Plan Document - Appendix A

Employer: ***TG Minto Corporation***

Plan Number: ***G0106318***

Plan Effective Date: ***March 1, 2017***

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The Extended Health Care and Dental Care Benefits are being provided directly by TG Minto Corporation which has contracted with the Employer or the Administrator to adjudicate and administer the claims for these benefits following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this Plan Document and the Employer's Benefit Plan.

This Plan Document produced July 29, 2022.

2 Group Benefits Schedule

Employer: TG Minto Corporation

Plan Number: G0106318

Plan Effective Date: March 1, 2017

Class Number(s)

010	Executives	(Plan A)
020	Management	(Plan B)
030	Factory Team Members - Hourly	(Plan C)
031	Factory Team Members - Staff	(Plan C)
040	Contract	(Plan D)

Plan Number(s)

A	Executives
B	Management
C	Factory Team Members
D	Contract

Effective Date for Increases in Plan Benefits

When first eligible for the increase

Associated Companies

None

Extended Health Care

Drug Benefit and Pharmacy Services for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under this Plan Document to covered persons who reside in Quebec will be administered as outlined in the Plan Document Addendum - Drug Benefit and Pharmacy Services For Covered Persons Who Reside In Quebec.

Classifications Eligible for Plan Benefits

Employees in Plans A, B, C and D

Dependents of Employees in Plans A, B, C and D are also covered for this Benefit.

Overall Plan Maximum

Unlimited

Deductible

Nil

Benefit Percentage (Co-insurance)

100% for
- Drugs (Diabetic Supplies only)
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies

90% for
- Drugs (excluding Diabetic Supplies)

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age

Employee’s age 70 or retirement, whichever is earlier

Survivor Extended Benefit

subject to the Employee's Termination Age for the Extended Health Care Benefit

Participation Basis

mandatory

4 Group Benefits Schedule – Plans A, B, C and D

Waiting Period

For Employees hired on or prior to the Plan Effective Date

none

For Employees hired after the Plan Effective Date

none

Covered Expenses and Maximums (per covered person)

Hospital

Semi-private: 120 days per disability

Chronic Care

Semi-private: 120 days per disability

Substance Abuse Rehabilitation Hospital

Semi-private: 120 days per disability up to a maximum of $10,000 per lifetime

ManuScript Generic Drug Plan 2

Prescription Drugs:

Fertility Drugs: $5,000 per calendar year

Anti-smoking Drugs: $500 per calendar year

Anti-obesity Drugs: $1,800 per calendar year

All other Covered Drug Expenses: Unlimited

Drug Payment Type: Direct Claims Payment

Professional Services

Chiropractor: $500 per calendar year. In addition, up to $50 per calendar year for x-rays.

Osteopath: $500 per calendar year. In addition, up to $50 per calendar year for x-rays.

Podiatrist/Chiropodist: $500 per calendar year. In addition, up to $50 per calendar year for x-rays.

Massage Therapist: $500 per calendar year

Naturopath: $500 per calendar year

Speech Therapist: $500 per calendar year

Physiotherapist: $500 per calendar year

Psychologist: $500 per calendar year

Audiologist: $500 per calendar year

Vision Care

Eye Exams: once per 24 consecutive months

Prescription Glasses: $350 per 12 consecutive months for persons under age 18 and $350 per 24 consecutive months for persons age 18 and over

Contact Lenses (where medically necessary): 1 lens per eye per lifetime

Visual Training: $200 per lifetime

Medical Services and Supplies

Private Duty Nursing: $25,000 per calendar year

Orthopaedic Shoes: 1 pair to a maximum of $150 per calendar year

Custom-Made Orthotics: $400 per calendar year

Referral outside Canada for medical treatment available in Canada: $3,000 per 3 calendar years

Out-of-Canada Maximum: $5,000,000 per lifetime

Hearing Aids: $300 per 5 calendar years

Support Stockings: 4 pairs per calendar year

Stump Socks: 5 pairs per calendar year

Surgical Brassieres: 2 per calendar year up to a maximum of $200 combined for surgical brassieres and breast prostheses

Breast Prostheses: $200 per calendar year combined for surgical brassieres and breast prostheses

Wigs and Hairpieces: $300 per lifetime

All other Medical Services and Supplies: Unlimited

Emergency Travel Assistance

Emergency Travel Assistance, a Travel Assist Benefit, is provided up to the maximum shown in the description of this Covered Expense under the Extended Health Care Benefit.

Dental Care

Classifications Eligible for Plan Benefits

Employees in Plans A, B, C and D

Dependents of Employees in Plans A, B, C and D are also covered for this Benefit.

Deductible

Nil

6 Group Benefits Schedule – Plans A, B, C and D

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

60% for Level III - Dentures

60% for Level IV - Major Restorative Services

Maximums

$2,500 per calendar year combined for Level I, Level II, Level III and Level IV

Dental Fee Guide

Current Fee Guide for General Practitioners approved by the Provincial Dental Association in the Province where the Employee resides

If the Employee resides in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by the Administrator.

Termination Age

Employee’s age 70 or retirement, whichever is earlier

Survivor Extended Benefit

subject to the Employee's Termination Age for the Dental Care Benefit

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Plan Effective Date

none

For Employees hired after the Plan Effective Date

none

Accident

an unexpected or unforeseen happening or event involving an external force, causing loss or injury, independently of all other causes.

Actively at Work

at work for the Employer or any Associated Company shown in the Benefit Schedule on a Full-time basis at the Employee's usual place of work.

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Adherence

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

Administrator

the organization which the Employer may from time to time appoint for purposes of performing services for the Plan.

Advisory Body

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

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the Employer.

Chronic Care Facility

a legally licensed institution, including the chronic care beds of a Hospital, which is eligible to receive payments under a provincial hospital plan, and which:

a) operates primarily to provide care for the chronically ill;

b) requires that every patient be under the care of a Physician;

c) provides 24-hour nursing services by registered nurses;

d) is not primarily operated as a maternity home, a nursing home or a place for rest, or for the care and treatment of the aged, the blind, the deaf, the mentally ill, Drug addicts, or alcoholics; and

e) is not primarily providing custodial care.

Dentist

a doctor of dentistry, licensed to practice dentistry in the place where the services are provided.

Dependent

an Employee's Spouse or Child who is covered under the Provincial Plan.

8 Definitions

- Spouse

the Employee's legal Spouse, or the person who has, for at least 12 months, been continuously living with the Employee in a role like that of a marriage partner.

Only one Spouse will be eligible for benefits under this Plan, and will be as indicated by the Employee on his application for benefits under this Plan. Where this information is not contained on the Employee's application, the person who qualifies last under this Plan's definition of Spouse will be the eligible Spouse.

- Child

an Employee's natural or adopted child, or stepchild, who:

a) is unmarried;

b) is not employed on a full-time basis;

c) is not eligible for plan benefits as an employee under this or any other group plan; and

d) is either under 21 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.

A child covered under this Plan Document, who is incapacitated due to a mental or physical disability on the date he reaches the age when he would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this Plan Document.

A child is considered incapacitated if he is incapable of engaging in any substantially gainful activity and is dependent on the Employee for support, maintenance and care, due to a mental or physical disability.

The Employer may require written proof of the Dependent's condition as often as may reasonably be necessary.

A stepchild must be living with the Employee to be an eligible Dependent.

Disability or Disabled

the state of being Totally Disabled.

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 Plan. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an Advisory Body.

Employee

a person who:

a) is directly employed by the Employer on a permanent and Full-time basis;

b) is compensated for services by the Employer; and

c) is residing in Canada.

Employer

TG Minto Corporation or any Associated Company shown in the Benefit Schedule.

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

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

Full-time basis

For Full-time Employees: normal work schedule of at least 30 hour(s) per week.

For Contract Employees: normal work schedule of at least 40 hour(s) per week, for a minimum of 9 months.

Full-time as used in this plan document can also mean and include Employees working on a Contract basis, whenever the context requires it.

Hospital

a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;

b) provides organized facilities for diagnosis, major surgery or rehabilitation;

c) provides 24-hour nursing service by registered nurses and has a Physician in regular attendance;

d) is not primarily operated as a nursing home or a place for rest, or for the care and treatment of the aged, the blind or deaf; and

e) is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill, unless the institution is eligible to receive payments under a provincial hospital plan.

For the purpose of this Plan, the chronic beds of a Hospital are not considered to be part of that Hospital.

10 Definitions

Immediate Family Member

a person who is:

a) the Employee;

b) the Employee's Spouse or Child;

c) the Employee's or Spouse's parent; or

d) the Employee's or Spouse's brother or sister.

Indefinite Lay-Off

a period during which the Employee is laid off work and for which there is no fixed recall date.

Interchangeable Drug

includes but is not limited to:

a) a generic equivalent to the brand name Drug deemed to be interchangeable by law where the Drug is dispensed;

b) 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.

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the place where the service is provided.

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.

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

For the purposes of this Plan, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and

b) the date the child is born.

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.

Parental Leave of Absence

the period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Patient Assistance Program

a program that provides assistance to covered persons 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. This 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.

Physician

a doctor of medicine, licensed to practice medicine in the place where the services are provided.

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.

Prior Plan

a previous Group Plan which covered all or some of the persons covered under this Plan, and which terminated within 31 days prior to the Effective Date of this Plan.

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

12 Definitions

Reasonable and Customary

the lowest of:

a) the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial;

b) the amount shown in the applicable professional association fee guide; or

c) the maximum price established by law.

Temporary Lay-Off

a period during which the Employee is laid off work and for which there is a fixed recall date.

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for plan benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Eligibility for Plan Benefits

Employee

An Employee is eligible for plan benefits under this Plan if he:

a) is a member of a Classification which is eligible for plan benefits, as set out in the Benefit Schedule;

b) is younger than the Termination Age shown in the Benefit Schedule; and

c) has continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

Re-hired Employees

If an Employee is re-hired within 6 months of termination of coverage under this Plan due to termination of employment, he must re-apply for coverage under this Plan, but will not be required to satisfy another Waiting Period.

Dependent

An Employee's Dependent becomes eligible for plan benefits at the same time that the Employee does. However, the Employee must apply for the Employee coverage in order for the Dependent to be eligible. A person who becomes a Dependent after the Employee becomes covered is eligible on the date that person becomes a Dependent.

Amount of Plan Benefit Coverage

The amount of plan benefit coverage for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

How to Become Covered

To become covered under this Plan, an eligible Employee must apply in writing on approved forms. Coverage for Dependents must also be applied for on approved forms.

When Evidence of Good Health is Required

For all benefits, except Dental Care, evidence of good health is required whenever an Employee makes a Late Application for coverage on any person.

In this case, the Employee will bear the cost of supplying evidence which conforms to the Administrator's rules.

Late Application

For non-mandatory benefits, an application is considered late when an Employee:

a) applies for coverage on any person after having been eligible for more than 31 days; or

b) re-applies for coverage on any person whose coverage had earlier been cancelled.

14 Eligibility for Plan Benefits

For mandatory and non-mandatory benefits, an application is considered late when, after having previously waived benefits under this Plan because he was covered for similar benefits under his Spouse's plan, an Employee:

a) applies for coverage more than 31 days after his benefits terminated under the Spouse's plan; or

b) if he applies for coverage, and benefits under his Spouse's plan have not terminated.

Late Dental Application

A late applicant for Dental coverage will be subject to a maximum of $125 per person, for the first 12 months of coverage.

Effective Date of Plan Benefits

Once an application for Employee or Dependent plan benefits has been completed, coverage becomes effective as follows, if the Employee is then Actively at Work:

a) for all plan benefit coverage which does not require evidence of good health, on the date the Employee or Dependent becomes eligible for this coverage; and

b) for all plan benefit coverage which does require evidence of good health, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when plan benefit coverage would otherwise take effect, this coverage will take effect on the next day on which he is again Actively at Work.

An Employee who is not Actively at Work on the Effective Date may still be eligible for plan benefits under this Plan through a Transfer of Benefits from the Prior Plan.

Dependent plan benefits will not take effect prior to the Effective Date of the Employee's plan benefits.

Increases in Plan Benefits

An increase in plan benefits on an Employee or Dependent will take effect as follows, if the Employee is then Actively at Work:

a) if evidence of good health is not required, on the Effective Date for Increases in Plan Benefits shown in the Benefit Schedule; and

b) if evidence of good health is required, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when an increase in plan benefits would otherwise take effect, this increase in plan benefits will take effect on the next day on which he is again Actively at Work.

Decreases in Plan Benefits

A decrease in the amount for which any person is covered takes effect when the person is first eligible for the decreased amount.

16 Transfer of Benefits from the Prior Plan

This Section applies only if this Plan replaces a Prior Plan.

Concessions Granted

The Employer grants the following concession to persons who were covered under the Prior Plan when it terminated:

a) a Transfer of Coverage for Employees not Actively at Work.

This concession is as described below.

Transfer of Coverage

- Eligibility

An Employee who is not Actively at Work on the Effective Date is still eligible under this Plan if he:

a) was covered under the Prior Plan when that Plan terminated; and

b) would be eligible for plan benefits under this Plan if Actively at Work on its Effective Date.

- Amount Transferred

An Employee eligible to transfer benefits will be eligible under this Plan for the lesser of:

a) the amount for which he was covered under the Prior Plan when it terminated; and

b) the amount of plan benefits for which he would be eligible under the Plan if Actively at Work on its Effective Date.

- Effective Date of Transfer

Plan benefits under a transferred benefit will become effective on the later of:

a) the date plan benefits provided under the Prior Plan would terminate in the absence of this provision; and

b) the Effective Date of this Plan.

Termination of Employee Plan Benefits

An Employee's plan benefit coverage terminates on the earliest of:

a) the date the Employee no longer satisfies the definition of Employee;

b) the date the Employee ceases to be Actively at Work;

c) the date the Employer terminates the Employee's coverage;

d) the date the Employee enters the armed forces of any country on a full-time basis;

e) the date this Plan terminates or coverage on the classification to which the Employee belongs terminates;

f) the date the Employee reaches the Termination Age, as shown under each Benefit in the Benefit Schedule; or

g) the date the Employee dies.

Termination of Employment Exceptions

If an Employee ceases to be Actively at Work, his coverage will normally terminate as specified under the Termination of Employee Plan Benefits provision. However, the Employer will waive this rule and continue plan benefit coverage under the conditions set out below. An Employee's plan benefit coverage can only be continued on a basis that does not discriminate against another Employee.

Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all plan benefit coverage will continue until the Employer terminates the coverage.

Due to Maternity, Parental or other Mandated Leave of Absence

If an Employee ceases to be Actively at Work due to Maternity, Parental or other leave of absence that is mandated by legislation, all plan benefit coverage may continue for the period of leave to which the Employee is entitled by legislation governing the Employer.

In jurisdictions where the continuation of plan benefit coverage is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required contribution must also accompany the request for termination.

Due to Other Leave of Absence or Temporary Lay-Off

If an Employee ceases to be Actively at Work due to a leave of absence other than Maternity or Parental leave, or due to Temporary Lay-Off, all plan benefit coverage may continue until the Employer terminates it, but in no event for more than 120 days after the Employee was last Actively at Work.

Due to Indefinite Lay-Off

If an Employee ceases to be Actively at Work due to a strike or Indefinite Lay-Off, plan benefit coverage will continue only if the Employer informs the Administrator that this is the case, but in no event for more than 120 days after the Employee was last Actively at Work.

18 Termination of Plan Benefits

Legislated Benefit Extensions

If legislation mandates that employee benefits continue for a limited period after an Employee's employment terminates, the Employer will extend each plan benefit for the minimum period required by law.

Termination of Dependent Plan Benefits

Plan benefit coverage on an Employee's Dependent terminates on the earliest of:

a) the date the Employee's plan benefit coverage terminates;

b) the date the Dependent is no longer eligible for coverage under the provisions of this Plan;

c) the date written notification is received from the Employee to cease his Dependent coverage because his Dependents are covered under another benefit plan for benefits similar to the ones in this Plan; or

d) the date a required contribution is due but not paid.

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the care of a covered person.

Payment is subject to any maximum amount shown in the Benefit Schedule and in the Covered Expenses section below. Lifetime maximums apply to all periods combined in which a covered person is covered by the Employer.

Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Covered Expenses

Expenses shown below are covered if they are:

a) Medically Necessary for the treatment of an illness or injury of a covered person and recommended by a Physician; and

b) incurred for the care of a person while he is covered under this Benefit; and

c) reasonable taking all factors into account; and

d) used as prescribed or recommended by a Physician; and

e) supported by Manulife Financial's Due Diligence process and the decision made by the Administrator to include as a Covered Expense and shared with the Employer as required.

These Expenses are covered to the extent that:

a) they are Reasonable and Customary, as determined by the Administrator or the Employer; and

b) they are not covered under the Provincial Plan or any other government-sponsored program; and

c) they can legally be covered; and

d) if they are 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 Plan Document as of the date of approval as determined by the Administrator and shared with the Employer as required.

All Extended Health Care Benefits are paid as if the covered person were eligible under the Provincial Plan.

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 Plan 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.

20 Extended Health Care Benefit

This Plan 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, a person will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife Financial's discretion, medical information, test results or other documentation will be required from the Physician to determine the eligibility of the Drug, service or supply.

Manulife Financial has the right to ensure covered persons 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 a covered person to apply to and participate in any Patient Assistance Program to which the covered person is entitled. Manulife Financial reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance the covered person is 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.

Advance Supply Limitation

Payment of any Covered Expenses under this Benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time, except for covered Drug expenses.

- Drug Expenses

The maximum quantity of Drugs that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by the Physician or Dentist; or

b) a 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.

Hospital Services in Canada

- Hospital Care

Hospital charges in excess of the charges for standard Ward accommodation, up to the Hospital maximum shown in the Benefit Schedule, provided:

a) the covered person was confined to Hospital on an in-patient basis; and

b) the accommodation was specifically elected in writing by the covered person.

- Chronic Care

Confinement in a Chronic Care Facility which starts within 14 days of discharge from a Hospital confinement of at least 5 days, up to the Chronic Care Maximum shown in the Benefit Schedule.

- Expenses Not Covered

Charges for any portion of the cost of Ward accommodation, utilization or copayment fees (or similar charges).

- Substance Abuse Rehabilitation Hospital

Confinement in a licensed Hospital (receives provincial funding), up to the Substance Abuse Rehabilitation Hospital Maximum shown in the Benefit Schedule.

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following when prescribed in writing by a Physician or Dentist and dispensed by a licensed Pharmacist, up to the maximum for this Covered Expense shown in the Benefit Schedule.

- Drugs For Treatment of an Illness or Injury

Charges for any Drug which by law or convention requires the written prescription of a Physician or Dentist.

Charges for life-sustaining drugs.

Charges for injectable medications.

Charges for the following expenses are not covered:

a) the administration of injectable Drugs;

b) Drugs, biologicals and related preparations which are administered in Hospital on an in-patient or out-patient basis;

c) Non Prescription injectable vitamins;

d) Charges for preventive vaccines and medicines (oral or injected);

e) Drugs determined to be ineligible as a result of Due Diligence; and

f) Drugs used in the treatment of a sexual dysfunction.

- Preventive Drugs

Charges for oral contraceptives, intrauterine devices and diaphragms.

- Diabetic Supplies

Charges for standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

- Payment of Covered Expenses

The maximum amount for any Covered Expense is the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the Covered Expense for any Drug to that of a lower cost Interchangeable Drug at the time the Drug is purchased.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

The amount payable is subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for Drugs and any maximum, as shown in the Benefit Schedule.

- No Substitution Prescriptions

Where a prescription contains a written direction from the Physician or Dentist that the prescribed Drug is not to be substituted with another product, the maximum amount covered is the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife Financial.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

Reimbursement at the cost of a prescribed Drug, where a Lower Cost Alternative Drug is available, will only be considered if medical evidence is provided by the treating Physician to support why the Lower Cost Alternative Drug cannot be tolerated or is ineffective.

The amount payable is subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for Drugs and any maximum, as shown in the Benefit Schedule.

- Direct Claims Payment

The Employer will provide a Pay Direct Drug Card for each Employee covered for this Benefit. The Pay Direct Drug Card is honoured by participating Pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered Drug expenses the covered Employee must:

a) present the Pay Direct Drug Card to the Pharmacist; and

b) pay any amounts that are not covered under this Benefit.

Reimbursement of covered Drug expenses will be payable directly to the Pharmacist. Prescriptions for covered drug expenses purchased without the Pay Direct Drug Card will be reimbursed directly to the Employee.

Vision Care

Charges for the following Vision Care expenses when prescribed by an ophthalmologist, optometrist, or oculist:

a) eye exams including refractions, up to the Eye Exams maximum shown in the Benefit Schedule;

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, up to the Prescription Glasses maximum shown in the Benefit Schedule;

c) contact lenses if prescribed as medically necessary or required to improve vision to at least a 20/40 level in the better eye, provided this level cannot be attained with glasses, up to the Contact Lenses maximum shown in the Benefit Schedule; and

d) visual training, up to the Visual Training maximum shown in the Benefit Schedule.

Professional Services

Services of a licensed chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, audiologist and psychologist, up to the Professional Services maximum shown in the Benefit Schedule.

The recommendation of a Physician is not required for Professional Services, except for services of a speech therapist.

Expenses for some of these Professional Services (excluding podiatrist/chiropodist) may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit are payable only after the Provincial Plan's maximum for the benefit year has been paid.

Expenses for podiatrist/chiropodist may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit are payable only after the Provincial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

a) a registered nurse; or

b) a registered nursing assistant (or equivalent designation) who has completed an approved medications training program.

Covered Expenses are subject to the Private Duty Nursing maximum shown in the Benefit Schedule.

Charges for the following services are not covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

c) service performed while the patient is confined in a hospital, a nursing home, or any similar institution; and

d) service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

The Employer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing services begin. The Administrator will then advise the Employee of any benefit that will be provided.

- Rental of Major Medical Equipment

The rental or, when approved by the Administrator or the Employer, purchase of:

a) Mobility Equipment: crutches, canes, walkers, and wheelchairs; and

b) Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals.

- Non-Dental Prostheses, Supports and Hearing Aids

Charges for external prostheses.

Charges for braces (other than foot braces), trusses, collars, leg orthosis, casts and splints.

Charges for the following expenses, when recommended by a Physician or podiatrist:

a) stock-item orthopaedic shoes;

b) modifications or adjustments to stock-item orthopaedic shoes or regular footwear; and

c) custom-made shoes which are:

i) constructed by a Certified Orthopaedic Footwear Specialist; and

ii) required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe.

Charges will be subject to the Orthopaedic Shoes maximum shown in the Benefit Schedule.

Charges for casted, custom-made orthotics which are recommended by a Physician or podiatrist, up to the Custom-Made Orthotics maximum shown in the Benefit Schedule.

Charges for cost, installation, repair, and maintenance of a hearing aid or aids (including charges for batteries), up to the Hearing Aids maximum shown in the Benefit Schedule.

Charges for support stockings up to the Support Stockings maximum shown in the Benefit Schedule.

Charges for surgical brassieres up to the Surgical Brassieres maximum shown in the Benefit Schedule.

Charges for breast prostheses up to the Breast Prostheses maximum shown in the Benefit Schedule.

- Other Supplies

The cost of ileostomy, colostomy and incontinence supplies.

The cost of oxygen.

The cost of medicated dressings and burn garments.

The cost of stump socks covered to a maximum of 5 pairs per calendar year.

The cost of fertility treatments covered to a maximum of $5,000 per lifetime.

The cost of wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to the Wigs and Hairpieces maximum shown in the Benefit Schedule.

The cost of viscosupplementation, to a maximum of $1,000 per calendar year.

- Diagnostic Procedures

Charges for microscopic and other similar diagnostic tests and services, rendered in a licensed laboratory in the province of Quebec.

- Ambulance

Charges for licensed ambulance service provided in the covered person's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available.

- Dental Treatment

Charges for the treatment of accidental injuries to the natural teeth or jaw. The accident must be due to a force or blow external to the mouth and have occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 12 months of the accident.

Injuries due to biting or chewing are not covered.

- Out-of-Province or Out-of-Canada

Charges incurred for the following medical treatment given outside the covered 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 covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to the Out-of-Canada Maximum shown in the Benefit Schedule.

   A Medical Emergency occurs when a covered person requires immediate medical attention while a covered person is 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.

   Stable means that the covered person:

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

1) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination; or

2) 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 covered person has been seen by a medical professional in relation to the symptoms; or

3) 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

4) been admitted to or treated at a hospital for the medical condition; or

ii) 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.

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.

b) referral out of Canada for medical treatment which is available in Canada, up to the Referral outside Canada maximum shown in the Benefit Schedule.

If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the Referral outside Canada maximum shown in the Benefit Schedule.

For all treatment given out of Canada, other than emergency medical treatment, the Employer:

i) requires that it be recommended as necessary by a Physician practicing in Canada, and

ii) suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

The Administrator will then advise the Employee of any benefit that will be provided.

Charges for the following are payable under this Covered Expense:

a) Physician's services;

b) Hospital room and board at standard Ward rates. Charges in excess of Ward rates are payable if this Benefit covers Hospital Services in Canada. In such case, the amount payable under this expense is subject to the Hospital maximum shown in the Benefit Schedule;

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

Travel Assistance

The following assistance services are provided for a covered person when required as a result of a Medical Emergency during the first 60 days while travelling outside such person's province of residence.

Medical Emergency Assistance

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

a) 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

b) 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.

Stable means that the 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 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.

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.

28 Extended Health Care Benefit

a) **24-Hour Access**

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

b) **Medical Referral**

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

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered 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 covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered 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.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an Immediate Family Member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered 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 the Administrator.

j) **Vehicle Return**

If a covered 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 covered person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

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

In the event of the death of a covered 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 preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help a covered 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 covered 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 covered person plans to travel.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family Physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a Physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed Drug; and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

The Administrator, and the company contracted by the Administrator 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 a covered 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 covered 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) for Out-of-Province or Out-of-Canada and Emergency Travel Assistance only, 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 covered 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 plan benefit coverage;

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

   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 covered person, an Immediate Family Member or a person who lives with the covered 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.

32 Dental Care Benefit

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the dental care of a covered person.

Payment is subject to any maximum amounts shown in the Benefit Schedule and to any limit on benefits shown in the Covered Expenses section below. Lifetime Maximums apply to all periods combined in which a person is covered by the Employer.

In determining if an expense is covered, the Employer may require the following information:

a) x-rays and a complete dental chart showing any extractions, fillings, or other work performed prior to the date of the incurred expenses for which claim is being made;

b) itemized bills from the dentist or other sources, of services or treatments; and

c) laboratory or hospital reports, casts, molds or study models, or other similar evidence of the condition or treatment of the teeth or mouth.

- Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Covered Expenses

Expenses shown below are covered if they:

a) are incurred for the necessary dental care of a covered person;

b) are incurred for the care of a person while he is covered under this Benefit;

c) are incurred for services provided by a Dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license;

d) are reasonable as determined by the Employer or the Administrator, taking all factors into account; and

e) do not exceed:

i) the fees recommended in the Dental Fee Guide shown in the Benefit Schedule, or

ii) reasonable and customary charges, as determined by the Employer or the Administrator, if such expenses are not included in the Dental Fee Guide shown in the Benefit Schedule.

Alternate Benefits

Where any two or more courses of treatment covered under this Benefit would produce professionally adequate results for a given condition, the Employer will pay Benefits as if the least expensive course of treatment were used. The Administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

a) complete oral examinations, one per 24 months

b) full mouth x-rays and panoramic x-rays, one per 24 months combined

c) recall examinations, once every 6 months

d) bitewing x-rays, once every 6 months

e) routine diagnostic and laboratory procedures

f) one unit of light scaling and one unit of polishing, once every 6 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months, when the service is performed in Quebec

g) fluoride treatment, once every 6 months

h) oral hygiene instruction, once every 6 months

i) space maintainers, only for dependents under age 18 (excluding appliances placed for orthodontic purposes)

j) fillings, (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants. Replacement fillings are covered only if:

   i) the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay; or

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

k) pre-fabricated full-coverage restorations (metal and plastic)

l) minor surgical procedures, simple extractions, and post surgical care

m) complicated extractions including impacted and residual roots

n) consultation, anaesthesia, and conscious sedation

o) denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

p) injection of antibiotic Drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Basic Services

a) surgical procedures not included in Level I (excluding implant surgery)

b) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

   i) scaling not covered under Level I, and root planing, up to a combined maximum of 10 units per calendar year

   ii) provisional splinting

   iii) occlusal equilibration, up to a maximum of 8 units per calendar year

c) endodontic services (which include root canals and therapy, root amputation, apexifications and periapical services). Root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime. Re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and endodontic treatment had begun exposing a tooth, the Employer will pay for expenses related to such treatment provided the expense is incurred within 31 days after the plan benefits terminate.

Level III - Dentures

a) initial provision of full or partial removable dentures

b) replacement of removable dentures, provided the new dentures are necessary due to one of the following:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable

   ii) the existing appliance is at least 60 months old and cannot be made serviceable

   iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

Open Space Limitation

No benefit will be payable if dentures are required solely to replace a natural tooth which was missing prior to the date the person became covered for this Covered Expense under this Plan.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a denture had been taken prior to the termination, the Employer will pay for expenses related to the installation of the denture provided the expense is incurred within 31 days after the plan benefits terminate.

Level IV - Major Restorative Services

a) crowns and onlays (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay)

b) inlays (covering at least 3 surfaces, provided the tooth cusp is missing)

c) initial provision of fixed bridgework

d) replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable

   ii) the existing appliance is at least 60 months old and cannot be made serviceable

   iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent bridge. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.

Open Space Limitation

No benefit will be payable if fixed bridgework is required solely to replace a natural tooth which was missing prior to the date the person became covered for this Covered Expense under this Plan.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a crown, onlay or bridgework had been taken prior to the termination, the Employer will pay for expenses related to the installation of the crown, onlay or bridgework provided the expense is incurred within 31 days after the plan benefits terminate.

Pre-Determination of Benefits

When a proposed course of treatment is expected to cost more than $500, a treatment plan should be filed with the Administrator before treatment begins.

The Administrator will then advise the Employee of the amount, if any, that is payable.

Expenses Not Covered

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

a) a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program;

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

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

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

e) charges for broken appointments, third party examinations, travel to and from appointments, or completion of claim forms;

f) charges for services or supplies:

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

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

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

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

g) treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction;

h) cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan;

i) implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the Employer will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge;

j) anti-snoring or sleep apnea devices;

k) treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition;

l) the replacement of removable appliances which are lost, mislaid or stolen; or

m) laboratory fees which exceed Reasonable and Customary charges, as determined by the Employer or the Administrator.

The Benefit

If an Employee dies while covered for this Benefit and while his Dependents are covered under this Plan, the Employer will continue the Dependent coverage for a period of up to 24 months. The Benefit Schedule shows which Dependent coverage will be continued under this Benefit.

Plan Benefit Coverage Continued

The coverage continued on a Dependent will be the same as that which was in effect on the date of the Employee's death. This coverage will be subject to any age reduction or termination shown in the Plan at that time.

Termination of Plan Benefit Coverage

The maximum period for extended coverage is 24 months. Coverage on any Dependent ceases prior to this:

a) if the Dependent would cease to qualify as a Dependent, even if the Employee were still alive;

b) if the Dependent obtains similar coverage elsewhere; or

c) if this Plan terminates.

38 Payment of Claims

Payees

All benefits for an Employee and such Employee's Dependents are payable to the Employee, unless the Employee has previously authorized payment to be made to the person and/or corporation which has rendered services, treatment or supplies. If the Employee is not alive, these benefits are payable to such Employee's estate.

- Payment of Small Amounts

If any amount up to $2,000 is payable to a person who is not alive or who cannot give a valid discharge for such payment, the Employer may pay the amount to:

a) any relative of that person; or

b) any person or institution incurring expenses for the care or maintenance of that person.

Requirement of Proof

No claim for benefits will be paid until the Employer receives satisfactory proof in writing that such benefits are payable under the terms of this Plan.

The Employer or Administrator reserves the right to request any additional information necessary, as determined by the Employer or Administrator, to validate the eligibility of a claim for benefits under this Plan. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

Claims for drug benefits which were not handled on a credit-card basis must be submitted on forms provided by the administering company and forwarded to the address shown on the form. Proof that benefits are payable must be submitted by or on behalf of the Employee and received by the Employer or the Administrator at their respective Head Offices or at one of their local offices within:

a) 12 months from the date the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while plan benefits under this Plan are in force. Upon termination of a person's plan benefits under this Plan, proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

   i) 12 months from the date the expense was incurred; or

   ii) 90 days from the date of termination of plan benefit coverage.

Date Costs are Incurred

The expense for a service or supply is deemed to have been incurred on the date the service was performed or the supply furnished. If a procedure involves multiple appointments, the expense is deemed to be incurred on the date the procedure is completed. For supplies that have to be ordered, the expense will be deemed to be incurred on the date the supplies were paid for. Proof of receipt of the supplies is required.

Continuing Proof

If benefits are being paid or coverage continued on a covered person because of disability, the Employer may require written proof that this person remains Disabled under the terms of this Plan. This proof will be required as often as may reasonably be necessary.

Examination by the Employer

The Employer reserves the right to have any person in respect of whom a claim is being made under this Plan submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the Administrator, as often as may reasonably be required. No benefits will be payable if, without reasonable cause, the covered person fails to undergo such examination.

Subrogation

If a covered person suffers personal injury or loss for which he has a right to bring action for damages against a third party, the Employer shall be subrogated to the covered person's rights to recover damages to the extent that it may be obligated to pay benefits to the covered person. In such case, the Employer will require the covered person to complete a subrogation reimbursement agreement. The Employer has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the covered person shall reimburse the Employer for benefits paid or payable. Unless notified to the contrary, the covered person's solicitor shall also represent the Employer's interests in such a recovery.

Time Limit on Legal Action

No legal action against the Employer or the Administrator may be commenced less than 60 days after proof has been filed in accordance with the above requirements. No such action may be brought more than two years after the last day on which proof of claim would be accepted under the terms of this Plan.

Co-ordination of Benefits

The Employer will co-ordinate its Extended Health Care and Dental Care Benefits payable under this Plan with other Plans which also cover a covered person for similar Benefits.

Plans Co-ordinated with this Plan

For the purposes of the Co-ordination of Benefits, Plan means:

a) other group insurance programs;

b) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan; and

c) individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

How Claims are Co-ordinated

Benefits payable under this Plan will be reduced, when necessary, so that no more than 100% of eligible expenses incurred during a calendar year are jointly paid by this Plan and all Plans which come before it in the Order of Benefit Payment.

For the purposes of this provision, eligible expenses are as defined in each Policy or Plan document, before any applicable payment limitations, such as deductible, benefit percentage and maximums, are applied. An expense is eligible only to the extent that it is Reasonable and Customary.

40 Payment of Claims

Order of Benefit Payment

The Order of Benefit Payment is established by applying the following rules to the various Plans which cover eligible expenses. The rules are applied from first to last until an order is established.

a) The Plan with no Co-ordination of Benefits provision in the Policy or Plan document is deemed to pay its benefits first (primary carrier).

b) If all Plans have a Co-ordination of Benefits provision, the following rules are applied to determine the Order of Benefit Payment. The rules depend on the basis on which the person is covered in the Plan.

   i) Employee/Member

      The Plan which covers the person as an employee/member is deemed to pay its benefits before a Plan which covers that person as a dependent.

      If the person is an employee/member under more than one Plan, the following order applies:

      1) the Plan where the person is an active full-time employee, then

      2) the Plan where the person is an active part-time employee, then

      3) the Plan where the person is a retiree.

   ii) Dependent - Spouse

      If a dependent spouse is also covered as an employee/member under another Plan, the Plan which covers the spouse as an employee/member is deemed to pay its benefits before the Plan which covers the spouse as a dependent.

      If the spouse is an employee/member under more than one Plan, the order of benefit payment is as outlined under “Employee/Member” above.

   iii) Dependent - Child

      If a dependent child is covered under more than one Plan, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

      However, in situations where the parents of the dependent child are separated or divorced, the following order applies:

      1) the Plan of the parent with custody of the child, then

      2) the Plan of the spouse of the parent with custody of the child, then

      3) the Plan of the parent not having custody of the child, then

      4) the Plan of the spouse of the parent not having custody of the child.

      Where divorced or separated parents share joint custody of the dependent child, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

c) For dental accidents, Extended Health Care Plans with accidental dental coverage determine benefits before Dental Plans.

d) If the Order of Benefit Payment cannot be established by the preceding rules, benefits will be pro-rated between or among the Plans in proportion to the amounts that would have been paid under each Plan had there been coverage by only that Plan.

Special Rules Applied

The Employer will apply the following rules in co-ordinating benefits under this Plan:

a) if a person does not apply for a benefit for which he is eligible under another Plan, the amount of such benefit will be estimated by the Employer and assumed to be paid;

b) if only part of a Plan provides for the co-ordination of benefits, this part will be considered a separate Plan from the part which does not provide for co-ordination;

c) this Plan is considered to be a Plan in applying the rules which establish an Order of Benefit Payment;

d) when a Plan provides benefits in the form of service rather than cash payments, the Reasonable and Customary value of the service rendered is deemed to be both an Allowable Expense and a benefit paid; and

e) if a person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Administration of the Provision

The Employer has the right to release to or obtain from any other insurer, person or institution, information needed to administer the Co-ordination of Benefits provision in this Plan. The Employer has the right to recover any payments in excess of the amount determined to be payable in accordance with this provision.

42 Administration of the Plan

Method of Administration

This Plan must be administered in accordance with the Employer's instructions.

Notice of New Employees

The Employer must supply enrolment material to eligible Employees and inform the Administrator of the addition of new Employees as they become eligible for plan benefit coverage.

Notice of Terminated Employees

The Employer must inform the Administrator of the termination of plan benefit coverage on Employees on or before the date on which this coverage terminates. The Employer is also responsible for the retrieval of every prescription drug credit-card issued under this Plan. Payments made or the cost of drugs dispensed with respect to ineligible persons because of the late receipt of termination notice or the Employer's failure to retrieve drug credit-cards will be recovered from the Employer if they can not be recovered from the Employee on whose behalf they were paid.

Uniform Practices

Options available to the Employer must be chosen and administered by the Employer on a uniform basis without prejudice to any Employee.

Clerical Error and Misstatement

A clerical error is a mistake in writing or copying data. A clerical error made by the Employer or the Administrator will not invalidate plan benefit coverage otherwise in force, or continue plan benefit coverage otherwise terminated under the terms of this Plan.

If a covered person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of plan benefit coverage;

b) the amount of plan benefits; and

c) any other rights or benefits under this Plan.

The Employer will adjust the plan benefits in force where these are affected by a clerical error or a misstatement of age.

Employee Contributions

The Administrator is not responsible for the collection of any employee contributions required for plan benefits under this Plan.

Termination of the Plan

The Employer may refer to the Discontinuance of Agreement provision of the Administrative Agreement between the Employer and the Administrator for further information on terminating the Plan.

Gender

In this Plan Document, unless the context requires otherwise, reference to the masculine gender will also include the feminine gender.

Currency of Payment

All amounts payable under this Plan, to or by the Employer, are payable in Canadian currency.

Conformity with the Law

If a provision of this Plan Document is contrary to any law to which it is subject, this provision will be deemed to conform to the minimum requirements of such law.

Administration

Manulife Financial may from time to time adopt such administrative practices as are reasonably necessary in providing benefits under this Plan.

44 PLAN DOCUMENT ADDENDUM

Drug Benefit and Pharmacy Services for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under the Plan Document to covered persons who reside in Quebec will be administered as outlined in this Addendum.

If a provision of the Plan Document or this Addendum is, in full or in part, contrary to the Legislation or any other law or regulation replacing it, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the then applicable laws and regulations.

Covered Expenses

The following expenses are covered:

a) drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and

b) covered pharmacy services that are to be paid when the drug is on the RAMQ List; and

c) drugs that are listed as a covered expense in the Plan Document but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List) and pharmacy services published for private plans

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans listed in the Act Respecting Prescription Drug Insurance and the Health Insurance Act for drugs that appear on the RAMQ List. For all other covered drug expenses, the provisions stated in the Plan Document will apply.

a) **Percentage Payable by the Administrator**

Prior to the Annual Out-of-Pocket Maximum being reached, the percentage of covered expenses payable under the Plan Document will be:

i) For any drugs on the RAMQ List which are not otherwise covered under the terms of the Plan Document, the percentage payable is as set out by the then applicable Legislation.

ii) For any Legislated pharmacy services which are not otherwise covered under the terms of the Plan Document, the percentage payable is as set out by the then applicable Legislation.

iii) For any drug on the RAMQ List which is covered under the terms of the Plan Document, the percentage payable is the greater of:

- the benefit percentage stated in the Plan Document, or

- the percentage as set out by the then applicable Legislation.

After the Annual Out-of-Pocket Maximum has been reached, the percentage of covered expenses payable under the Plan Document will be 100%.

b) **Annual Out-of-Pocket Maximum**

The Annual Out-of-Pocket Maximum is a portion of covered drug expenses or covered pharmacy services which must be paid by a covered person in a calendar year, before the percentage payable under the Plan Document will be 100%. Amounts that will be applied to the Annual Out-of-Pocket Maximum are:

i) the deductible amounts, and

ii) the portion of covered drug expenses that is payable by the covered person, when the benefit percentage under the Plan Document is less than 100%, and

iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The Annual Out-of-Pocket Maximum for the Employee and his Spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for dependent children.

For the purposes of calculating the Out-of-Pocket Maximum for the Employee and his Spouse, those portions of covered drug expenses and covered pharmacy services paid for dependent children will be applied to the person who is closest to reaching the Annual Out-of-Pocket Maximum.

c) **Deductible**

Deductible amounts, if any, stated in the Plan Document will apply, up to the Annual Out-of-Pocket Maximum. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums, if any, stated in the Plan Document will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated in the Plan Document is reached is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Eligible Dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of attainment of:

i) the age specified in the Plan Document, and

ii) age 26.

Drug coverage and covered pharmacy services provided for Dependent Children after the age stated in the Plan Document is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services performed for a drug in the RAMQ List are covered, and

iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

Provided the person is otherwise eligible for the drug benefit under the Plan Document, the Termination Age, if any, specified in the Plan Document will not apply. Drug coverage provided after the Termination Age specified in the Plan Document is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered,

ii) only covered pharmacy services related to a drug on the RAMQ List are covered,

iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation,

iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

v) the premium required for the drug coverage is the premium for the Extended Health Care Benefit.

g) **Continuation of Coverage - Concerted Work Stoppages**

In the event of a strike, lock-out or other concerted work stoppages, coverage will continue until the later of:

i) the length of time, if any, specified in the Plan Document, and

ii) 30 days.

Coverage for drugs that are listed as a covered expense in the Plan Document, but are not on the RAMQ List

With respect to drugs that are covered under the Plan Document but are not on the RAMQ List, all the provisions stated in the Plan Document will apply.