

LABOURERS' INTERNATIONAL UNION OF NORTH AMERICA LOCAL 837
RETIREE BENEFITS
(Contributions required \$30.00 per month)

Revised January 1, 2010

YOU MUST ADVISE OUR OFFICE IF YOUR SPOUSE HAS INSURANCE ELSEWHERE AND PROVIDE US WITH THE DETAILS OF THE PLAN FOR THE PURPOSE OF CO-COORDINATING BENEFITS

- **\$10,000 Life Insurance for Member**
- **\$5,000 Life Insurance for Spouse**

Health Coverage

- **50% reimbursement of REASONABLE AND CUSTOMARY charges for most prescriptions drugs up to a maximum of \$3,000 per calendar year. All medication purchased must require a doctor's prescription and not be able to be purchased over the counter.**
- **All injections must be dispensed by a licensed pharmacist and taken to your physician to be administered, in order to be covered.**
- **50% reimbursement of Vaccines.**
- **Dispensing Fees are limited to \$8.00 per prescription or refill.**
- **The \$100 Government Drug Deductible is not reimbursable.**
- **50% reimbursement for prescription eyeglasses and/or contact lenses up to a maximum of \$250 every 24 months from date of purchase.**
- **50% reimbursement for one eye examination every 24 months up to a maximum of \$50.**
- **50% reimbursement for hearing aids up to a maximum of \$400 every five years. MUST BE RECOMMENDED BY AN OTOLARYNGOLOGIST.**
- **Smoking Cessation Products are limited to a lifetime maximum of \$125.**
- **Drugs for the treatment of Erectile Dysfunction are limited to 50% reimbursement up to \$400 per insured person per calendar year.**
- **Reimbursement will be provided for reasonable and customary charges for one Prostate Specific Anitgen (PSA) test per calendar year.**
- **Private Duty Nursing is covered up to a lifetime maximum of \$10,000.**

Dental Coverage

DO NOT SEND CLAIMS ELECTRONICALLY – WE REQUIRE PAPER CLAIM FORMS MAILED TO THE ADMINISTRATIVE OFFICE (@ LABOURERS UNION)

- **Deductible: Single - \$10 per year**
- **Deductible: Family - \$25 per year**
- **Basic & routine expenses are payable at 50% of the 2008 ODA (Ontario Dental Association Fee Guide)**
- **Covered expenses include six-month check-up, x-rays, fillings, extractions, dentures, repairs & relines of dentures, and endodontics (root canals).**
- **Calendar year maximum is \$1,600 per person.**
- **Estimates are required for dental work over \$500.**
- **No periodontal (except 10 units of scaling per year), no crowns or bridgework or orthodontic work.**
- **Bonded fillings reduced to non-bonded.**

Children are covered under the Plan up to the age of 25, provided that they are attending school on a full-time basis. Once a child turns 21, and each year after that, we require a letter stating full-time status from the Educational Institution they are attending.

NOTE DUES ARE \$8 PER MONTH & MUST BE PAID ON TIME TO ENSURE BENEFIT COVERAGE.