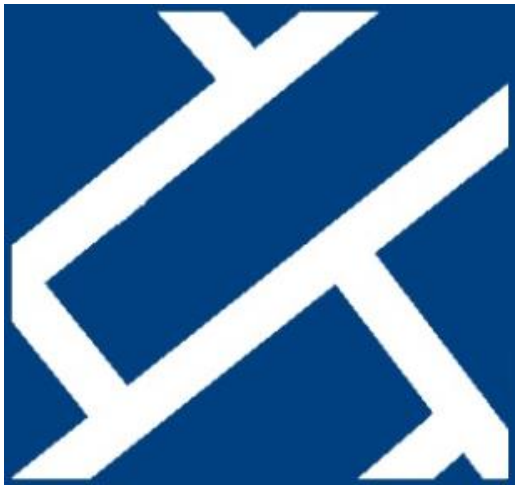
BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN



Group Insurance

January 1, 2023

BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

GROUP INSURANCE PLAN

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

While every effort has been made to ensure the accuracy of the summary contained in this booklet, this booklet is not an insurance contract and does not grant or confer any contractual rights. The booklet was prepared as of January 1, 2023, and subsequent to that date the Trustees may have made changes to the Benefit Plan or to the Eligibility Rules of the Fund. All of your rights under the program are governed by the provisions of the master contract issued to the Trustees by Manulife Financial, by the Eligibility Rules and other rules enacted by the Trustees from time to time, and by the applicable provincial and federal laws. A copy of the current master contract and the current Eligibility Rules and other rules of the Plan can be obtained upon application to the Plan Administrator.

The Major Medical and Dental benefits described in this booklet are integrated with benefits for which the Trust Fund has a liability. This liability is limited to the level of deposits required to be made to Manulife Financial for coverage. Manulife Financial is liable for all benefits in excess of the level of deposits, providing they are covered under the terms of the Insurance Contract.

The Trustees reserve the right to make changes to the benefit program or to the Eligibility Rules without notice, but the Trustees will endeavor to give reasonable notice to all Members of any such changes.

This booklet contains important information and should be kept in a safe place for future reference.

BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

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To All Eligible Members:

This booklet contains an up-to-date description of the benefits provided by the Fund, as of January 1, 2023

The booklet provides an outline of the benefits to which you and your family are entitled, of the rules governing eligibility for these benefits, and of the procedures that should be followed when making a claim.

Be sure to read this booklet carefully so you will be acquainted with all the various benefit provisions. Should you have any questions regarding your benefits, do not hesitate to contact the Plan Administrator where a staff member will be pleased to assist you.

Sincerely,

BOARD OF TRUSTEES

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SUMMARY OF BENEFITS

LIFE INSURANCE

$30,000

ACCIDENTAL DEATH AND DISMEMBERMENT

$30,000

DEPENDENT LIFE INSURANCE

Spouse	$10,000
Each Child	$4,000

WEEKLY DISABILITY

Benefit	$650 per week;
Elimination period	16 weeks;
Maximum	36 weeks of benefit payments

MAJOR MEDICAL

Deductible	Nil
Coinsurance	80% of prescription generic drug expenses, including oral contraceptives 80% of all other eligible expenses, 100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members, rehabilitation hospital, out of province /Canada coverage (except if noted otherwise) Eyeglass frames and lenses or contact lenses up to a total maximum of $600 during any 24 consecutive month period from the last date of service (12-month period from the last date of service for persons under 18 years of age); coverage also includes reimbursement of safety glasses for Members. 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $100 maximum once every 24 months 50% Orthopaedic shoes that are not part of a brace
Maximum	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) $1,000,000 lifetime maximum per individual for Out of Province/Canada Expenses (includes Emergency Travel Assistance).

DENTAL

Deductible	Nil
Coinsurance	80% of eligible Basic expenses 80% of eligible Major expenses 50% of eligible Orthodontic expenses
Maximum	$2,000 per calendar year for eligible Basic expenses $2,000 per calendar year for eligible Major expenses $1,500 lifetime maximum for eligible Orthodontic expenses for dependent children only. 2021 Dental Fee Schedule

Fee Guide - Benefits are paid in accordance with the Provincial Dental Fee Schedule approved by the Trustees. Please see the Dental Expense section for a list of eligible expenses.

ELIGIBILITY RULES

EMPLOYEES WHO MAY BE ELIGIBLE FOR BENEFITS

1. Any employee for whom his employer is obligated or permitted to contribute to the Fund by an applicable Collective Bargaining Agreement or other agreement between an employer and the Fund.

2. Any full-time salaried officer or employee of any applicable Local for whom coverage under this Plan has been approved by the Trustees.

3. Any employee of the Trustees for whom coverage under this Plan has been approved by the Trustees.

4. Any other employee of certain employers for whom coverage under this Plan has been approved by the Trustees.

Contributing employer means any employer who is obligated or permitted to contribute to the Trust Fund.

Note: To become eligible and to remain eligible for coverage an employee (and each employee's dependent) must be a Canadian resident and maintain provincial coverage.

ELIGIBLE DEPENDENTS

An employee's eligible dependents are:

1. The employee's spouse, and

2. unmarried children primarily dependent upon the employee for support, who are:

    a) under the age of 21 years (but at least 15 days of age for Dependent Life Insurance), or

    b) at least 21 years of age but under 25 years of age and attending an accredited educational institute, college or university on a full-time basis, or

    c) at least 21 years of age and dependent upon the employee by reason of mental or physical infirmity. Proof of mental or physical infirmity must be submitted within 31 days after coverage would otherwise terminate. Additional proof may be required from time to time. (Not applicable to Dependent Life Insurance. Please refer to "Continuation of Major Medical and Dental Care Benefits for Incapacitated Children" in the General Information section.)

Stepchildren and legally adopted children are covered provided they are dependent upon the employee for support and maintenance.

"Spouse" means either:

a) a person who, as of the time in question, is legally married to the employee or

b) is the common-law spouse of the employee, that is, a person who, though not legally married to the employee, is a person who has cohabited with the employee in a husband and wife relationship for at least one continuous year before incurring the expense for which a claim is made. (Please refer to "Establishing Proof of Common-Law Spouse" in the General Information Section.)

To establish that the common-law spouse has been living with the employee for at least one year, the employee must complete the Declaration of Common-Law Spouse section on the reverse side of the Registration Form, naming the common-law spouse as a dependent. This form must then be on file in the Plan Administrator for a period of one year before the common-law spouse is eligible for benefits.

If the employee has a common-law spouse, as defined above, but the spouse has not been registered with the Plan Administrator for at least one year, the employee can have the Declaration of Common-Law Spouse signed by a Commissioner of Oaths. This will eliminate the one-year Plan Administrator filing requirement; however, the common-law relationship must still have existed for at least one year before the claim expense was incurred.

If more than one person qualifies as the employee's spouse, the person designated on the Registration Form as the spouse, will be the person the Plan recognizes as the spouse. To be valid, the Registration Form must be signed by the employee and received by or filed with the Trustees or the Administrator. In the absence of this designation, the Plan will consider the person qualified under (a) in the above definition to be the employee's spouse.

EFFECTIVE DATE OF COVERAGE

The effective date of coverage for any employee is the date on which the employee qualifies for coverage in accordance with the following rules, provided the employee is actively at or available for work on his effective date. No payments are to be made for services rendered prior to the effective date of insurance.

Usually, coverage for an employee's eligible dependents becomes effective on the same date that the employee's coverage becomes effective. However, coverage for a common-law spouse becomes effective as described above. No benefit payments will be made for services received before the employee's effective date.

HOW EMPLOYEES BECOME ELIGIBLE

An employee will become eligible on the first day of the second calendar month which follows a period of not more than six consecutive months during which the employee worked at least 300 hours for contributing employers.

If an employee dies during the one month waiting period before eligibility commences or is reinstated, a death benefit will be paid under the Life Insurance Benefit and under the Accidental Death and Dismemberment Benefit (if it is an accidental death). No waiver of premium, or

dependent Life benefits or other Plan provisions will be applicable and no accidental dismemberment benefits will be payable.

CONTINUATION OF ELIGIBILITY

Hours worked for contributing employers by each employee will be credited to the individual's "reserve account". One hundred and twenty (120) hours of work credit will be deducted from each eligible employee's "reserve account" for each month of insurance coverage, and employees will continue to remain eligible as long as their reserve accounts contain at least 120 hours of work credit.

Employees will be allowed to accumulate excess hours in their reserve accounts up to a maximum of 720 hours.

CONTINUATION OF ELIGIBILITY WHILE DISABLED

Whenever an eligible employee is disabled and is receiving Workers' Compensation Board (WCB) benefits or Employment Insurance (E.I.) sickness and accident benefits or Fund Weekly Disability Benefits for at least two consecutive weeks in any calendar month, no deduction will be made from his reserve account for that month. In other words, his hour-bank reserve accumulation will be "frozen". This situation will continue until the month following the month in which the disability ends. Protection is extended for a maximum period of three months under this rule. This extension of coverage is only available to members who belong to a local within the jurisdiction of this Trust Fund (that is, Local Union No.1, Alberta; and Local Union No.1, Saskatchewan).

If you receive Workers' Compensation Board (WCB) benefits or E.I. sickness and accident benefits you must notify the Plan Administrator of the duration of your disability so that your hour-bank reserve accumulation may be frozen for the period described above. A "Request for Freezing of Hours" form may be obtained at your Local Union Office or the Plan Administrator via the website.

CONTINUATION OF ELIGIBILITY WHILE ATTENDING TRADE SCHOOL

Whenever an apprentice employee attends a recognized trade school related to his employment for at least two weeks in any calendar month, no deduction will be made from his reserve account for that month. This will continue until the month following the month in which his said classes end, provided however that an employee may not obtain a deduction deferment under this clause for any period of schooling longer than three consecutive months for any one series of apprenticeship classes. To obtain a deduction deferment under this clause approval is required from the Local Union Office.

TERMINATION OF BENEFITS

An employee's (and his dependents') eligibility under this Plan will terminate at the end of the second month following the month in which the work credits in his reserve account fall below 120 hours, after deduction of 120 hours for the current month. Coverage may be extended beyond the normal termination date in the event of disability or the employee's death. Details of any such extensions are provided elsewhere in this booklet.

REINSTATEMENT

An employee whose eligibility has terminated will again become eligible if his reserve account shows a total of at least 120 hours within the four-calendar month period subsequent to the termination of his eligibility. Such reinstatement will be effective on the first day of the second month which follows the month in which this requirement is met. If the Member is not reinstated within a four-calendar month period, any reserve hours in his account will be forfeited. Such a Member will again become eligible for insurance upon completion of the initial eligibility requirements described earlier.

EXTENSION OF COVERAGE BY SELF-PAYMENT

An employee, whose eligibility terminates, may continue coverage for himself and his family by making self-payments, sent to the Plan Administrator. Prior notification of entitlement to continued coverage on a self-payment basis will be provided and no interruption in payments will be permitted. **If there is a lapse in self-payments, no further self-payments will be accepted and coverage will cease.**

To be eligible to make self-payments, you must meet one of the following criteria:

1) You are an apprentice who is attending a recognized trade school related to this trade; or
2) You are in receipt of Workers Compensation Board (WCB) benefits, Employment Insurance (EI) sickness and accident benefits, or the Fund Weekly Disability Benefit.

Coverage may be continued by making self-payments to the Plan Administrator, for up to a maximum of six consecutive self-payments, and no more than six self-payments within a 24-month period.

NOTE:

- Members covered on a self-payment basis are not eligible for Weekly Disability benefit coverage.
- You must be a Member in good standing at a Local Union who is available for work with a contributing employer (your availability for work will be verified with the Local Union Office on a monthly basis)

For further information concerning the number of self-payments, and any other requirements which must be met, please contact the Plan Administrator.

DECEASED EMPLOYEES - LENGTH OF DEPENDENT COVERAGE

In the event of any employee dying while he is eligible for health and welfare benefits through hour bank deductions, the benefits payable under the Plan applicable at the time of death for such deceased employee's dependents shall continue for either the three calendar months immediately following the date of death or until the deceased employee's hour bank runs out in the normal course, whichever is later; however, if any dependent of such deceased employee leaves the covering province during the period of extra coverage and any applicable legislation limits such as out of province coverage, then the coverage permitted shall be reduced accordingly.

PARTICIPATION BY NON-BARGAINING EMPLOYEES OF CONTRIBUTING EMPLOYERS

Employers may insure themselves and any Members of their organizations who are not covered by a Collective Bargaining Agreement by making the required payments to the Fund as stipulated by the Trustees from time to time.

Non-bargaining employees may become and remain eligible provided they meet prescribed non-bargaining eligibility rules. The Board of Trustees reserves the right to amend these rules at any time and to require proof that all conditions and requirements are being met. Full information concerning participation of non-bargaining employees can be obtained by contacting the Plan Administrator.

GENERAL INFORMATION

WHEN YOUR DEPENDENCY STATUS CHANGES

If you marry or have children, a new Registration Form must be completed and forwarded to the Plan Administrator each time you acquire a new dependent.

CONTINUATION OF MAJOR MEDICAL AND DENTAL CARE BENEFITS FOR INCAPACITATED CHILDREN

Major Medical and Dental Care Benefits will continue beyond the date an unmarried child attains the limiting age for coverage, provided proof is submitted to Manulife Financial within 31 days after such date that such child:

- is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- became so incapacitated prior to attainment of the limiting age; and
- is chiefly dependent upon the employee for support and maintenance.

Thereafter, such proof must be submitted to Manulife Financial, as required, but not more often than yearly.

NAMING A BENEFICIARY

You may name a beneficiary, subject to governing law while applying for group insurance or by filing notice in accordance with instructions provided by the Plan Administrator. You may change an existing beneficiary, subject to governing law, by filing notice in accordance with instructions provided by the Plan Administrator. Once notice has been filed, it takes effect as of the date it was signed with respect to any payment made after the time it was filed. If there is no designated beneficiary living at the time of death, then Manulife Financial shall pay the benefit to your estate.

Manulife Financial does not accept beneficiary designations for any benefits other than Member Life Insurance and Member Accidental Death and Dismemberment.

ESTABLISHING PROOF OF COMMON-LAW SPOUSE

With respect to establishing that your common-law spouse has been living with you for at least one year, a Registration Form must be completed, naming your common-law spouse. This Form must then be received in the Plan Administrator for a period of one year before your common-law spouse and children of that common-law spouse are eligible for benefits.

BOOKLET

When you are eligible you will receive a booklet describing your benefits if you have filed a Registration Form with the -Plan Administrator.

WORKING OUTSIDE THE COUNTRY

If you are working outside of Canada, it may impact your benefit coverages. Please contact the Plan Administrator for further information.

CHANGE IN ADDRESS

If you should have a change of address, it is important that you notify the Plan Administrator immediately by completing a new Registration Form.

CHANGES IN PLAN PROVISIONS

The Eligibility Rules, Benefit Plan Provisions and Insurance Contract may be altered by the Trustees from time to time without the necessity of prior notice being made to those affected thereby.

DEFINITIONS

Total Disability
Total disability as used herein means your complete inability to perform any and every duty pertaining to any occupation or employment.

Provincial Medicare Act
"Provincial Medicare Act" used with respect to any Province means the Act or Acts providing Medical Care benefits for residents of such Province, originally established in agreement with the Government of Canada pursuant to the Medical Care Act (Canada) and such term shall also include any and all regulations made under such Act or Acts.

Hospital Insurance Act
"Hospital Insurance Act" used with respect to any Province means the Act providing hospital insurance for residents of such Province, established in agreement with the Government of Canada pursuant to the Hospital Insurance and Diagnostic Services Act (Canada) and such term shall also include any and all regulations made under such Act.

Hospital
"Hospital" means, for insurance purposes, an institution which keeps patients regularly overnight, has full therapeutic facilities for the care of the injured, sick or chronically ill, and is under the supervision of a staff of physicians who are Doctors of Medicine, and regularly provides 24 hours nursing service by registered graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, rest homes, and places for the aged, drug addicts, or alcoholics do not qualify as hospitals.

Rehabilitation Hospital
"Convalescent/Rehabilitation Hospital" means, for insurance purposes, an institution which has a transfer arrangement with one or more hospitals and regularly provides skilled nursing care during the convalescent/rehabilitation stage of an injury or disease and its charges for ward care for the individual are reimbursed under a Provincial Hospital Plan. Unless they fully meet this definition, institutions for rest, the aged, custodial care, drug addicts, or for the care of pulmonary tuberculosis, mental illness or mental retardation do not qualify as convalescent/rehabilitation hospitals.

Physician
"Physician" means a person currently licensed or certified to provide medical services by the appropriate licensing or registration authority established by the Medical Profession Act, or comparable Act if not so titled, of the jurisdiction in which the services are rendered.

Dentist
"Dentist" is limited to a person duly licensed to practice dentistry by the Government authority having jurisdiction over the licensing and practicing of dentistry in the locality where the service is rendered.

Reasonable Charge
"Reasonable Charge" means that portion of the charge to a person for a service, drug, medication, supply, aid or appliance which is not in excess of the charge customarily made in the same area for a supply or a similar service rendered by a dentist, physician or practitioner of like knowledge and skill to a person of similar age and sex, circumstances and medical condition. However, charges for drugs, medications, supplies, aids or appliances of a luxury nature, are not eligible.

Necessary Service
"Necessary Service" as used with respect to the number of services rendered to a person means a number consistent with accepted good practice as recognized generally by the profession to which the practitioner rendering the services belongs. Manulife reserves the right to seek advice from other Members of the profession on this question.

Adherence
use of drug, service or supply in accordance with the terms for which it was prescribed.

Advisory Body
Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.

Disease Management Programs
an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug
a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence
a process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Group Policy. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Exclusive Distribution
Manulife Financial approved vendors.

Experimental or Investigational
not approved as an effective, appropriate and essential treatment of an illness or injury.

Interchangeable Drug
includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

Life-Sustaining Drugs
non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative
if two or more drugs, supplies or services result in therapeutically similar results, the lower cost alternative will be considered.

Medically Necessary
accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of a phase of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is eligible under the Group Policy.

Patient Assistance Program
a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics
the scientific discipline that compares the value of one pharmaceutical drug or drug therapy to another. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Prior Authorization
A claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

EMPLOYEE LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary, if living, otherwise to your estate. You may change your beneficiary at any time by providing written notice to the Plan Administrator, subject to any policy or legal limitations.

DISABILITY PROVISION

If you become both totally and permanently disabled before age 65, and continue to be so disabled, for at least nine consecutive months, the amount of Life Insurance for which you were covered at the time you became so disabled will be continued free of charge until you cease to be both totally and permanently disabled or you reach age 65, whichever occurs first. "Totally and Permanently Disabled" means that solely because of an illness or injury, the employee is, and will continue to be, unable to work at any occupation for which he is, or may reasonably become, fitted by education, training or experience. You must submit proof of your continuing disability as may be required by the Insurer.

Note: In order to qualify for the Waiver of Premium benefit you must notify the Plan Administrator of your disability within one (1) year of your last active day at work, or the last day you were available for work due to disability. Proof of your disability, satisfactory to the Insurer must be provided within 18 months of that last active working day or the last day you were available for work due to disability.

CONVERSION OPTION

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you did not apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

EXTENSION OF BENEFIT

If you die within 31 days of the date your Employee Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this Plan even if you did not apply for conversion.

DEPENDENT LIFE INSURANCE

In the event of the death of one of your eligible dependents while insured, the amount of Dependent Life Insurance is payable to you, if living, otherwise to your estate.

CONVERSION OPTION

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during the 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you did not apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

EXTENSION OF BENEFIT

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

ACCIDENTAL DEATH AND DISMEMBERMENT

EMPLOYEE ACCIDENTAL DEATH BENEFIT

If you sustain an accidental bodily injury while covered and if a covered loss occurs as a direct result, and within one year of the accident, the following benefit will be paid:

For Loss of:	Percentage of Amount Insured
Life	100%
Both hands or both feet	100%
Both arms or both legs	100%
Sight of both eyes	100%
Sight of one eye	$66^{2}/_{3}$%
Speech and hearing	100%
Speech or hearing	$66^{2}/_{3}$%
Hearing in one ear	$16^{2}/_{3}$%
Thumb and index finger of same hand	$33^{1}/_{3}$%
Four fingers of one hand	$33^{1}/_{3}$%
All toes of one foot	$12^{1}/_{2}$%
Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200%

For Loss of, or Loss of Use of:

Arm or leg	75%
Hand or foot	$66^{2}/_{3}$%

No more than the largest percentage shown for a body Member will be paid for the loss of more than one part thereof.

Not more than 100% will be paid for all losses sustained in any one accident, with the exception of Quadriplegia, Paraplegia and Hemiplegia, for which no more than 200% will be paid.

"Loss" as above used with reference to Quadriplegia, Paraplegia, and Hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalanges of both the thumb and index finger; as used with reference to four fingers of one hand means complete severance through or above the first phalanges of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.
"Loss" as used with reference to "loss of use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

EXPOSURE AND DISAPPEARANCE

If you disappear as a direct result of the accidental disappearance, wrecking or sinking of the conveyance in which you were an occupant, accidental death will be deemed to have occurred; provided there is no evidence within one year thereafter that you are still alive.

REPATRIATION BENEFIT

If injuries result in loss of your life outside 200 km from your permanent city of residence and within 365 days of the date of the accident, payment will be made for the actual expenses incurred, but not more than $10,000, for the preparation and transportation of your body back to your city or town of residence.

FAMILY TRANSPORTATION

When a covered loss results in you being confined to a hospital more than 200 km from your permanent city or town of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a Member of your immediate family, an amount equal to the actual expenses incurred, but not more than $10,000, will be paid for roundtrip transportation by the most direct route by a licensed common carrier for one immediate family Member to you.

Immediate family means your spouse (or common-law spouse), parent, grandparent, child age 18 or over, brother or sister.

REHABILITATION BENEFIT

If a benefit, other than a benefit for loss of life, becomes payable, an additional benefit equal to the reasonable and necessary expenses actually incurred up to a limit of $10,000 will be paid for your training, provided:

- such training is required because of the "injuries" sustained in the accident and in order for you to be qualified to engage in an occupation in which you would not have been engaged except for such "injuries;" and
- expenses be incurred within two years from the date of the accident.

All such expenses are limited to the cost of the training and materials needed for such training.

SEAT BELT RIDER

If you are a passenger or driver of a private passenger type automobile and are involved in an accident for which a benefit is payable under this contract, the benefit will be increased by 10% if you were wearing a properly fastened seat belt. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

HOME ALTERATION AND VEHICLE MODIFICATION

If you receive a benefit for accidental loss, other than death, and are subsequently required to use a wheelchair to be ambulatory due to the same cause for which the benefit became payable, upon presentation of proof of payment, this benefit will pay:

- the one-time cost of alterations to your residence, to make it wheelchair accessible and habitable, if carried out by an experienced individual in such alterations, and recommended by a recognized organization providing support and assistance to wheelchair users; and
- the one-time cost of modifications necessary to a motor vehicle owned by you, to make the vehicle accessible or drivable for you, if carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities; up to a combined maximum of $10,000, provided these are made on behalf of you.

TO WHOM ARE BENEFITS PAID

Your accidental death benefit will be paid to the beneficiary designated under your Life Insurance benefit or to your estate if no such designation is made. Any other benefits are payable to you and are described in the schedule of losses.

LIMITATIONS

No amount will be paid for a loss that results from or is contributed to by:

- war, whether declared or not;
- suicide or attempt threat, while sane or insane;
- self-inflicted injury, while sane or insane;
- active full-time service in the armed forces of any country;
- travelling or flying in, or descending from, any kind of aircraft, as a pilot, operator or Member of the crew. However, insurance will include injury sustained while the person is riding as a passenger with no duties whatsoever, in or on, boarding or alighting from any aircraft having a current and valid air worthiness certificate, or from any transport type aircraft operated by the transport command of the Canadian Armed Forces Air Transport Command or by the similar Transport Service of any country but excluding while flying in any aircraft owned or operated by an employer.

WEEKLY DISABILITY BENEFIT

Members covered on a self-payment basis are not eligible for this benefit.

Benefit

You will be paid a benefit of $650 per week if you are totally disabled due to non-occupational accidental bodily injury or illness and are unable to perform your regular work. Total disability means your complete inability to his or her job duties.

The benefit will commence after the seventeenth week of continuous disability due to an illness or accident. To qualify for benefits, you must visit your doctor within the first three days of an illness.

After benefit payments begin, successive periods of total disability separated by less than two weeks of active work or availability for active work shall be considered as one period of disability, unless the subsequent disability is due to injury or sickness entirely unrelated to the causes of the previous disability and commences after return to or availability for work.

NOTE: In order to be eligible for payment, Weekly Disability claims must be submitted within 6 months of the commencement of disability.

What is Not Eligible

Weekly Disability benefits are not payable for:

- a disability caused by self-inflicted injury or illness, unless medical evidence establishes that the injuries are related to a mental health illness.
- a disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot,
- a disability for which you are entitled to benefits under any Workers' Compensation Act or the Saskatchewan or Quebec Automobile Insurance Act,
- periods of disability when you are on vacation and receiving full pay,
- any day you do any kind of work for pay or profit.

Complications because of pregnancy are covered. However, if you are on a maternity leave of absence or could be placed on this type of leave (in accordance with relevant government legislation or the leave agreed upon by you and your employer), you will not be eligible for disability benefits during this time. If you are an Alberta resident, this does not apply for any portion of a period of maternity leave during which you are disabled due to pregnancy.

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will enable Manulife Financial to be reimbursed for any amount(s), including interest, you recover from a third party for loss of income, or medical or dental expenses which, together with any amount(s) paid or payable under any of the benefits of this Plan, would exceed your actual loss.

When Manulife Financial is notified of payment by a third party of any judgment or settlement, further disability payments under this Plan will terminate until Manulife Financial has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid from this Plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Extension of Benefits

If you are disabled on the date your coverage ends and that disability continues uninterrupted, Weekly Disability benefits will continue until the end of the benefit period under the Plan or until you recover, whichever occurs first.

MAJOR MEDICAL

EMPLOYEE AND DEPENDENT COVERAGE

In the event that you incur any of the Eligible Expenses listed below, you will be paid a percent of such expenses as outlined in the Summary of Benefits.

LIFETIME MAXIMUM BENEFIT

The total lifetime benefit payable in respect of you or your dependents is limited to the Lifetime Maximum Benefit specified in the Summary of Benefits.

On each January 1st, up to $1,000 of the Overall Benefit Maximum which has been paid by Manulife will be automatically reinstated. However, the total will not exceed $100,000 per individual.

If your individual benefit payments amount to more than $1,000 you may apply to have your full maximum restored, subject to medical evidence of insurability that is satisfactory to Manulife Financial.

ELIGIBLE EXPENSES

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- supported by Manulife Financials due diligence process and due diligence for the drug, supply or service has been completed where required

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this policy will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This policy will not automatically assume eligibility for all drugs, services and supplies prescribed. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife Financial using the due diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include, include with prior authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments, you or your eligible dependents may be required to have tried an alternative treatment.

At Manulife Financial's discretion, medical information, test results or other documentation may be required from your physician to determine the eligibility of the drug, service or supply.

Manulife Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence
Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs
Manulife Financial may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Manulife Financial reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs
Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Prescription Drug Expenses
Medically necessary drugs or medicine (including oral or injectable contraceptives) which can only be obtained if prescribed by a licensed physician or dentist or other professional authorized by provincial legislation to prescribe drugs and dispensed by a registered pharmacist or licensed doctor (M.D.). Any other charges by a physician, such as professional fees, are not covered. Drugs, serums, vaccines (excluding preventative vaccines) or injectable diagnostic aids are covered when injected by or under the supervision or direction of a legally qualified physician (M.D.).

Nicotine patches and gums are not eligible for reimbursement.

Drugs determined to be ineligible as a result of due diligence are not eligible for reimbursement.

Erectile dysfunction drugs are limited to $500 per individual per calendar year.

Coverage is provided based on generic drugs and medicines. Full coverage (that is, 80% for all participants) of brand name drugs and medicines will only be provided if a generic equivalent does not exist. If a generic drug does exist and a brand name drug is purchased, you will be required to pay all expenses in excess of 80% of the cost of the generic equivalent (even if the doctor requests no substitutes).

Prescription drug expenses can be obtained using your Benefit Card. If you have your prescription filled at a pharmacy that does not participate in the program, you must pay for the cost of the prescription and submit your receipt in accordance with the claim instructions detailed later in this booklet.

Vision Care Expenses

Vision Care Expenses are payable when recommended by a legally qualified optometrist or ophthalmologist and provide reimbursement for the following:

1. Eyeglass frames and lenses or contact lenses up to a total maximum of $600 during any 24 consecutive month period from the last date of service (12-month period from the last date of service for persons under 18 years of age); coverage also includes reimbursement of safety glasses for Members.
2. Laser eye surgery at 50% to a lifetime maximum of $1,000 per individual.
3. Eye examinations performed by a licensed ophthalmologist or optometrist. Coverage is limited to one routine examination every two calendar years to a maximum of $100 per individual.

No benefits are provided for, prescription sunglasses, anti-reflective coatings or tints other than No.1 or No. 2.

Extended Health Expenses

1. <u>Rehabilitation Hospital (Within Home Province)</u>

   Daily charges in excess of the ward rate up to semi-private room limit, but not beyond 120 days. Confinement must follow three consecutive days of hospital confinement. A new Maximum Stay will apply if the covered person has not been confined in a convalescent hospital for at least 90 days.

   A rehabilitation hospital is a place that:

   - has a transfer arrangement with hospitals;
   - provides inpatient nursing care (that meets minimum provincial regulations) for the rehabilitation stage of an injury or illness; and
   - is approved as a rehabilitative hospital for payment of the ward rate under the provincial health plan.

Health Practitioners

Charges, including x-ray charges, up to the benefit maximum shown in the schedule, by a practitioner who is registered and legally practicing within the scope of his license as:

- a chiropractor, physiotherapist and massage therapist, per practitioner maximum of $300 per calendar year. Laboratory tests and x-rays performed by a chiropractor up to a maximum of $25 per calendar year;
- a naturopath, Christian science practitioner, osteopath or podiatrist, up to $8.00 per visit to a maximum of 20 visits per calendar year per each type of practitioner;

- a psychologist*, up to a maximum of $500 per calendar year;
- a speech therapist. Charges only for restoratory or rehabilatory speech therapy by a qualified speech therapist. Treatment must be for speech loss or impairment due to illness (or surgery on account of illness) other than a functional nervous disorder. If the condition is due to a congenital abnormality, corrective surgery must have been performed prior to the therapy.

* when treatment is prescribed by a licensed doctor (M.D.) as to duration and type

No amount will be paid for any visits for which any amount is payable under the covered person's provincial health plan, unless permitted by law.

4. Charges for the services of a registered nurse (R.N.), licensed practical nurse, or certified nursing assistant (C.N.A.) which are rendered in the patient's home, provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a legally qualified physician (M.D.) and only if it is medically necessary. Eligible expenses are limited to a $10,000 lifetime maximum per individual.

5. Charges for supplies and the rental of, or, at Manulife Financial's option, the purchase of durable medical equipment of the type and model adequate for the covered person's medical needs based on the nature and severity of the disability, such as, but not limited to:

- hospital beds, wheelchairs, canes, crutches, walkers and trusses;
- rigid or semi-rigid braces for back, neck, arm or leg and non-dental prostheses such as artificial limbs and eyes; including replacement if required because of a change in physical condition;
- respiratory equipment, including oxygen;
- kidney dialysis equipment;
- contact lenses or glasses following cataract surgery (limited to one pair per lifetime); and
- splints, casts, catheters, and hypodermic needles;

but excluding personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to:

- Heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

Before incurring any major expenses you should submit details to Manulife Financial to determine to what extent benefits are payable. In any event, a letter will be required from a licensed doctor (M.D.) describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

6. Diagnostic laboratory and x-ray expenses.

7. Charges for professional ambulance service, other than airline or railroad to the nearest hospital qualified to provide the necessary treatment. Emergency transportation by airline or railroad to and from the nearest hospital qualified to provide the necessary treatment, provided such charges are reasonable and customary.

8. Charges for necessary dental treatment by a licensed dentist which are reasonable and customary and are required as the result of a non-occupational accidental injury by external means to sound natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed with 12 months of the accident to be a covered medical expense.

9. Charges for laboratory tests and x-rays performed by a Chiropractor, subject to a maximum eligible expense of $25 per calendar year per individual.

10. Charges for necessary services in a hospital's outpatient department on account of sickness or accidental bodily injury. (Coverage is provided only to the extent permissible by law.)

11. Charges for one hearing aid (excluding batteries) in any 24 consecutive month period up to a maximum of $250, provided by a certified, clinical audiologist.

12. Reasonable and customary charges for restoratory or rehabilatory speech therapy by a qualified speech therapist. Treatment must be for speech loss or impairment due to illness (or surgery on account of illness) other than a functional nervous disorder. If the condition is due to a congenital abnormality, corrective surgery must have been performed prior to the therapy.

    No amount will be paid for any visits for which any amount is payable under the covered person's provincial health plan, unless permitted by law.

13. Charges for custom made arch supports, orthotic devices, lifts, wedges (but not for sports), Dennis Browne splints and shoes purchased and used in the application of such splints to a maximum of $300 every two years. Charges for orthopedic shoes that are not part of a brace or splint will be reimbursed at 50% once every 2 years with no maximum just subject to Reasonable & Customary; orthopedic shoes which are part of a brace will be reimbursed at 80% once every 2 years with no maximum just subject to Reasonable & Customary; orthotic devices will be reimbursed at 80% once every 2 years up to a maximum of $300.

Exclusions and Limitations

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

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- the covered person's commission of, or attempt to commit, an assault or a criminal offence.

The foregoing list of eligible expenses shall not include any of the following:

1. Charges which are considered an insured service of any provincial government plan;
2. Charges for general health examinations and preventive vaccines;
3. Charges for surgical procedures or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedures or treatment;
4. Charges for medical or surgical procedures by a physician other than as provided under outside Canada expenses;
5. Charges which are from an occupational injury or sickness covered by any Workers' Compensation law or similar legislation;
6. Charges for dental work where a third party is responsible for payment of such charges;
7. Charges for hospital room and board expenses in Canada;
8. Charges, for which there would be no charge made in the absence of this coverage;
9. Charges for dental work, except as provided under dental care for accidental injury;
10. Charges for core, services or supplies, if the payment is prohibited by law;
11. Charges other than those listed as eligible expenses under major medical;
12. Charges for care, services or supplies if prohibited by law.

Extension of Benefits

If a covered person is Totally Disabled on the date coverage under these benefits terminates, entitlement to benefits will be the same as though such coverage had not terminated, for as long as such person remains continuously so disabled, but not beyond the earlier of:

- the date such person becomes covered under any other group-type plan provided similar coverage; or
- three months.

Totally Disabled Means:

- for an employee, that such person cannot, because of illness or injury, engage in such person's regular occupation and is not working for pay or profit; and
- for a dependent, that such person cannot, because of illness or injury, engage in most of the normal activities of a person of the same age and sex.

Out-of-Province/Canada Emergency and Emergency Travel Assistance Benefit

(Applicable to Members under age 65 only, and their dependents. Coverage will terminate for both the Member and their dependents when the Member reaches age 65.)

Charges incurred for the following medical treatment given outside the insured person's province of residence:

a) treatment required as a result of a Medical Emergency arising during the first 6 weeks while temporarily outside the province of residence provided that the insured person who receives the treatment is also insured by the Provincial Plan during the absence from the province of residence.

A Medical Emergency occurs when an insured person requires immediate medical attention while travelling outside his province of residence due or related to:

i) a sudden, unexpected injury which occurs or a new medical condition which begins while a covered person is travelling outside his province of residence; or

ii) a previously identified medical condition that was Stable*, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

Such Medical Emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is able to return to his province of residence. No coverage is provided for any Medical Emergency related to a pregnancy for covered persons who are pregnant and travelling within 4 weeks of the due date.

These charges are subject to the Out-of-Province/Canada Maximum shown in the Benefit Schedule.

* Stable means a condition as pertaining to the Out-of-Province or Out-of-Canada benefit, whereby a covered person:

a) has not in the 90 days before the departure date:

i) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination, or

ii) experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the insured/covered person has been seen by a medical professional in relation to the symptoms, or

iii) been prescribed or recommended a change in treatment or medication related to the medical condition by a Physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, or

iv) been admitted to or treated at a hospital for the medical condition, or

b) did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

Charges for the following are payable under this Covered Expense:

a) Physician's services;

b) Hospital room and board for semi-private accommodation;

c) the cost of special Hospital services;

d) Hospital charges for out-patient treatment;

e) licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or Hospital where adequate treatment is available; and

f) medical evacuation for admission to a Hospital or medical facility in the province where the patient normally resides.

Covered Expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

All other charges incurred while outside the province of residence are payable under the appropriate Covered Expense on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for an insured person during the first 6 weeks while such person is temporarily outside his province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that the insured person is covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this plan.

In addition, Emergency Travel Assistance also provides the insured person with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Dependent children who are attending school outside Canada are eligible for coverage only while travelling to and from their province of residence and the school.

Details regarding the Emergency Travel Assistance benefit are provided below, as well as in the Emergency Travel Assistance brochure.

Medical Emergency Assistance

A Medical Emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while an insured person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the insured person is stable enough to return to his province of residence.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims coordinated on behalf of the insured person.

Payment and co-ordination of expenses will take into account the coverage that the insured person is eligible for under a Provincial Plan and this Policy. If such payments are subsequently determined to be in excess of the amount of benefits to which the insured person is entitled, Manulife Financial shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from the covered person.

d) **Medical Care Monitoring**

Medical care and services rendered to the insured person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the insured person, the attending physician, the insured person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer an insured person to and from the nearest medical facility or to a medical facility in the insured person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the insured person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children under age 16 are left unattended due to the hospitalization of an insured person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

This expense is subject to a maximum of $5,000 (Canadian) per medical emergency, combined for items f), g) and i).

g) **Trip Delay**

If a trip is delayed due to an illness or injury of an insured person, one-way economy transportation will be arranged to enable each insured person to return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

This expense is subject to a maximum of $5,000 (Canadian) per medical emergency, combined for items f), g) and i).

h) **After Hospital Convalescence**

If an insured person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for accommodation after the originally scheduled departure date will be paid, subject to a maximum of $75 per day for up to 5 days per insured person.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for one immediate family Member to visit an insured person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by Manulife Financial.

This expense is subject to a maximum of $5,000 (Canadian) per medical emergency, combined for items f), g) and i).

j) **Vehicle Return**

If an insured person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person’s home or nearest appropriate rental agency will be paid, up to a maximum of $500 (Canadian) per trip.

k) **Meals and Accommodation**

Under the circumstances described in part g) of this provision, expenses incurred for meals and accommodation will be paid, subject to a maximum of $700 (Canadian) per family.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of an insured person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the return of the deceased will be paid, up to a maximum of $5,000 (Canadian) per insured person.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help an insured person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the insured person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the insured person plans to travel.

Please Note: The Exclusions and Limitations shown on page 24/25 will also apply to this benefit.

Exceptions

Manulife Financial, and the company contracted by Manulife Financial to provide the travel assistance services described in this Benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of an insured person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

DENTAL EXPENSE BENEFIT

EMPLOYEE AND DEPENDENT COVERAGE

As the wording of this dental coverage is technically oriented, the Insurance Company suggests that you take this booklet with you when you visit your dentist.

EXTENSION OF BENEFITS

No benefits for eligible expenses will be paid after the termination of the Master Policy or after your insurance under this coverage ceases except a) to complete the installation of dentures within 90 days of the termination of coverage provided the impression was taken prior to termination or b) an identifiable procedure involving a tooth, or immediate gum area, provided active treatment was started while the Member or dependent was insured.

Dental benefits will not be payable during this 90-day period if you or your dependent are entitled to benefits for such expenses under any other plan on the date the dental expense is incurred.

DENTAL CLAIM FORM REQUIRED

No payment will be made unless a Dental Claim Form, satisfactory to the Insurer, is submitted to the Plan Administrator.

SUBMISSION OF TREATMENT PLAN

The Insurance Company reserves the right to use the least expensive method of treatment that would provide a professionally adequate result (called an alternate course of treatment provision). In case where there are optional methods of dental treatment, the least expensive procedure consistent with proper dental care will be paid. For example, if you are planning to have bridgework done in a situation where a denture would also be serviceable, then the Plan would provide payment for up to the cost of the denture only.

In order for you and your dentist to learn in advance how much the Plan will pay and how much must be paid by you, it is recommended that a treatment plan be filed with the Plan Administrator whenever a planned course of treatment is expected to exceed $500.

To use this service, simply have your dentist complete a treatment plan, on forms available from the Plan Administrator. This treatment plan, together with x-rays (if the proposed treatment involves crowns or bridgework) and the cost of the proposed treatment, should be forwarded to the Plan Administrator.

This treatment plan identifies what the Plan will cover **before** dental treatment begins. It identifies coverage and limitations for specific services and clarifies insurance percentages, specific limits and Dental Fee Guide allowances. The treatment plan is not intended to limit you in your choice of dentist, to tell you or your dentist what treatment should be performed, to tell the dentist what fee to charge, nor to guarantee reimbursement after coverage ceases.

ELIGIBLE EXPENSES

Charges for the following supplies and services are considered eligible expenses if they do not exceed the Fee Guide for General Practitioners or Specialists of the Dental Association approved by the Trustees. Please contact the Plan Administrator for details.

BASIC SERVICES - 80% REIMBURSEMENT, MAXIMUM BENEFIT $2,000 PER CALENDAR YEAR PER PERSON

1. **Diagnostics**: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

   (a) oral examinations: recall oral examination (including associated x-rays) limited to once every 12 months, complete oral exam and diagnosis is covered only once every 24 months;

   (b) x-rays: however, complete series or equivalent are only eligible once every two years;

   (c) study casts: once every 12 months;

   (d) consultations.

2. **Preventive Therapy**: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

   (a) polishing (prophylaxis) and topical fluoride treatments, once every 12 months;

   (b) space maintainers including stainless steel crowns, but only if the crown is placed on a deciduous tooth which (a) has several cavities which would otherwise require filling or (b) is non-restorable using normal restorative dental material;

   (c) pit and fissure sealants for persons under 19 years of age.

3. **Basic Restorative Dentistry**: The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings). In addition, sedative dressings are covered.

4. **Extractions**: Uncomplicated removal of teeth.

5. **Endodontics**: Emergency endodontic procedures and conservative root canal therapy.

6. **Periodontics**:

   (a) Adjunctive Service as follows: scaling, root planing or occlusal equilibration, (limited to 8 units per year for all procedures combined), acute infections, and provisional splinting;

   (b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;

   (c) Special Periodontal Appliances.

7. **Oral Surgery**: Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

8. **Anesthesia**: Anesthesia where reasonably and customarily required in connection with other covered procedures.

9. **Repairs, Relining, and Rebasing of Dentures**: Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

10. **Removable Prosthetic Devices**: The initial installation of partial or full dentures including adjustments during the three-month period following installation, and precision attachments for dentures.

    1. Replacement of existing dentures is not covered except if:

    (a) The replacement is required to replace a temporary denture by a permanent denture within 12 months from the date of installation of the temporary denture; or

    (b) The existing dentures are at least five years old and no longer serviceable.

    2. Addition of teeth to an existing partial denture will be covered.

    Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

MAJOR SERVICES - 80% REIMBURSEMENT - MAXIMUM BENEFIT $2,000 PER CALENDAR YEAR PER PERSON

1. Fixed Prosthetic Devices: Inlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays and onlays to form abutments).

    Replacement of fixed bridgework is covered only if the existing bridgework is at least five years old and no longer serviceable.

    Addition of teeth to an existing bridgework, if required.

2. Repairs: Repair or re-cementing of crowns, inlays and bridgework.

ORTHODONTIC SERVICES: 50% Reimbursement (dependent children only) – MAXIMUM BENEFIT $1,500 PER DEPENDENT CHILD PER LIFETIME.

1. Diagnostic procedures, including modes;
2. Therapy and appliances; and
3. Correction of malocclusion

OTHER PRACTITIONERS

Services or supplies must be rendered and dispensed by a licensed dentist, except that:

- scaling and cleaning of teeth may be done by a licensed dental hygienist; and
- installation, adjustment, repair, relining or rebasing of full dentures, may be done by a denturist, denture therapist, technician or mechanic, who is registered and practicing within the scope of his license.

Charges for such care, services and supplies will be deemed to be eligible expenses up to the lesser of:

- the amount shown in the practitioner's Fee Guide of the province where the charges are incurred; or
- the Fee Guide for dentists.

EXCLUSIONS AND LIMITATIONS

1. Payments will not be made for any dental procedure in respect of any injury or dental disease for which treatment first began before the employee or dependent became insured for that dental procedure;
2. Services or supplies that are primarily for cosmetic dentistry;
3. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
4. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
5. Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;
6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover;
7. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;
8. Any hospital charges for board and room and related services and supplies;
9. Any dental examinations required by a third party;
10. Diagnostic procedures in connection with any benefit categories excluded as eligible expenses;
11. Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants;
12. A full mouth reconstruction for a vertical dimension correction or for diagnosis or correction of a temporomandibular joint dysfunction;
13 Stainless steel crowns on permanent teeth;
14. Nutritional counselling or oral hygiene instruction;
15. Protective athletic appliances;
16. Replacement of a lost or stolen prosthesis.

GENERAL PROVISIONS

CO-ORDINATION OF BENEFITS

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

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

The plan that does not have a co-ordination of benefits provision pays before the plan that does (most, if not all, Insurance Company plans have such a provision).

The plan that covers the person as:

- an employee or Member pays before the plan that covers such person as a dependent; or
- a dependent child of the parent, covered as an employee or Member, whose birthday occurs first during the calendar year, pays first.
- If both parents have their birthday on the same day, benefits under the Plan will be shared in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

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

To implement this provision, the Plan may:

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

Allowable expense means any necessary reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

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

The exclusion of governmental benefits or services under this Plan are described in the "Exclusions" sections.

QUESTIONS AND ANSWERS

1. **How do I become covered under the Plan?**

Once hours that you have worked for a contributing employer have been reported to the Plan Administrator, an hour bank reserve account is established for you.

A "Registration Form" must be completed immediately and returned to the Plan Administrator. Blank Registration Forms are available at your Local Union Office or the Plan Administrator.

2. **What is the Individual's Hour Bank Reserve Account?**

This is an account kept by the Plan Administrator for each employee who works for a contributing employer. These employers report the number of hours worked by the employee to the Plan Administrator. The hours are placed in the employee's reserve account.

This is similar to a bank account, with hours being deposited instead of dollars. To pay for this coverage, an employee has hours deducted or withdrawn from his account.

For example: Let us have a look at the way a covered employee's account would operate, if he has 180 hours in his hour bank or reserve account at the beginning of the month.

Month	Account Balance at Beginning of Month	Hours * Reported in Month	Hours Charged For Coverage	Reserve Account Balance
1	180 Hours	116 Hours	120 Hours	176 Hours
2	176	185	120	241
3	241	75	120	196
4	196	Nil	120	76
5	76	100	120	56
6	56	125	120	61

* These are the hours worked two months before the current month. They are always reported a month late, that is, after the end of the month worked, and are credited to the month following that. For example, hours worked in January are reported in February and provide March eligibility.

NOTE: For eligible non-bargaining employees there are certain variations applicable to the procedures regarding the hour bank system, details of which may be obtained from the Plan Administrator.

3. **Is a medical examination necessary to be covered under the benefits?**

No! Initial eligibility in the Plan does not require a medical examination.

4. **When do my dependents get coverage under this Plan? What benefits do they qualify for?**

Your dependents become covered for benefits at the same time you become eligible. A Registration Form must be on file in the Plan Administrator for at least one year before your common-law spouse (as indicated on the Form) is eligible for coverage.

5. **What happens if I move from one Employer in the industry to another?**

If your new employer is required to make contributions, your reserve account will continue to be credited with hours reported. Your benefits are portable within the industry in Alberta and Saskatchewan.

6. **Once I am covered, how do I know if I have sufficient hours in my reserve account to pay for my coverage in future months?**

Your Local Union Office and the Plan Administrator will have the latest hour bank reserve account balances for each eligible employee.

NOTE: Each eligible employee is responsible for knowing what his reserve account balance is at any time.

HOW BENEFITS WILL BE PAID AND CLAIM INSTRUCTIONS (SUBJECT TO ELIGIBILITY)

To assist you in filing a claim you will find below a step-by-step outline of the procedure that you should follow:

Please note that the Insurance Company will investigate all claims to prevent fraud against the Plan. The Board of Trustees and the Plan Administrator fully support the Insurance Company and will assist them in this regard.

Manulife Financial shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may require during the pendency and payment period, if any of such claim.

Legal action to recover benefits under this Plan must begin within two years (six years for Life Insurance) of the date of loss.

LIFE INSURANCE

1. The Plan Administrator should be notified as soon as possible.
2. A certified copy of the death certificate or Medical Examiner's Report should be submitted to the Plan Administrator as soon as it can be obtained.
3. The Life Insurance benefit will be paid as soon as satisfactory proof of death and beneficiary designation are furnished to the insurer, provided it is submitted within 6 months after the date of death.
4. To qualify for Waiver of Premium, notification must be provided to the Insurer within one (1) year of your last active day of work or the last day you were available for work due to disability. Proof of your disability, satisfactory to the Insurer, must be provided within 18 months of your last active day of work or the last day you were available for work due to disability.

ACCIDENTAL DEATH AND DISMEMBERMENT

1. The Plan Administrator should be notified as soon as possible.
2. A certified copy of the death certificate or Medical Examiner's Report should be submitted to the Plan Administrator as soon as it can be obtained.
3. The Accidental Death and Dismemberment benefits will be paid as soon as proof of such loss has been verified by the Insurer, provided it is submitted within 6 months of the date of the accident.

WEEKLY DISABILITY

1. Apply for Employment Insurance Sickness Benefits immediately.
2. Obtain from your Local Union Office or the Plan Administrator, a "Weekly Disability - Statement of Claim" form.
3. Complete your portion of the claims form.
4. Ask your doctor to complete the physician's portion of the claim form. Any changes made by the doctor for completion of this Report (or any other medical information) is your responsibility.
5. Send the completed forms to the Plan Administrator.
6. Claims must be submitted within 6 months after the start of Disability.
7. From time to time other forms may be sent to you for completion. Ensure they are completed as required and return them to the Plan Administrator.

DENTAL

1. When you, or your dependents, have incurred covered dental expenses, please obtain a Dental Care Statement form from your Local Union Office or the Plan Administrator and have your dentist complete his portion.
2. A separate form must be used for each individual.
3. Complete your portion of the form and send to the Plan Administrator.
4. If you wish to have insurance payments paid directly to your dentist, and if the dentist is willing to accept payment directly, notify the Plan Administrator by signing the assignment section of the form.
5. Claims must be submitted within 18 months of the date expenses were incurred but not more than 6 months after the date coverage terminates.

MAJOR MEDICAL BENEFITS

1. Obtain from your Local Union Office or the Plan Administrator, a "Supplementary Health Claim" form ("Vision Care - Statement of Claim" form for Vision Care expenses, "Standard Hospital Claim" form for hospital expenses).
2. Using a separate form per family member, itemize the bills for out-of-pocket expenses for covered services and supplies.
3. Attach receipts and send to the Plan Administrator every 90 days (monthly for major bills).
4. Claims must be submitted within 18 months of the date expenses were incurred but not more than 6 months after the date coverage terminates.

Major Medical, Vision, Dental - Secondary Payer Claims

If you are applying for reimbursement of expenses for which this Plan is the secondary payer (see "Co-ordination with Other Benefits" in the General Provisions section of this booklet) you must submit those expenses to your spouse's plan first. Keep a photocopy of each receipt and ask your spouse's plan to return the original receipts to you once your claim has been settled.

You should also receive an explanation outlining how the initial payment was calculated. Submit this explanation along with all necessary claim forms and receipts to the Plan Administrator for payment of the balance of the allowable expenses.

Time Limit for Legal Action with respect to benefits covered by Manulife Financial

You may not commence legal action against Manulife Financial (with respect to benefits underwritten by Manulife Financial) less than 30 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife Financial for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

Access to Plan Documents with respect to benefits covered by Manulife Financial

You or any of your covered dependents have the right to request a copy of any or all the following items:

- the sections of the Group Policy and/ or Plan Document that apply to you and your dependents,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

Manulife Financial reserves the right to charge you for such documentation after your first request.

NOTE: Be sure that you indicate your certificate number, and complete name and address on all correspondence sent to the Plan Administrator.

SEND ALL COMPLETED CLAIM FORMS TO THE PLAN ADMINISTRATOR.

Ellement Consulting Group
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www.ellement.ca
Email: bricklayers@ellement.ca
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