

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

**Group
Insurance**

April 1, 2008

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

**GROUP
INSURANCE
PLAN**

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

While every effort has been made to ensure the accuracy of the summary contained in this booklet, this booklet is not an insurance contract and does not grant or confer any contractual rights. The booklet was prepared as of April 1, 2008, and subsequent to that date the Trustees may have made changes to the Benefit Plan or to the Eligibility Rules of the Fund. All of your rights under the program are governed by the provisions of the master contract issued to the Trustees by Manulife Financial, by the Eligibility Rules and other rules enacted by the Trustees from time to time, and by the applicable provincial and federal laws. A copy of the current master contract and the current Eligibility Rules and other rules of the Plan can be obtained upon application to the Fund Office.

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

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

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

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

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To All Eligible Members:

This booklet contains an up-to-date description of the benefits provided by the Fund, as of April 1, 2008.

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

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

Sincerely,

BOARD OF TRUSTEES

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SUMMARY OF BENEFITS

LIFE INSURANCE

- \$30,000

ACCIDENTAL DEATH AND DISMEMBERMENT

- \$30,000

DEPENDENT LIFE INSURANCE

Spouse - \$10,000
Each Child - \$4,000

WEEKLY DISABILITY

Benefit - \$423 per week;
Elimination period - 17 weeks;
Maximum - 35 weeks of benefit payments

MAJOR MEDICAL

Deductible - Nil
Coinsurance - 80% of prescription generic drug expenses, including oral contraceptives
- 100% of all other eligible expenses (except if noted otherwise)
- \$400 maximum every 24 months from the last date of service for glasses or contact lenses (12 months from the last date of service for insured under age 18)
- 50% laser eye surgery expenses to a lifetime maximum of \$1,000
- Eye examinations – \$60 maximum once every two calendar years
Maximum - \$100,000 lifetime maximum per individual (including a \$10,000 lifetime maximum for private duty nursing)
- \$1,000,000 lifetime maximum per individual for Outside Canada, includes Emergency Travel Assistance.

DENTAL

Deductible - Nil
Coinsurance - 80% of eligible Basic expenses
- 80% of eligible Major expenses
Maximum - \$2,000 per calendar year for eligible Basic expenses
- \$2,000 per calendar year for eligible Major expenses

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

ELIGIBILITY RULES

EMPLOYEES WHO MAY BE ELIGIBLE FOR BENEFITS

1. Any employee for whom his employer is obligated or permitted to contribute to the Fund by an applicable Collective Bargaining Agreement or other agreement between an employer and the Fund.
2. Any full-time salaried officer or employee of any applicable Local for whom coverage under this Plan has been approved by the Trustees.
3. Any employee of the Trustees for whom coverage under this Plan has been approved by the Trustees.
4. Any other employee of certain employers for whom coverage under this Plan has been approved by the Trustees.

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

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

ELIGIBLE DEPENDENTS

An employee's eligible dependents are:

1. The employee's spouse, and
2. unmarried children primarily dependent upon the employee for support, who are:
 - a) under the age of 21 years (but at least 15 days of age for Dependent Life Insurance), or
 - b) at least 21 years of age but under 25 years of age and attending an accredited educational institute, college or university on a full-time basis, or
 - c) at least 21 years of age and dependent upon the employee by reason of mental or physical infirmity. Proof of mental or physical infirmity must be submitted within 31 days after coverage would otherwise terminate. Additional proof may be required from time to time. (Not applicable to Dependent Life Insurance. Please refer to "Continuation of Major Medical and Dental Care Benefits for Incapacitated Children" in the General Information section.)

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

“Spouse” means either:

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

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

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

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

EFFECTIVE DATE OF COVERAGE

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

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

HOW EMPLOYEES BECOME ELIGIBLE

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

If an employee dies during the one month waiting period before eligibility commences or is reinstated, a death benefit will be paid under the Life Insurance Benefit and under the Accidental

Death and Dismemberment Benefit (if it is an accidental death). No waiver of premium, or dependent Life benefits or other Plan provisions will be applicable and no accidental dismemberment benefits will be payable.

CONTINUATION OF ELIGIBILITY

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

In this connection, employees will be allowed to accumulate excess hours in their reserve accounts up to a maximum of 720 hours.

CONTINUATION OF ELIGIBILITY WHILE DISABLED

Whenever an eligible employee is disabled and is receiving Workers' Compensation Board (WCB) benefits or Employment Insurance (E.I.) sickness and accident benefits or Fund Weekly Disability Benefits for at least two weeks in any calendar month, no deduction will be made from his reserve account for that month. In other words, his hour-bank reserve accumulation will be "frozen". This situation will continue until the month following the month in which the disability ends. Protection is extended for a maximum period of three months under this rule. This extension of coverage is only available to members who belong to a local within the jurisdiction of this Trust Fund (that is, Local No.1, Edmonton; Local No.2, Calgary and Local No.1, Saskatchewan).

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

CONTINUATION OF ELIGIBILITY WHILE ATTENDING TRADE SCHOOL

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

TERMINATION OF BENEFITS

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

REINSTATEMENT

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

EXTENSION OF COVERAGE BY SELF-PAYMENT

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

To be eligible to make self-payments, the member must be an active member in good standing with the Union and you are either: an apprentice who is attending a recognized trade school related to your employment or in receipt of Workers' Compensation Board (WCB) benefits, Employment Insurance (EI) sickness and accident benefits, or the Fund Weekly Disability Benefit. Coverage may be continued by making self-payments to the Fund Office, for up to a maximum of six consecutive self-payments, and no more than six self-payments within a two-year period.

NOTE:

- Members covered on a self-payment basis are not eligible for Weekly Disability benefit coverage.

For further information concerning the amount of self-payments, and any other requirements which must be met, please contact the Fund Office.

DECEASED EMPLOYEES - LENGTH OF DEPENDENT COVERAGE

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

PARTICIPATION BY NON-BARGAINING EMPLOYEES OF CONTRIBUTING EMPLOYERS

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

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

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.

CONTINUATION OF MAJOR MEDICAL AND DENTAL CARE BENEFITS FOR INCAPACITATED CHILDREN

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

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

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

CHANGE IN BENEFICIARY

You may change your designated beneficiary at any time (subject to provincial law) by completing a new Registration Form and forwarding it to the Fund Office. Such change will take effect as of the date the request or change was executed but without prejudice to Manulife Financial for any payments made before such request was received.

ESTABLISHING PROOF OF COMMON-LAW SPOUSE

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

BOOKLET

When you are eligible you will receive a booklet describing your benefits, if you have filed a Registration Form with the Fund Office.

WORKING OUTSIDE THE COUNTRY

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

CHANGE IN 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.

CHANGES IN PLAN PROVISIONS

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

EMPLOYEE LIFE INSURANCE

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

DISABILITY PROVISION

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

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

CONVERSION OPTION

If your Employee Life Insurance reduces or terminates, you may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required. The eligibility requirements, the type of policy and the amount of coverage that you may convert are described in the Contract issued to the Trustees. Contact the Fund Office for details. Written application together with the initial premium due must be submitted to Manulife Financial within 31 days of the date your Employee Life Insurance terminates.

EXTENSION OF BENEFIT

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

DEPENDENT LIFE INSURANCE

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

CONVERSION OPTION

If Dependent Life Insurance for your spouse terminates because your Employee Life Insurance terminates, or because of your death, your spouse may be eligible to convert to an individual life insurance policy without a medical examination or health questionnaire being required. The eligibility requirements, the type of policy and the amount of coverage that your spouse may convert are described in the Contract issued to the Trustees. You or your spouse should contact the Fund Office or the nearest Manulife Financial office for details. Written application together with the initial premium due must be submitted to Manulife Financial within 31 days of the date your spouse's coverage terminates.

EXTENSION OF BENEFIT

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

ACCIDENTAL DEATH AND DISMEMBERMENT

EMPLOYEE ACCIDENTAL DEATH BENEFIT

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

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

For Loss of, or Loss of Use of:

Arm or leg	75%
Hand or foot	66 ² / ₃ %

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

Not more than 100% will be paid for all losses sustained in any one accident, with the exception of Quadriplegia, Paraplegia and Hemiplegia, for which not more than 200% will be paid.

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

“Loss” as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

“Loss” as used with reference to “loss of use” means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

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

EXPOSURE AND DISAPPEARANCE

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

REPATRIATION BENEFIT

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

FAMILY TRANSPORTATION

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

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

REHABILITATION BENEFIT

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

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

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

SEAT BELT RIDER

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

HOME ALTERATION AND VEHICLE MODIFICATION

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

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

TO WHOM ARE BENEFITS PAID

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

LIMITATIONS

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

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

WEEKLY DISABILITY BENEFIT

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

Benefit

You will be paid a benefit of \$423 per week, if you are totally disabled due to accidental bodily injury or illness and are unable to perform your regular work. Total disability means your complete inability to perform any and every duty pertaining to any occupation or employment.

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

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

Weekly Disability benefit payments will be reduced by the amount of any pension benefit an employee receives including disability pensions and Canada Pension Plan pensions.

NOTE: In order to be eligible for payment, Weekly Disability claims must be submitted within 90 days of the commencement of disability.

What is Not Eligible

Weekly Disability benefits are not payable for:

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

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

Third Party Liability

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

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

If a lump sum payment is made under 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.

MAJOR MEDICAL

EMPLOYEE AND DEPENDENT COVERAGE

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

LIFETIME MAXIMUM BENEFIT

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

Each year, up to \$1,000 will be automatically reinstated to the maximum amount available in benefits. However, the total will not exceed \$100,000 per individual.

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

ELIGIBLE EXPENSES

Eligible expenses are reasonable and customary charges for needed medical care, services or supplies, as described below, and received while the person is covered, for either an illness or injury that is non-occupational or for pregnancy.

Prescription Drug Expenses

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

Nicotine patches and gums are not eligible for reimbursement.

Viagra and other erectile dysfunction drugs are limited to \$500 per individual per calendar year.

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

Prescription drug expenses can be obtained using your ClaimSecure Identification Card. 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.

Vision Care Expenses

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

1. Eyeglass frames and lenses or contact lenses up to a total maximum of \$400 during any 24 consecutive month period from the last date of service (12 month period from the last date of service for persons under 18 years of age);
2. Laser eye surgery at 50% to a lifetime maximum of \$1,000 per individual.
3. Eye examinations performed by a licensed ophthalmologist or optometrist. Coverage is limited to one routine examination every two calendar years to a maximum of \$60 per individual.

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

Outside Canada Expenses

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

Emergency

If, while travelling outside Canada for periods of not more than six weeks, hospitalization or medical treatment is required due to emergency and non-elective reasons, the following expenses are covered provided part of the expense is considered an eligible expense under your provincial health plan:

1. Hospital charges in excess of any provincial government plan allowance, whether payable or not, for each day of such hospital confinement (but not beyond 14 days*), up to the customary amount charged for standard or public ward accommodation.
2. Charges in excess of any government plan allowance, whether payable or not, for the services of a legally qualified physician (M.D.).
3. Charges in excess of any provincial government allowance, whether payable or not, for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization and other inpatient and outpatient medical services.
4. The maximum hospital stay of 14 days does not apply if a licensed doctor (M.D.) certifies that the covered person should not be moved back to his home province.
5. Charges for professional licensed ambulance service in excess of the provincial plan, whether payable or not, including air or rail ambulance service, to transport the covered person back to a hospital within his home province, provided prior approval is obtained from Manulife Financial.
6. Charges for blood, blood products and their transfusion in excess of the provincial plan, whether payable or not.

EMERGENCY TRAVEL ASSISTANCE

Manulife Financial offers Emergency Travel Assistance (ETA) services which are administered by World Access Canada Inc. (WA), part of a global travel assistance company serving over 40 million people worldwide. If you should require medical assistance while travelling, contact World Access as soon as possible (before seeking treatment) so they can ensure you get the care you need without incurring unnecessary expenses, WA's multilingual Call Center is available 24 hours a day, 365 days a year worldwide. You can reach WA at the telephone numbers listed on your emergency Travel Assistance card.

It is important to carry your card with you at all times when travelling as this is the only way WA can check your coverage.

Your ETA coverage is in effect for trips of not more than 6 weeks.

EMPLOYEE AND DEPENDENT COVERAGE

Note: Coverage is limited to a period of 6 weeks from the date you or your insured dependent leave the province of residence. Therefore, if you and/or your dependents are confined to a hospital on the 42nd day, this coverage will continue until the date of discharge. 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.

Call World Access for the following services, which are covered:

Pre-Trip

- a) Information concerning visa, inoculation, passport or immunization requirements of the foreign countries in which you'll be travelling;
- b) Assistance to find the nearest embassy or consulate in the country in which you will be travelling.

Legal Services

- a) Assistance in locating a lawyer or to arrange bail, if required;
- b) Assistance in arranging for the secure pick-up and delivery of any important documents (where possible).

LIFETIME MAXIMUM BENEFIT

The total lifetime benefit payable in respect of an insured employee or dependent is \$1,000,000 per insured individual.

SERVICES

The following benefits are covered in the event of an emergency ("emergency" means a sudden injury or illness where there is an urgent or pressing need for immediate medical care) which occurs while you or your dependents are travelling for non-medical reasons outside your province of residence:

1) The following Personal Assistance Services are covered:

- a) Multilingual assistance by toll-free telephone, 24 hours a day, 365 days a year, for insured individuals and providers of medical services to obtain aid and assistance;
- b) Referral to a legally qualified physician, dentist, legal advisor or an appropriate medical care facility;
- c) Assistance in replacement (but not cost) of necessary travel documents or tickets in the event of theft or loss;
- d) A centre for communication of messages between you and your family, friends or business associates. Messages are held for 15 days, 24 hours a day;
- e) Medical consultation and monitoring of medical care and services if you or your dependents are hospitalized;
- f) For help in obtaining funds by wire or bank transfer (the funds and any costs of wire transfer would be your responsibility);
- g) For assistance in reporting missing baggage and following up with the transportation company;
- h) If your luggage has been lost or stolen.

The following eligible expenses are covered:

- a) Medical Services - Charges incurred for medical and surgical fees, semi-private hospital accommodations, prescribed drugs, x-rays and other in-patient expenses incurred that are reasonable and customary for the area;
- b) Emergency Transportation - Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in your home province. Upon written recommendation of a physician, such charges shall include a medical attendant if necessary who is neither a resident in the employee's home nor a relative of the employee or the employee's spouse;
- c) Return of Deceased - Charges incurred for the return of a deceased employee or dependent to the place of former residence in Canada, subject to a maximum benefit of \$5,000 per individual;
- *d) Return of Dependent Children - Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary;
- *e) Return Trip Delay - Transportation - Charges incurred for delay of the return trip of an insured individual due to the hospitalization of that individual or another insured individual with whom the individual is travelling, limited to the cost of one way economy class transportation to your province of residence;

- *f) Visit of Family Member - Charges incurred for transportation of an immediate family member to visit a hospitalized insured individual. Such individual must have been travelling alone and confined to a hospital for more than 7 days. The cost of transportation is limited to return economy fare for one family member. An immediate family member is defined as a spouse, parent, child, brother or sister or a person with whom the insured individual normally resides;
- g) Return of Vehicle - Charges incurred in connection with the return of an insured's vehicle in the event the insured is unable to return it due to illness, injury or death, subject to a maximum benefit of \$500 per trip. The vehicle will be returned to the insured's residence or nearest appropriate rental agency. Such charges shall not include commercial transport vehicles;
- h) Return Trip Delay - Accommodation - Charges incurred for commercial accommodation and meals for insured individuals while staying with a hospitalized insured family member when their return trip is delayed due to an illness or accident. Such charges are subject to a maximum benefit of \$700 per family;
- i) Convalescent Benefit - Charges incurred for accommodation for insured individuals requiring convalescence following hospitalization, subject to a maximum benefit of \$75 per day for not more than 5 days for each insured individual.

* Charges for d), e) and f) above, are subject to a combined maximum benefit of \$5,000 per emergency.

EXCLUSIONS (to the Emergency Travel Assistance coverage)

The foregoing list of services shall not include any of the following:

- charges listed as Exclusions under the Supplementary Health Expense section of this booklet except charges for medical treatment or surgical procedure by a physician;
- charges which are not incurred as a result of an emergency while travelling;

LIABILITY

The Insurer is not responsible for the availability, quantity, quality or results of any medical treatment received by an insured individual, or for the failure of an insured individual to receive Medical treatment for any reason.

It is important to call World Access in advance of your travels, if there is a chance the country you'll be travelling to is in distress or strife to ensure there is no problem getting emergency assistance while travelling. The Department of Foreign Affairs and International Trade publishes and updates a list of countries that are currently affected. You can obtain this list by calling World Access (see your card for telephone numbers).

Extended Health Expenses

1. Convalescent Hospital (Within Home Province)

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

A convalescent hospital is a place that:

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

2. Charges in excess of any provincial plan benefits (whether payable or not) for the services of a Naturopath, Osteopath or Podiatrist, or Christian Science Practitioner up to a maximum eligible expense of \$8 per visit and 20 visits per calendar year, per type of practitioner. For the services of a Chiropractor, you will be reimbursed up to an annual maximum of \$200 per person.

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

3. Reasonable and customary charges in excess of the provincial plan (whether payable or not) for the professional services provided by the following licensed, certified or registered practitioners when they are operating within their recognized fields. Treatment must be prescribed by a legally qualified physician (M.D.).

- Psychologist, up to a maximum of \$500 per individual per calendar year.
- Physiotherapist, up to a maximum of \$200 per individual per calendar year.

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

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

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

- hospital beds, wheelchairs, canes, crutches, walkers and trusses;
- rigid or semi-rigid braces for back, neck, arm or leg and non-dental prostheses such as artificial limbs and eyes; including replacement if required because of a change in physical condition;

- respiratory equipment, including oxygen;
- kidney dialysis equipment;
- contact lenses or glasses following cataract surgery (limited to one pair per lifetime); and
- splints, casts, catheters, and hypodermic needles;

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

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

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

6. Diagnostic laboratory and x-ray expenses.
7. Charges for professional ambulance service, other than airline or railroad to the nearest hospital qualified to provide the necessary treatment. Emergency transportation by airline or railroad to and from the nearest hospital qualified to provide the necessary treatment, provided such charges are reasonable and customary;
8. Charges for necessary dental treatment by a licensed dentist which are reasonable and customary and are required as the result of a non-occupational accidental injury by external means to sound natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be a covered medical expense;
9. Charges for laboratory tests and x-rays performed by a Chiropractor, subject to a maximum eligible expense of \$25 per calendar year per individual;
10. Charges for necessary services in a hospital's outpatient department on account of sickness or accidental bodily injury. (Coverage is provided only to the extent permissible by law.)
11. Charges for one hearing aid (excluding batteries) in any 24 consecutive month period up to a maximum of \$250;
12. Charges for restorative or rehabilitative speech therapy by a qualified speech therapist. Treatment must be for speech loss or impairment due to illness (or surgery on account of illness) other than a functional nervous disorder. If the condition is due to a congenital abnormality, corrective surgery must have been performed prior to the therapy.

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

13. Charges for custom made arch supports, orthotic devices, lifts, wedges (but not for sports), Dennis Browne splints and shoes purchased and used in the application of such splints. Charges for orthopaedic shoes that are not part of a brace or splint will be reimbursed at 50%. Maximum reimbursement is \$300 every two years.

Exclusions and Limitations

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

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

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

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

Extension of Benefits

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

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

Totally Disabled Means:

- for an employee, that such person cannot, because of illness or injury, engage in such person's regular occupation and is not working for pay or profit; and

- for a dependent, that such person cannot, because of illness or injury, engage in most of the normal activities of a person of the same age and sex.

DENTAL EXPENSE BENEFIT

EMPLOYEE AND DEPENDENT COVERAGE

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

EXTENSION OF BENEFITS

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

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

DENTAL CLAIM FORM REQUIRED

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

SUBMISSION OF TREATMENT PLAN

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

In order for you and your dentist to learn in advance how much the Plan will pay and how much must be paid by you, it is recommended that a treatment plan be filed with the Fund Office whenever a planned course of treatment is expected to exceed \$300.

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

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

ELIGIBLE EXPENSES

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

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

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
 - (a) oral examinations: recall oral examination (including associated x-rays) limited to once every 12 months, complete oral exam and diagnosis is covered only once every 24 months;
 - (b) x-rays: however, complete series or equivalent are only eligible once every two years;
 - (c) study casts: once every 12 months;
 - (d) consultations.

2. **Preventive Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
 - (a) scaling and polishing (prophylaxis) and topical fluoride treatments, once every 12 months;
 - (b) space maintainers including stainless steel crowns, but only if the crown is placed on a deciduous tooth which (a) has several cavities which would otherwise require filling or (b) is non-restorable using normal restorative dental material;
 - (c) pit and fissure sealants for persons under 19 years of age.

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

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

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

6. **Periodontics:**
 - (a) Adjunctive Service as follows: scaling, root planing or occlusal equilibration, (limited to 8 units per year for all procedures combined), acute infections, and provisional splinting;
 - (b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
 - (c) Special Periodontal Appliances.

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

8. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures.
9. **Repairs, Relining, and Rebasing of Dentures:** Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.
10. **Removable Prosthetic Devices:** The initial installation of partial or full dentures including adjustments during the six month period following installation, and precision attachments for dentures.

Replacement of existing dentures is not covered except if:

- (a) The replacement is required to replace a temporary denture by a permanent denture within 12 months from the date of installation of the temporary denture; or
- (b) The existing dentures are at least five years old and no longer serviceable.

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

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

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

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

Addition of teeth to an existing bridgework, if required.

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

OTHER PRACTITIONERS

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

GENERAL PROVISIONS

CO-ORDINATION OF BENEFITS

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

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

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

The plan that covers the person as:

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

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

To implement this provision, the Plan may:

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

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

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

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

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

QUESTIONS AND ANSWERS

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

Once hours that you have worked for a contributing employer have been reported to the 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 employee who works for a contributing employer. These employers report the number of hours worked by the employee to the Fund Office. The hours are placed in the employee’s reserve account.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Please note that the Insurance Company will investigate 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 Financial shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any of such claim.

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

LIFE INSURANCE

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

WEEKLY DISABILITY

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

DENTAL

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

MAJOR MEDICAL BENEFITS

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

Major Medical, Vision, Dental - Secondary Payer Claims

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

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

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

SEND ALL COMPLETED CLAIM FORMS TO THE FUND OFFICE.

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