LiUNA! LOCAL 493

NexgenRx Inc.

2021 Active Members Benefit 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

2021Benefits Booklet

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GENERAL INFORMATION

The Labourers' 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: 01Jan 20

CONTACT INFORMATION

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

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

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

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-ordinated 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.

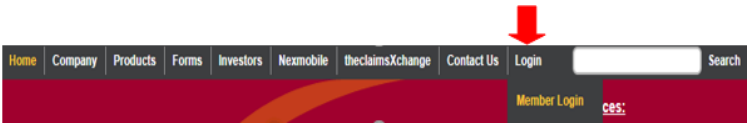
Submitting Your Claims on the Web

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:

Instructions for First Time Login:

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



4. Enter your username and temporary password and click Login
5. Please read the Welcome Page
6. Click NEXT.
7. Enter your temporary password and create a new password
8. Provide your email address
9. Create a Security Question/Answer for security purposes
10. Click NEXT
11. Review the Conditions of Use and click on Accept to Complete the Activation
12. A message will confirm that your account has been activated
13. The next time you log in, enter your username and your new password to access your account on NexgenRx Benefits Member Web

Mobile App

NexMobile App is designed to increase convenience for Plan Members.

You can submit a claim by taking a picture of your claim receipt on your handheld device with NexMobile submission feature. It's the easiest and fastest way to submit a claim. In fact, it's as "quick as a selfie!"

DOWNLOAD OUR FREE nexmobile APP AVAILABLE FOR ANDROID OR IPHONE DEVICES

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, fax or email your claim to: Local 493 Benefit Services
584 Clinton Ave Sudbury, ON, P3B 2T2
benefits493@liunalocal493.ca
Fax: 1-705-674-6728

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	$8 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 calendar 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 for each mask)
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

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 calendar year.

The plan has the following inner limits:

- Professional Fees are covered to $1,000 per person per calendar Year
- Prescribed smoking cessation products are covered at 2 courses of treatment per person every 3 calendar years to a maximum of $1,000
- Oral contraceptives are covered to a maximum of $400 per person per calendar year
- All Opiates and Opioids are covered to $500 per person per calendar year
- Sclerotherapy related drugs are covered to a maximum of $20 per person per treatment
- Immunizations and Vaccines (oral or injected) require a physician's referral
- Erectile Dysfunction drugs are covered to $400 per person per calendar year

Covered expenses under the drug plan include both the ingredient cost and the dispensing fee. The plan covers up to $8 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

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.

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 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.

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
- 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
- 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
- Phototherapy Equipment and maintenance parts
- Prosthetic Supplies
- Prosthetic Repairs
- PSA tests
- Punctal and Punctum Plugs
- Respiratory equipment & supplies such as Aero Chambers, Apnea Monitors, CPAP machine & supplies (masks are limited to 2 per calendar year up to a maximum of $350 for each mask), 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 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 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 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 planing) are payable up to 6 units every calendar year
- White (composite) fillings are covered on all teeth

- 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)

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