CARPENTERS' AND MILLWRIGHTS' HEALTH & WELFARE BENEFIT TRUST FUND OF SASKATCHEWAN

Group Insurance

April 1, 2022

This booklet is for your general information only and is not the Insurance Policy. In the pages which follow, you will find a brief description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim. The final determination, however, of any claim, question or problem which may arise will be governed by the Trust Agreement and the Insurance Policies issued by the Manulife Financial Insurance Company. These documents are available for examination at the Fund Office.

Manulife Financial Group Policy - 3942
Life Insurance, Accidental Death & Dismemberment, Dependent Life, Weekly Disability, Long Term Disability for Millwrights Local 1021 only, Supplementary Health & Dental

Manulife Financial Group Policy - 10080
Emergency Travel Assistance

CARPENTERS' AND MILLWRIGHTS' HEALTH & WELFARE BENEFIT TRUST FUND OF SASKATCHEWAN

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

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BENEFIT TRUST FUND OF SASKATCHEWAN

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To Eligible Carpenters and Millwrights:

This revised booklet has been published to give you an up-to-date description of the benefits provided by the Trust Fund as of April 1, 2022.

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

Be sure to read this booklet carefully so you will be acquainted with all of the various benefit provisions. If you have any questions, concerning your eligibility or the benefit program, do not hesitate to contact the Fund Office where a member of the staff will be pleased to assist you.

Sincerely,

BOARD OF TRUSTEES

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SCHEDULE OF BENEFITS

Members

Life Insurance	$100,000 (reduces by 50% at age 65, terminates at age 70)
Accidental Death and Dismemberment	$100,000 (reduces by 50% at age 65, terminates at age 80)
Weekly Disability Income	1st day accident; 1st day hospitalization; 8th day sickness; $638 per week for 52 weeks of disability. (Integrated with Employment Insurance benefits).

Dependents

Dependent Life Insurance	$10,000 for spouse; $5,000 for each child

Members and Dependents

Supplementary Health Expenses	80% of the first $850 of eligible prescription drug expenses each calendar year, and 100% thereafter; 50% for orthopaedic shoes up to a $400 maximum if not part of a brace or splint; 100% of all other eligible expenses; Private Duty Nursing $10,000 per calendar year; (prior approval is required) Semi-private hospital room accommodation; Hearing Aids $700 every three (3) calendar years; Paramedical practitioners $500 per calendar year maximum per practitioner; Foot care Orthopaedic supplies $400 per person per calendar year and $400 per person per calendar year for Orthopaedic Shoes which do not form part of a brace or splint.
Vision Care	Glasses or contact lenses, to a maximum of $700 per 24 months, (12 months under age 18). Polarized lenses and prescription sunglasses for the Member only are included in the vision care maximum stated above. Coverage is included for 50% reimbursement of laser eye surgery expenses to a lifetime maximum of $1,500. One eye exam limited to $120 per calendar year. Safety glasses (for Members only) $500 every 12 months.
Emergency Travel Assistance	60 days per trip; unlimited maximum; terminates at age 65.
Dental Expenses	100% of eligible Routine and 80% of eligible Major Restorative expenses; $3,000 per calendar year combined maximum per individual. 50% of orthodontia expenses for dependent children under age 18; lifetime maximum reimbursement of $2,000. Based on the 2021 Saskatchewan Dental Association Fee Schedules.

Long Term Disability	
(Millwrights Local 1021 only)	Flat $3,000 monthly benefit
	Elimination period – 52 weeks
	2 years of benefit payments own occupation and any occupation thereafter
	No direct offsets
	Maximum period to age 65

ELIGIBILITY RULES

Members Who May Be Eligible For Benefits

1. Any Member for whom his employer is obligated to make contributions to the Fund by an applicable Collective Bargaining Agreement.
2. Any full-time salaried officer or Member of any applicable Local for whom coverage under this Plan has been approved by the Trustees.
3. Any Member of the Trustees for whom coverage under this Plan has been approved by them.
4. Any other Member 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 Fund.

NOTE: Retired Members are not covered under this plan.

Eligible Dependents

A Member's eligible dependents are:

1. The Member's spouse, where spouse means either:
   a) a person who, as of the time in question, is legally married to the Member, or
   b) a person designated by the Member on his or her Registration Form as his or her "spouse", provided, however, that if such designated person is not legally married to the Member, the Member must have lived with him or her for at least one year prior to the incurring of the eligible expense or service in question, so as to qualify him or her as a "spouse" for the purposes of the payment of such expense or service, and further provided that:
      i) the said designated person shall not be deemed to have lived with the Member for the said year prior to the incurring of the eligible expense or service in question unless and until one year has elapsed from the time of receipt by the Administrator of a Registration Form on which the Member has designated such person as his or her "spouse" as provided for earlier in this sub-paragraph (b), or
      ii) the Administrator may (but is not obligated to do so) require from such Member or such Member's designated "spouse" a statutory declaration or other evidence sufficient to satisfy the Administrator of his or her qualification or otherwise for such payment (see page 5 for more information), or
      iii) if a person qualifies under (a) and another person qualifies under (b), then of the two persons so qualified, the one who has been designated to receive the benefit or benefits in question by an instrument in writing, signed by such Member and received by or filed with the Trustees or the Administrator, or in the absence of such designation the person qualified under (a) shall be deemed the "spouse" for the purposes of this Plan.

and

2. Member's unmarried children in respect of whom the Member is eligible for deduction for the purpose of calculating taxable income under the Income Tax Act (Canada) who are:
   a) from live birth but under the age of 21 years, 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) with respect to Supplementary Health and Dental, at least 21 or 25 years of age if a student and

dependent upon the Member 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.

Effective Date of Coverage

Effective date of coverage for any Member (or dependents) is the date on which the Member qualifies for coverage in accordance with the following rules - except that no payments are to be made for services rendered prior to that date.

How to Become Eligible

New Members will become eligible for benefits after working a minimum of 300 hours in not less than two or more than three consecutive months for contributing employers. The following month is a waiting period and eligibility will commence on the first day of the month following the waiting period.

Continuation of Eligibility

Hours worked for contributing employers by each Member will be credited to the individual's "reserve account". One hundred hours of work credit will be deducted from each eligible Member's "reserve account" for each month of insurance coverage, and Members will continue to remain eligible as long as their reserve accounts contain at least 100 hours of work credit.

In this connection, Members will be allowed to accumulate excess hours in their reserve accounts up to a maximum of 900 hours.

Continuation of Eligibility While Disabled

Whenever an eligible Member is disabled and is receiving Workers' Compensation Benefits or Fund Weekly Disability benefits, or Employment Insurance Accident and Sickness benefits, for at least two weeks in any calendar month, no deductions will be made from his reserve account for that month. In other words, his reserve accumulation will be "frozen". The maximum period for which such a~~n~~ Member's hours will be frozen under this rule for any one continuous period of disability will be six months.

If you receive Workers' Compensation Benefits or Employment Insurance Accident and Sickness benefits, you must notify the Fund Office of the duration of your disability so that your reserve accumulation may be frozen for the period described above. "Freezing of Hours" forms may be obtained at your Local Union Office or the Fund Office.

Continuation of Eligibility While Attending Trade School

Whenever an apprentice Member attends a recognized trade school related to his employment for at least two consecutive weeks in any calendar month, no deduction will be made from his reserve account for that month and this situation will continue until the month following the month in which his said classes end, provided, however, that a Member 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. The Member must complete a Freezing of Hours form.

Termination of Eligibility

A Member's 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 100 hours, after deduction of 100 hours for the current month.

Reinstatement

A Member whose eligibility has terminated will again become eligible if his reserve account shows a total of at least 100 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 his 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 eligibility requirements described earlier.

Extension of Eligibility By Self-Payment

A Member who is in good standing with the Union and whose eligibility terminates may continue coverage for himself and his family from month to month (up to a maximum of nine consecutive self-payments) by making self-payments to the Fund Office. The first payment must be made prior to the termination of eligibility; payments must be continuous so long as the Member is eligible to make them, and must be made in advance of the month for which coverage is desired. Members on a self-payment basis are NOT eligible for Weekly Disability benefits. They cannot self-pay for Long Term Disability benefit.

For further information concerning the amount of self-payment, grace periods that may be allowed by the Trustees for such payments, and other requirements which must be met, please contact the Fund Office.

Changes in Eligibility Rules

These rules may be altered by the Trustees from time to time without the necessity of prior notice being made to those affected thereby.

Deceased Members - Length of Dependent Coverage

In the event of any Member dying while he is eligible for health and welfare benefits under the eligibility rules, the Supplementary Health and Dental benefits payable under the Plan applicable at the time of death for such deceased Member's dependents shall continue for either the three calendar months immediately following the date of death or until the deceased Member's hour bank runs out in the normal course, whichever is later; however, if any dependent of such deceased Member 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 of Non-Bargaining Members of Contributing Employers and Members of the Union

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. These M~~m~~embers may become and remain eligible provided they meet prescribed rules. The Board of Trustees reserves the right to amend these rules at any time and require proof that all conditions and requirements are being met. Full information concerning participation of these M~~m~~embers can be obtained by contacting the Fund Office.

NOTE: Irrespective of the number of hours which each participating non-bargaining Member may work in any month for the Company, contributions for such participating non-bargaining Members will be made on the basis that each such Member has worked 160 hours in that calendar month.

GENERAL INFORMATION

When Your Dependency Status Changes

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

Establishing Proof of Common-Law Spouse

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

If you have a common-law spouse, but the spouse has not been registered with the Fund office for at least one year, you can have the Declaration of Common-Law Spouse signed by a Commissioner of Oaths. This will eliminate the one year Fund Office filing requirement and your spouse then becomes eligible for benefits the date the form is received in the Fund Office; however, your common-law relationship must still have existed for at least one year before the claim expense was incurred.

Change of Address

If you should have a change of address, it is important that you notify the Fund Office immediately by completing a new Registration Form or submit the change in writing.

Co-ordination of Benefits (Supplementary Health and Dental Benefits Only)

If a person eligible under this Plan is also eligible under another plan, benefits under all plans are adjusted 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 eligible 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.

To implement this provision, the Plan may:

- subject to the consent of the eligible 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 eligible 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 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 is described in the “Exclusions” section.

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

"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 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 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, or prescribing guidelines recommend alternate Drugs, supplies or services be tried first that are lower in cost, 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 an illness or injury. Manulife Financial has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered under the Plan.

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 evaluates the value of pharmaceutical Drugs, clinical services or supplies. The discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. 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.

MEMBER LIFE INSURANCE BENEFIT

Benefit

In the event of your death while insured, from any cause, the Life Insurance benefit is payable to the beneficiary named by you on your Registration and Declaration of Beneficiary Form, if living, otherwise to your estate. The Life Insurance Benefit is $100,000, reduces to $50,000 when you reach age 65, and terminates when you reach age 70.

Beneficiary

You may name anyone you desire as the beneficiary to whom your Life Insurance will be paid. You may advise the Fund Office of a change in beneficiary at any time by submission of a new Registration Form. The change will become effective on the date the Fund Office receives your new Registration Form. You should review your beneficiary designation to be sure that it reflects your current intent.

Permanent Total Disability

If you become totally and permanently disabled while you are eligible under the Plan and before age 65, your Group Life Insurance will continue as long as you are so disabled (but not beyond age 65), even though you lose eligibility, subject to the following requirements:

1. You must be totally disabled for at least nine months, and
2. Medical evidence must show that your disability is presumably permanent, and
3. Written notice and proof of your disability must be given to the Insurance Company within 12 months following the date you cease active work or availability for active work, due to disability.

Subsequent proofs of disability must be furnished thereafter as required.

Totally and Permanently Disabled as used above, means that solely because of an illness or injury, you are, and will continue to be, unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

Conversion Privilege

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 didn't 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 Member 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 BENEFIT

Benefit

In the event of the death, from any cause, of one of your eligible dependents while insured, the Dependent Life Insurance benefit is payable to you. The Dependent Life Insurance benefit amount payable is $10,000 for your eligible spouse and $5,000 for each eligible child.

Permanent Total Disability

If your Life Insurance is continued by reason of total and permanent disability as provided in the Member Life Insurance section, the Life Insurance then in effect for your eligible dependents will also be continued.

Conversion Privilege

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 this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't 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 dependent spouse dies within 31 days of the date your Dependent Life Insurance terminates, the amount your spouse could have converted will be paid as a death benefit under this Plan even if your spouse did not apply for conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Coverage

This Plan provides coverage for accidents which occur anywhere, at any time, on or off the job. You will be covered whether you are at home or travelling, including air travel as a passenger, pilot or crew personnel in any certified aircraft flown by a duly licensed pilot.

This Plan does not cover any loss resulting from, or contributed to by, suicide or attempt thereat, or self-inflicted injury, or war or act of war, whether declared or not. It also excludes any loss suffered while on active service in the armed forces of any country.

Coverage terminates at age 80.

Schedule of Benefits

If you sustain an accidental bodily injury while insured and if an insured loss occurs as a direct result, and with one year of the accident, the following will be paid to you, if living, otherwise to your beneficiary(ies), if living, or to your estate. Benefit payments are based on a Principal Sum of $100,000, which reduces to $50,000 when you reach age 65 and terminates when you reach age 80. Benefits are payable in accordance with the following schedule:

Loss of Life	The Principal Sum
Loss of or loss of use of Both Hands or Both Feet	The Principal Sum
Loss of or loss of use of One Hand and One Foot	The Principal Sum
Loss of the Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of or loss of use of Both Arms or Both Legs	The Principal Sum
Loss of or loss of use of One Arm and One Leg	The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of or loss of use of One Arm or One Leg	Three-Quarters of the Principal Sum
Loss of or loss of use of One Hand or One Foot	Two-Thirds of the Principal Sum
Loss of the Entire Sight of One Eye	Two-Thirds of the Principal Sum
Loss of Speech or Hearing	One-Half of the Principal Sum
Loss of Thumb and Index Finger of Either Hand or Four Fingers of One Hand	One-Third of The Principal Sum
Loss of Hearing in One Ear	One-Sixth of The Principal Sum
Loss of All Toes of One Foot…..	One-Eighth of The Principal Sum

Paralysis Benefit

Quadriplegia (complete paralysis of both upper and lower limbs)	Two Times The Principal Sum

Paraplegia

(complete paralysis of both lower limbs) .....Two Times The Principal Sum

Hemiplegia

(complete paralysis of both lower limbs of one side of body)Two Times The Principal Sum

Only one of the amounts shown above (the largest applicable) will be paid for injuries to the same limb resulting from any one accident. Notwithstanding the amounts specified above, the maximum payable under this policy for all losses sustained by an Insured Person as a result of the same accident shall not exceed the Principal Sum.

If your insurance is terminated because of loss of eligibility, the Group Policy will provide an extension of coverage for 31 days. During this extension, you will continue to be covered for this benefit as if you were still an eligible Member.

Definitions

“Injury” means bodily injury caused by an accident occurring while the policy is in force with respect to the Insured Person for whom a claim is presented and resulting in loss covered by the policy.

“Loss” as above used with reference to hand or foot means complete severance at 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 at or above the elbow or knee joint; as used with reference to thumb or finger means complete severance at or above the first phalange; as used with reference to eye means the irrecoverable loss of the entire sight thereof; and as used with reference to hearing means the total and irrecoverable loss thereof, and as used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds.

“Loss” as above used with reference to Quadriplegia, Paraplegia and Hemiplegia means the complete and irrecoverable paralysis of such limbs.

This policy is subject to an Aggregate Limit of Indemnity of $2,000,000 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident which results in an accumulation of losses exceeding $2,000,000, the amount payable with respect to each Insured Person will be reduced proportionately.

Limitations

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

- war or act of war, whether declared or not;
- active service in the armed forces of any country;
- suicide or attempt thereat; or
- self-inflicted injury.

Extension of Benefit

If your insurance is terminated because of loss of eligibility, the Group Contract will provide an extension of coverage for 31 days. During this extension, you will continue to be covered for this benefit as you were still an eligible Member.

WEEKLY DISABILITY BENEFIT

NOTE: **In order to be eligible for payment, Weekly Disability claims must be submitted within 180 days of the commencement of disability.**

Benefit

You will be paid a benefit of $638 per week, if you are disabled solely due to accidental bodily injury or illness and are unable to perform your regular work.

The benefit will commence from the first day of disability due to an accident, or from the 8th day of disability due to sickness; however, if you are hospitalized for at least 24 hours, benefits will commence on the first day of hospitalization. If you do not visit and are not treated by a licensed doctor (M.D.) within the first three days of your disability, then the benefits will not start until the date you do visit the doctor. You must remain under the ongoing care of a licensed doctor (M.D.) to be eligible for benefits.

If you qualify for Accident and Sickness benefits under the Employment Insurance (E.I.) plan, the Fund's benefits will be suspended when E.I. benefits begin (not later than 7 days from the date of disability). If you continue to be disabled after exhaustion of your E.I. benefits (maximum 15 weeks), then the Fund will resume its payments to you for a maximum period of protection of 52 weeks of disability including the period covered by E.I. benefits.

If you do not qualify for E.I. benefits, the Fund's benefit will be payable as long as you remain disabled up to a maximum of 52 weeks disability.

Successive periods of total disability separated by less than one week 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.

What is Not Eligible

Weekly Disability benefits are not payable for:

- a disability caused by a purposely self-inflicted injury, unless medical evidence establishes that the injuries are related to a mental health illness.
- a disability resulting from insurrection, rebellion, war (whether declared or not), service in the armed forces of any country, or participation in a riot or civil commotion;
- a disability for which you are entitled to benefits under any Workers' Compensation Act or any provincial Automobile Insurance Act, where permitted by law;
- any disability that results from you committing, or attempting to commit, an assault or criminal offence;
- 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, Saskatchewan or Manitoba resident, this does not apply to the portion of a period of maternity leave during the post-natal recovery period.

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

If a lump sum payment is made under judgement 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.

LONG TERM DISABILITY BENEFIT (MILLWRIGHTS LOCAL 1021 MEMBER)

The Benefit

If a Member becomes Totally Disabled while insured for this Benefit, Manulife Financial will pay a Disability Benefit as outlined below, provided the Millwrights Local 1021 Member meets Manulife Financial's Entitlement Criteria.

Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.

Benefit Amount

Flat $3,000

Qualifying Period

52 weeks

Maximum Benefit Period

up to the end of the month in which the Member attains age 65

Definition of Total Disability or Totally Disabled

Restriction or lack of ability due to an illness or injury which prevents a Member from performing the essential duties of:

a) his own occupation (type of work, not just the Member's own job), during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

b) any occupation for which the Member is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part a) of this provision.

The availability of work will not be considered by Manulife Financial in assessing the Member's Disability.

A Member who must hold a government permit or license to perform his duties will not be considered Totally Disabled solely because such permit or license has been withdrawn or not renewed.

Entitlement Criteria

Manulife Financial will apply the following criteria in determining a Member's entitlement to Disability Benefits:

a) the Member has been continuously Totally Disabled throughout the Qualifying Period. If the Member ceases to be Totally Disabled during this period and then becomes Totally Disabled again within 2 weeks due to the same or related cause, the Qualifying Period will be extended by the number of days during which the Total Disability ceased;

b) Manulife Financial receives medical evidence documenting how the Member's illness or injury causes restrictions or lack of ability, such that the Member is prevented from performing the essential duties of:

   i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

ii) any occupation for which the Member is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part i) of this provision;

c) the Member is receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial;

At any time, Manulife Financial may require the Member to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Periods for Which the Member is Not Entitled to Benefits

The Member is not entitled to benefit payments for any period that he is:

a) not receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial;

b) receiving Employment Insurance maternity or parental benefits;

c) on lay-off during which the Member becomes Totally Disabled;

d) on leave of absence during which the Member becomes Totally Disabled, unless Manulife Financial is required to pay benefits during this period as a result of legislation, regulation or case law (in some provinces, Employers with a benefit plan are required to provide benefits to a Member during the health-related portion of a Maternity Leave of Absence);

e) receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan;

f) working in any occupation, except as provided for under the Partial Disability Benefit or Rehabilitation Assistance provision; or

g) incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

h) not residing in Canada, unless prior approval is obtained from Manulife Financial under periods for which the Member is not entitled to benefits.

i) or his Union is on strike, if his disability commenced on or after the date the strike began, subject to any provincial or federal employment legislation or labour standards act; however, a Member may satisfy his Qualifying Period while on strike.

Amount of Disability Benefit

The benefit amount payable will be reduced so that the Member's total income from All Sources does not exceed 85% of the Member's pre-disability Earnings if this Benefit is taxable, or 85% of the Member's pre-disability Net Earnings if this Benefit is non-taxable.

All Sources include those stated above and any benefit the Member is entitled to receive from:

a) any group, association or franchise plan;

b) any retirement or pension plan;

c) earnings or payments from any employer, including severance payments and vacation pay;

d) self-employment;

e) any government plan, excluding Employment Insurance Benefits; and

f) Canada or Quebec Pension Plans' excluding dependent benefits.

Benefit Calculation

Manulife Financial will apply the following rules in determining the Member's Disability Benefit:

a) benefits from other sources which began before the commencement of the Member's current Disability will not be taken into account;

b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial;

c) subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;

d) benefits payable under individual disability income insurance will not be taken into account;

e) for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial; and

f) if a Member does not apply for a benefit for which he is eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid.

Subrogation

Conditional monthly payments shall be made to a Member with a potential loss of income claim against a third party who caused or contributed to the Disability. Any such payments are subject to Manulife Financial's subrogation right to reimbursement when the Member is indemnified through a judgement or settlement.

Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of the Member's monthly benefit amount.

Rehabilitation Assistance

Once Manulife Financial determines that a Member is Totally Disabled, where appropriate and at Manulife Financial's discretion, the Member may be offered rehabilitation to assist him in returning to gainful employment, either to his pre-disability occupation or to another occupation.

In partnership with the Employer and the Member, Manulife Financial will provide the Member with a structured Vocational Plan that will prepare the Member for a return to work:

a) with the Employer;

b) with an alternate employer; or

c) in a self-employed capacity.

In considering whether Rehabilitation Assistance is appropriate for a Member, Manulife Financial will take into account:

a) the nature, extent and expected duration of the Member's Disability;

b) the Member's level of education, training or experience; and

c) the nature, scope, objectives and cost of the Vocational Plan.

A Member will continue to be entitled to Disability Benefits while participating in the Vocational Plan. The Member's Disability Benefit will be reduced by earnings received from any employment only if the Member's total income from all sources exceeds:

a) 100% of his pre-disability Earnings, if this Benefit is taxable; or

b) 100% of his pre-disability Net Earnings, if this Benefit is non-taxable.

If a Member ceases to participate in a Vocational Plan because of a change in his medical status, Manulife Financial will require medical evidence documenting how the Member's medical condition has deteriorated such that the Member's inability to continue with the Vocational Plan is due to an increase in restrictions or lack of ability.

If the Member is not available or does not co-operate or participate in the Vocational Plan, the Member will no longer be entitled to Disability Benefits.

Partial Disability

If a Member is Disabled but able to work under a program approved in writing by Manulife Financial and performs at any time:

a) during the Qualifying Period and the 24 months immediately following the Qualifying Period:
    1. any of the duties of the Member's own occupation on a part-time basis; or
    2. the duties of any other occupation on a full-time or part-time basis; or

b) after the 24 months specified in part a) of this provision, the duties of any occupation on a part-time basis;

such Member will still be entitled to a benefit. The Member's Disability Benefit will be reduced by 50% of the Member's income from such work. The Member's Disability Benefit will be further reduced by earnings received from any employment if the Member's total income from all sources exceeds:

a) 100% of his pre-disability Earnings, if this Benefit is taxable; or

b) 100% of his pre-disability Net Earnings, if this Benefit is non-taxable.

Termination of Benefit Payments

Disability benefit payments will cease on the earliest of:

a) the date the Member ceases to meet this Benefit's definition of Totally Disabled, except as provided for under the Partial Disability Benefit provision;

b) the date the Member does not supply Manulife Financial with appropriate medical evidence documenting how the Member's illness or injury causes restrictions or lack of ability, such that the Member is prevented from performing the essential duties of:
    i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and
    ii) any occupation for which the Member is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part i) of this provision;

If the Member is receiving a Partial Disability Benefit, benefits will cease on the date the Member does not supply Manulife Financial with appropriate medical evidence documenting how his illness or injury limits him to returning to work in a reduced capacity, as defined under the Partial Disability Benefit.

a) the date the Member does not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial;

b) the date on which benefits have been paid up to the Maximum Benefit Period shown in the Benefit Schedule; or

c) the date the Member dies.

Recurrent Disability

Where a Member becomes Totally Disabled again from the same or related causes as those for which Long Term Disability benefits have been paid under this Policy and such Disability recurs within 6 months from the end of the period for which benefits were paid under this Policy, Manulife Financial will waive the Qualifying Period.

All such recurrences will be considered a continuation of the same Disability. The benefit payable will be based on the Member's Earnings as at the original date of Disability. Benefits for all recurrences will not be paid for a combined period longer than the Maximum Benefit Period shown in the Benefit Schedule.

If the same Disability recurs more than 6 months after the end of the period for which benefits were paid, such Disability will be considered a separate Disability.

Two Disabilities which are due to unrelated causes are considered separate Disabilities if they are separated by a return to work of at least one day.

Waiver of Premiums

Premiums required on behalf of a Member for this Benefit will be waived during any period for which Long Term Disability Benefits are payable.

Continuation of Insurance

If a Member's insurance terminates for reasons other than reaching the Termination Age for this Benefit, as shown in the Benefit Schedule, Manulife Financial will continue insurance under this Benefit if the Member is Totally Disabled and:

a) entitled to receive benefits; or

b) fulfilling the Qualifying Period.

The Member must satisfy Manulife Financial's Entitlement Criteria in order for the Disability Benefit to be payable.

The insurance continued is subject to all the provisions of this Policy.

Taxability

The Policyholder must notify Manulife Financial in writing 31 days prior to a change in the tax status of this Benefit. Manulife Financial reserves the right to adjust the amount of insurance and the premium rates if such a change occurs, whether or not notification has been given. The effective date will be the date of change.

Disabilities Not Covered

No benefits are payable for any Disability directly or indirectly related to:

a) self-inflicted injuries or illnesses, unless medical evidence establishes that injuries are related to a mental health illness;

b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;

c) medical or surgical care which is not Medically Necessary;

d) the committing of or the attempt to commit an assault or criminal offence;

e) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Member's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;

f) abuse of addictive substances, including Drugs and alcohol, unless the Member is actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial; and

g) a Pre-Existing Condition which causes Disability within the first 12 months of insurance under this Benefit. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which a Member was treated or attended by a Physician, or for which Drugs were prescribed, within 90 days prior to the date the Member's insurance under this Benefit became effective.

SUPPLEMENTARY HEALTH EXPENSES BENEFIT

Members and Dependents

This benefit pays for 80% of the first $850 of each calendar year's eligible prescription drug expenses and 100% of each year's eligible drug costs over $850, 50% of the expenses for orthopaedic shoes not part of a brace or splint (up to a $400 maximum), and 100% of all other eligible expenses, subject to any other limits described.

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
- associated with any drug, supply or service that was subject to the due diligence process the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by Manulife Financial and shared with the Plan Administrator as 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. 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 as a covered expense, 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 or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contradictions to alternative treatments exist.

At Manulife Financial's discretion, medical information, test results or other documentation will 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.

1. Drugs and medicines, including vaccinations, immunizations, and oral contraceptives which can be obtained only with a licensed doctor's (M.D.) or licensed dentist's prescription (or other professional authorized by provincial legislation to prescribe drugs) and dispensed by a registered pharmacist or licensed doctor (M.D.) legally authorized to dispense such drugs.

   Proprietary and patent medicines, food supplements, vitamins, drugs for the treatment of erectile dysfunction and smoking deterrents are not eligible expenses. Drugs determined to be ineligible as a result of due diligence are not eligible for reimbursement.

   Coverage is provided based on generic drugs and medicines. Full coverage (that is, 80% or 100% as applicable) 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 the cost of the generic equivalent.

   Eligible expenses can be obtained using your ClaimSecure Identification Card. This card provides information to the pharmacy regarding you and your registered dependents who are eligible under this Plan as the primary payer (see "Coordination of Benefits" in the General Information section of this booklet).

   If you have your prescription filled at a pharmacy that does not participate in the ClaimSecure 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.

2. Hospital Board and Room (within home province) and other necessary services and supplies up to the difference between the hospital's daily charge for ward and average semi-private accommodations. The Definitions section contains a definition of a hospital.

3. Daily charges for Rehabilitation Hospital (within home province) up to the semi-private room and board limit, but not beyond a maximum stay of 120 days. Confinement must begin within 14 days of hospital discharge. A new maximum stay will apply if the insured person has not been confined in a rehabilitation hospital for at least 90 days.

4. Professional ambulance service, including where necessary, scheduled airline, rail or air ambulance services, when used to transport the individual from the place where he is injured by an accident or stricken by an illness to the first hospital where treatment is given, or from a hospital to a rehabilitation hospital. No other expenses in connection with travel are included.

5. Registered graduate nurse (R.N.) including Victorian Order Nurse (V.O.N.), licensed practical nurse (L.P.N.) and registered nursing assistant (R.N.A.) other than a nurse who ordinarily resides in your home, or who is a Member of you or your spouse's family, provided such services have been ordered by a physician. Nursing services are limited to a $10,000 calendar year maximum benefit for each insured family Member. Prior approval is required.

6. Treatments by a provincially licensed chiropractor, osteopath, naturopath, podiatrist, acupuncturist, or Christian Science practitioner up to $500 per calendar year per practitioner and up to $25 per disability for X-rays. *

7. Treatment by a licensed physiotherapist, registered massage therapist or occupational therapist,

limited to $500 per practitioner per person per calendar year. *

8. Diagnosis and treatment by a person duly qualified and registered and legally engaged in the practice of psychology on the written recommendation of a physician, limited to $500 per person per calendar year. Expenses incurred for marriage counselling, hypnotherapy and group therapy are excluded. *

9. Restoratory or rehabilatory speech therapy by a qualified speech therapist, limited to $500 per person per calendar year. Treatment must be for speech loss or impairment due to illness (or surgery on account of illness). 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 visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.*

10. Rental of iron lung or other durable medical or surgical equipment.

11. Dental treatment due to an accident which occurs while insured. The following dental services received within 12 months of an accident are eligible to the extent permitted by provincial plans; treatment by a dentist or dental surgeon of accidental injuries (external to the mouth) to natural teeth including replacement of such teeth and related x-rays.

12. Artificial limbs, eyes and larynx, crutches, splints, casts, trusses and braces for back, neck, arm or leg, including replacement due to a change in physical condition when prescribed or ordered by the attending physician. Breast prosthesis will be limited to $350 per breast every 24 months.

13. Anaesthesia, oxygen, blood and blood products.

14. Orthopaedic supplies (limited to $400 per person per calendar year): arch supports; lifts; wedges; Dennis Browne splints and shoes purchased and used in the application of such splints, on the written recommendation of a licensed doctor (M.D.).

    Fifty percent of the charge for orthopaedic shoes that are not part of a brace or splint will be eligible (up to a maximum reimbursement of $400 per calendar year), on the written recommendation of a licensed doctor (M.D.).

15. Hearing aids purchased on the written recommendation of a physician certified as an otolaryngologist $700 every three (3) calendar years per person. Hearing aid repairs, batteries and ear molds are not considered eligible expenses.

16. Eye examinations performed by a licensed ophthalmologist or optometrist that are not covered by your provincial health plan. Coverage is limited to one eye examination per calendar year, up to a maximum benefit of $120 per person.

17. Vision care expenses which include expenses for glasses or contact lenses up to a maximum benefit of $700 per person every 24 consecutive months (12 months for person under 18 years of age). Polarized lenses and prescription sunglasses for the Member only are included in the above vision care maximum.

    In addition to the above, reimbursement will also be provided, for Members only, for expenses incurred for prescription safety glasses, up to a maximum benefit of $500 every 12 consecutive months.

18. 50% reimbursement of laser eye surgery expenses, to a lifetime maximum of $1,500.

No benefits are provided for non-prescription lenses.

Vision care expenses are eligible when prescribed by a physician (including an ophthalmologist) or an optometrist.

Limitations

No amount will be paid for care, services or supplies:

- for drugs, sera, or injectable drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under Out-of-Province;
- if the payment is prohibited by law;
- that a covered person may obtain as a benefit under any governmental plan or law;
- for which no charge would have been made in the absence of this coverage; or
- for dental work, except as provided under Dental Care For Accidental Injury.

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.

Extension of Supplementary Health Benefits

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

- The date such person becomes insured under any other group-type plan providing similar coverage; or
- 3 months.

Totally Disabled as used above means:

- for a Member, 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 AND EMERGENCY TRAVEL ASSISTANCE

Members and Dependents

Only insured individuals under age 65 are eligible for this coverage. Coverage is limited to a period of 60 days from the date you or your insured dependent leave the province of residence. Dependent children who are attending school outside Canada are eligible for coverage for a period of 60 days from the date they leave their province of residence. Coverage is integrated with coverage provided by your provincial plan and you must be covered by your provincial plan to be eligible for this benefit.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect of an insured Member or dependent is unlimited.

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 60 days 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 and Travel Assistance benefits, 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 60 days 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) <u>24-Hour Access</u>

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 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.

e) 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).

f) 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).

g) After Hospital

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.

h) 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.

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.

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.

Expenses Not Covered

No benefit is payable for any expense which is directly or indirectly related to:

a) any illness or injury arising out of or in the course of employment when the person is insured by or is eligible for coverage by workers' compensation;

b) any illness or injury for which benefits are payable under any government plan or legally mandated program;

c) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness

d) war, insurrection, the hostile action of any armed forces or participation in a riot or civil commotion;

e) the committing of or the attempt to commit an assault or criminal offence;

f) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the insured person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;

g) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

h) charges for services or supplies:

   i) when there would have been no charge at all in the absence of insurance;

   ii) when reimbursement would have been made under a government-sponsored plan in the absence of insurance;

   iii) which are received from a medical or dental department maintained by an employer, association or trade union;

   iv) which are required for recreation or sports but which are not Medically Necessary for regular activities;

   v) which would have been payable by the Provincial Plan if proper application had been made;

   vi) which are performed or provided by the insured person, an Immediate Family Member or a person who lives with the insured person;

   vii) which are provided while confined in a Hospital on an in-patient basis;

   viii) which are not specified as a Covered Expense under this Benefit;

i) medical or surgical care which is cosmetic; or

j) medical treatment which is not usual and customary, or which is Experimental or Investigational in nature.

DENTAL EXPENSES BENEFIT

Members and Dependents

This benefit pays for 100% of the cost of eligible Routine Dental Expenses, 80% of eligible Major Restorative expenses and 50% of eligible Orthodontic expenses.

The maximum Routine and Major combined benefit for all eligible Dental Expenses for one family Member in any one calendar year is $3,000. The maximum for Orthodontic treatment is $2,000 per eligible child per lifetime.

Dental benefits are payable in accordance with the 2021 Saskatchewan Dental Association Fee Schedule.

Routine Dental Expenses

- oral examinations, including scaling and cleaning of teeth, but not more than one examination or 6 units of scaling and cleaning in any period of six consecutive months;
- topical application of sodium or stannous fluoride;
- dental x-rays;
- extractions;
- oral surgery, including excision of impacted teeth;
- fillings, (including white fillings on molars);
- anaesthetics administered in connection with oral surgery or other eligible dental services;
- treatment of periodontal and other diseases of the gums and tissues of the mouth;
- endodontics treatment, including root canal therapy;
- space maintainers and stainless steel crowns for baby teeth;
- injections of antibiotic drugs by the attending dentist;
- repair, resurfacing or recementing of crowns, inlays, onlays, bridgework, or dentures, or relining of dentures.

Major Restorative Expenses

- initial installation (including precision attachments for dentures and adjustments during the six month period following installation) of partial or full removable dentures including temporary dentures;
- replacement of a denture if it was installed five years or more prior to its replacement, providing the existing denture cannot be made serviceable;
- replacement of a temporary denture by a permanent denture within twelve months from the date of installation of the temporary denture;
- addition of teeth to an existing denture;
- services or supplies for implantology, including tooth implantation or transportation and surgical insertion of fabricated implants.
- inlays, onlays, gold fillings, crowns, and initial installation of fixed bridgework (including inlays and crowns to form abutments);
- replacement of fixed bridgework if it was installed five years or more prior to its replacement, providing

the existing bridgework cannot be made serviceable.

Orthodontic Expenses (for dependent children under age 18)

- The charges made for Orthodontic treatment (including the correction of malocclusion).

Exclusions

The following Dental Expenses are not eligible under this benefit:

1. Dental treatment received or started before dental coverage begins.
2. Oral hygiene instruction, nutritional counselling, or protective athletic appliances.
3. Charges for pantographic records.
4. Missed or cancelled dental appointments, or completion of claim forms.
5. Charges for any dental procedure which is paid for or otherwise provided for under any law of the government.
6. Services and supplies that are partially or wholly cosmetic in nature.
7. Services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.
8. The replacement of a lost or stolen prosthetic device.
9. Personalization or characterization of dentures.
10. Dental treatment as a result of a disease or injury that is occupational.
11. Stainless steel crowns on permanent teeth;
12. Prostheses, including crowns and bridgework, and the fitting thereof which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this Benefit is discontinued or more than 60 days after this Benefit is discontinued or after termination of coverage for any other reason.
13. Protective athletic appliances.

Predetermination of Benefits

If charges for a planned course of treatment by a licensed dentist would exceed $300, proposed details and x-rays should be submitted to Manulife Financial for approval. Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

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

Alternate Services

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

Extension of Dental Expenses Benefit

If you or your dependent's eligibility terminates, dental benefits are payable during the subsequent 60-day period, provided the Group Policy remains in force, for an identifiable procedure involving a tooth, or immediate gum area, provided active treatment was started while the person was insured.

Dental benefits will not be payable during this 60-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.

Charges will be covered for prostheses, including crowns and bridgework, and the fitting thereof, which were ordered while the person was covered but which were finally installed or delivered within 60 days after this Benefit is discontinued or termination of coverage for any other reason.

EXCLUSIONS APPLICABLE TO WEEKLY DISABILITY, SUPPLEMENTARY HEALTH AND DENTAL EXPENSES BENEFITS

No Payment will be made for charges:

1. incurred prior to the date you or your dependents' coverage became effective;

2. which the Member or dependent would not be required to pay if there were no insurance;

3. incurred on account of injury or other loss sustained as a result of war, or any act of war, whether war is declared or not, or by any act of international armed conflict or conflict involving armed forces of any international authority with respect to Weekly Disability and Supplementary Health;

4. incurred as a result of, or contributed to by, insurrection, rebellion or participation in a riot or civil commutation, purposefully self-inflicted injury or the insured person's commission of, or attempt to commit, an assault or a criminal offence, with respect to Weekly Disability and Supplementary Health;

5. incurred for conditions for which the Member or dependent is entitled to receive benefits under the provision of any Workers' Compensation or similar law or any legislation applicable to persons who have served in the armed forces;

6. for telephone advice;

7. for transportation of a practitioner who renders a service;

8. incurred for examinations required for the use of a third party such as examinations for employment or for attendance at a school or camp;

9. incurred for services which are precluded from insurance with a non-governmental insurance carrier under the terms of any governmental plan or law;

10. for services and supplies which are not necessary for treatment of an injury or sickness and are not recommended by the attending Physician or Dentist;

11. for services and supplies which are unreasonable;

12. for service and supplies to the extent that they are paid for or provided for under the Medicare Act or the Hospital Insurance Act of the Province.

MEMBER ASSISTANCE PROGRAM

LifeWorks is an innovative wellbeing solution that:

• Supports you with a confidential **Member Assistance Program (MAP)** and wellbeing resource, available 24/7 by phone, online, and by mobile app.

• Connects you to information, tips, and updates to support your wellbeing.

• Rewards you with a range of special offers and **Perks,** helping you save money on daily essentials and luxury brands.

Dealing with a personal or work issue?

The MAP can provide support, referrals, and resources related to many issues, including the following:

Adoption issues	Alcohol & drug abuse	Anxiety
Budgeting, Financial worries, & reducing debt	Childcare & parenting issues	Concern for another person's alcohol/drug abuse
Conflict of work	Crisis & trauma	Depression
Domestic abuse	Education issues	Elder care/caregiving issues
Gambling & other addictions	Grief & loss	Job burnout
Legal matters	Relationship issues	Separation and divorce
Stress	Work-related problems & job stress	

The MAP encourages Members and those close to them to seek help early, before a minor problem becomes more serious. The MAP is designed to address short-term issues and to identify resources and referrals for emergency and long-term issues. When in doubt, contact the MAP for help or support.

No matter the issue, MAP support is just a click or phone call away.

Call us: 1-844-880-9142

Visit us online: www.login.lifeworks.com

QUESTIONS AND ANSWERS

1. How do I become eligible under the Plan?

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

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

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

This is an account kept by the Fund Office for each Member who works for a contributing employer. These employers report the number of hours worked by the Member to the Fund Office. The hours are placed in the Member's reserve account. This is similar to a bank account, with hours being deposited instead of dollars. In order to pay for his coverage, a Member has hours deducted or withdrawn from his account.

For example: Let us look at the way an eligible Member's account would operate, if he has 180 hours in his hour-bank or reserve account at the beginning of the month.

Mo.	Account Balance at Beginning of Month	Hours* Reported in Month	Hours Charged For Eligibility	Reserve Account Balance
1	180 hrs	116 hrs	100 hrs	196 hrs
2	196	185	100	281
3	281	75	100	256
4	256	Nil	100	156
5	156	100	100	156
6	156	125	100	181

* These hours are worked in the previous month. They are always reported a month late, i.e., after the end of the month worked.

NOTE: For eligible non-bargaining Members there are certain variations applicable to the procedures of the hour-bank system, details of which may be obtained from the Fund Office.

3. Is a medical examination necessary to get this Insurance?

No! All benefits for you and your dependents are available without any test of insurability.

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

Your eligible dependents become covered for benefits at the same time you become eligible. A Registration Form must be on file in the Fund Office for at least one year before your common-law spouse and any children of that common-law spouse (as indicated on the form) are eligible for coverage. (See page 3 for more information).

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.

6. Once I am eligible, 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 Fund Office will have the latest hour-bank reserve account balances for each eligible Member.

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

7. Do I have to be under a Doctor's care in order to qualify for Weekly Disability benefits?

Yes! You must see a doctor as soon as possible if you have been injured or are sick enough to be unable to work. If you delay going to a doctor, your claim could be refused, reduced, or held up for further investigation. If you do not visit and are not treated by a licensed doctor (M.D.) within the first three days of your disability, then the benefits will not start until the date you do visit the doctor.

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 any and all claims to prevent fraud against the Plan. The Board of Trustees and the Fund Office fully support the Insurance Company and will assist them in this regard.

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

Send All Completed Forms to the Fund Office

Life Insurance

1. Notify the Fund Office immediately.
2. A certified copy of the death certificate should be submitted to the Fund Office as soon as it can be obtained.

Accidental Death and Dismemberment

1. Notify the Fund Office immediately.
2. A certified copy of the Medical Examiner's Report should be submitted to the Fund Office as soon as it can be obtained.

Weekly Disability

1. Apply to Employment Insurance for Sickness and Accident benefits.
2. Obtain a claim form from your Fund Office or the Local Union Office immediately.
3. Complete in detail the Member's portion of the claim form and then have your doctor complete the appropriate portion.
4. Mail the form directly to the Fund Office **no later than 180 days from the date you were first disabled**.

Supplementary Health

1. Obtain from your Local Union Office or the Fund Office, a "Medical Supplies Statement" form.
2. Using a separate form per family Member, itemize the bills for out-of-pocket expenses for eligible services and supplies.
3. Attach original receipts and send directly to the Fund Office every 90 days (monthly for major bills).

Dental

1. When you, or your dependents, have incurred eligible dental expenses, please obtain a Dental claim form from your Local Union Office or the Fund Office and have your dentist complete his portion.
2. A separate claim form must be used for each individual.
3. In the case of a major bill, if you wish to have insurance payments paid directly to your dentist and if

the dentist is willing to accept payment directly, notify the Fund Office.

Supplementary Health, Dental - Secondary Payer Claims

If you are applying for reimbursement of expenses for which this Plan is the secondary payer (see "Co-ordination of Benefits" in the General Information 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 Fund Office for payment of the balance of the eligible expenses.

IMPORTANT - PLEASE NOTE

Be sure that you indicate your social insurance number or identification number and complete name and address on all correspondence sent to the Fund Office.

SEND ALL COMPLETED CLAIM FORMS TO THE FUND OFFICE

Ellement Consulting Group

Winnipeg Office:
1345 Taylor Avenue
Winnipeg, Manitoba Canada R3M 3Y9

Edmonton Office:
10154 108 Street NW
Edmonton, Alberta, Canada T5J 1L3

Toll Free: 1.855.523.6376
www.ellement.ca or
benefits@ellement.ca

Proof of Loss Requirements

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

- 6 months after the date of death under the Death Provision for Life Insurance Benefits;
- 12 months after the date the Member ceases active work because of total and permanent disability under the Permanent Total Disability Provision for Life Insurance Benefits;
- 6 months after the date of loss for Accidental Death and Dismemberment Benefits;
- 180 days after the start of Weekly Disability and 180 days after the end of the waiting period, for Long Term Disability Benefit; and
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Supplementary Health and Dental Benefits.

Time Period for Legal Action

You may not commence legal action against the Plan Administrator or Manulife Financial less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the Plan Administrator or Manulife Financial for the recovery of money payable under this 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 of 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.

For reprints, please contact:

Ellement Consulting Group
10154 108 Street NW
Edmonton, Alberta, Canada T5J 1L3

Telephone:204.594.4604
Toll Free: 1.855.523.6376
www.ellement.ca
benefits@ellement.ca