be held liable for any acts or omissions of any person or organization providing services in connection with this program.

FUTURE OF THE PLANS

The Trustees hope and expect to continue the welfare plan indefinitely. The Plans will be amended as and when circumstances require or permit, and terminated in the event that the Collective Agreements no longer require contributions.

The Welfare Plan Benefits for Unemployed Members, which are described in this booklet, are provided at no or little subsidized cost to eligible Members. The Trustees also hope and expect to continue these benefits indefinitely; but because the cost of them is paid out of the surplus of the Welfare Trust Fund, the Trustees necessarily reserve the right to amend suspend, terminate or require that persons covered by those plans make a contribution toward their cost.

We also remind you that the trustees of the plans have the right to change the plans at anytime. So, the statements made in this booklet may not reflect the current terms of the plans.

As these changes may not justify the expense of printing a new booklet, you will receive information in separate communications about changes that are made to the terms of the plans from time to time in the future. Changes to the Plans may also be updated on the plan's website www.local493.com/benefits.

Statements made in this booklet are not legally binding promises or representations. In the event of any conflict, discrepancy or inconsistency between the actual terms of Welfare Plan insurance contract and this booklet, the welfare plan insurance contract will prevail.

Please refer to the Welfare Plan insurance contract for authoritative and detailed information about the Welfare Plan. This document is available from the plan Administrator upon request. You are strongly encouraged to ask questions at any time about your entitlements under the plans.

This booklet contains important information about your coverage, and should be kept in a safe place. It supersedes and replaces all previous communication material provided to you.

LiUNA! LOCAL 493

Labourers' Local 493 Welfare Trust Fund
584 Clinton Ave
Sudbury ON P3B 2T2

705-805-5601

www.local493.com