Labourers' International Union of North America

Your Group Benefit Plan

LiUNA!

Local 837

Manulife Financial

LiUNA Local 837

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

You or any of your covered dependents have the right to request a copy of any or all of the sections of the Group Policy and/or Plan Document that apply to you and your dependents.

Manulife Financial Group Policy

XL2490 – Life Insurance
XC2490 – Accidental Dismemberment
50124 – Weekly Disability, Supplementary Health Care, Dental Care

Labourers' Local 837 Health and Welfare Trust Fund
44 Hughson Street South
Hamilton, Ontario
L8N 2A7
Telephone: 905-529-1116

Manulife Financial Group Benefits- Dental Claims
P.O. Box 1654
Waterloo, ON
N2J 4W2

Manulife Financial Group Benefits- Health Claims
P.O. Box 1653
Waterloo, ON
N2J 4W1

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

Revised January 1, 2019

LiUNA Local 837

General Provisions Applicable to Dental and Supplementary Health Care Benefits

LiUNA Local 837

SCHEDULE OF BENEFITS

LIFE INSURANCE FOR MEMBERS

Classification	**Amount**
All eligible active members:	$100,000

LIFE INSURANCE FOR DEPENDENTS

Classification	**Amount**
All eligible active members:	
Spouse	$10,000
Each Child	$10,000

Note:
The Life Insurance for Dependents will terminate when the Life Insurance for Members terminates.

ACCIDENTAL DISMEMBERMENT FOR MEMBERS

Classification	**Amount**
All eligible active members:	$30,000

WEEKLY DISABILITY BENEFIT FOR MEMBERS

Classification	**Amount**
All eligible active members:	$543

Benefits Commence

Accident:	From 1st day
Illness:	From the 8th day (If hospitalized for at least 18 hours, benefits may commence on the earlier of the 8th day of disability or the date of hospitalization.
Benefit Duration:	Up to 26 weeks, including EI. This is a Taxable Benefit.

LiUNA Local 837

DENTAL CARE BENEFITS

Classification

All eligible active members and their eligible dependents:

COVERED CHARGES
(See Benefit Description for Coverage Details)

Fee Guide

Payments under this plan will be based on the Ontario Dental Association Fee Guide approved by the Trustees. Please contact the Benefit Office for details.

	Amount
Calendar Year Deductible	$25 per person but not more than $50 per family
Percentage Payable	
Routine Care	100%
Major Restorative	80%
Orthodontics	60%
Calendar Year Benefit Maximum for all covered Dental expenses (except Orthodontics)	$2,500
Lifetime Benefit Maximum for Orthodontics	$3,000

LiUNA Local 837

SUPPLEMENTARY HEALTH CARE BENEFITS

Classification

All eligible active members and their eligible dependents:

COVERED CHARGES
(See Benefit Description for Coverage Details)

- Drugs and Medicines with Benefit Card
- Ambulance
- PSA Testing
- Vision Care
- Chiropractor, Massage Therapist, Physiotherapist, Chiropodist and Foot Care Service
- Hearing Aids
- Orthotics/Orthopedic Shoes
- Durable Medical Equipment and Supplies
- Out of Province/Canada Expenses
- Emergency Travel Assistance
- EAP/Counselling
- Health Care Spending Account (HCSA)
- Medical Marijuana

	Amount
Calendar Year Deductible	Nil
Percentage Payable	
Orthotics/Orthopedic Shoes	50%
Referral Treatment Outside Canada	50%
All other charges (including Out-of-Canada Emergency Medical Treatment and Emergency Travel Assistance)	100%

Drugs:

Covers all drugs that legally require a prescription;
Dispensing Fee Maximum; Preventive immunization and vaccines;
Smoking cessation prescription drugs;
Anti-Obesity drugs; Erectile Dysfunction drugs; Fertility Drugs

Health Practitioners' Benefit Maximums

Chiropractor (including charges for x-rays), Massage Therapist and Physiotherapist, Podiatrist and Chiropodist Services	$1,000 for all practitioners combined
Hearing Aid Benefit Maximum (in any 60-month period)	$400
Custom Made or Modified Orthopedic Shoes, Arch Supports, Molds or Orthotics (per 12 consecutive months)	$600 combined

Vision Care Benefit Maximum

Lenses, Frames or Contact Lenses (Also includes prescription sunglasses and polarization of prescription glasses)	$500 per 12 months
Prescription Safety Glasses	$200 per 24 months
Laser Eye Surgery	$1,000 per Lifetime
Eye exams for a covered person age 20 to 64 inclusive	$50 per 24 months
Durable Medical Equipment and Supplies	$1,000 per calendar year
Out-of-Province/Canada Emergency Care	
Maximum	$5,000,000 per lifetime
Hospital Room and Board Limit	Ward

Referral outside Canada for medical treatment Available in Canada

Maximum	$3,000 every 3 years
Hospital Room and Board Limit	Ward

GENERAL PROVISIONS

Member Eligibility

You may be eligible for coverage if you:

1. Reside in Canada and are covered under a Provincial Health Insurance Plan
2. Are a member in good standing of Local 837
3. Work for a contributing employer (any employer that is obligated or permitted to contribute to the fund)
4. Work the required number of hours for eligibility, as described later.

Dependent Eligibility

Your eligible dependents are:

1. Your spouse, where spouse means either:
   a) A person who, as of the time in question, is legally married to you, by virtue of a religious or civil ceremony
   b) A person who is living with you at the time an expense is incurred and who is publicly represented as your spouse, and who has been living with you for a period of at least 12 consecutive months and is designated as your spouse on your enrolment form when you first join the plan. If the person is added as your spouse after you join, you must complete a new enrolment form and send it the Benefit office. The enrolment form must have been on file for at least one year before the designated person is eligible for benefits. It is the responsibility of the member to contact the Benefit Office of LiUNA after the 12 month period.
2. Your unmarried children from live birth but under the age of 21 who are dependent upon you for maintenance and support and are not employed on a regular, full-time basis
3. Your unmarried children age 21 and over but under the age of 25 who are dependent upon you for maintenance and support and are not employed on a regular and full-time basis, and are attending school at an accredited college or university on a full-time basis, (a letter confirming full-time attendance must be provided to the Benefit Office each year)
4. Your unmarried children over the age of 21 who are incapable of self-support by reason of mental or physical handicap and became so while dependent upon you for maintenance and support and while not employed on a regular and full-time basis, and while covered as a dependent under 2 or 3 above. (Not applicable to Dependent Life Insurance coverage.)

The word "children" means, in addition to your own or lawfully adopted child, any step-child or other child, who depends upon you for maintenance and support, and is not employed on a regular and full-time basis and lives with you in a regular parent-child relationship.

Children of your spouse must also be included on the enrolment form and become eligible when your spouse does.

Eligible Dependents must reside in Canada and must be covered under a provincial Health Insurance Plan.

Effective Date of Coverage

Coverage for you and your dependents will become effective on the date on which you qualify for coverage in accordance with the following rules. No payments are made for services rendered or costs incurred prior to that date.

Initial Eligibility

Hours you work for contributing employers, for which contributions have been received, will be credited to your Hour Bank. You will become eligible for coverage on the first day of the second calendar month, after the accumulation of 360 credited hours in your Hour Bank.

Continuation of Eligibility

Once you are eligible, additional hours for which contributions have been received will be credited to your Hour Bank, and each month 120 hours will be deducted from your Hour Bank for insurance coverage. You may accumulate up to a maximum of 2880 credited hours which will provide you with 24 months of coverage after you stop working.

All members who have either not worked or not been in good standing with Local 837 for a period of 24 consecutive months shall lose the hours remaining to their credit.

Continuation of Eligibility While Disabled

If you become disabled due to a work related injury and are eligible for Workplace Safety and Insurance Board (WSIB) benefits, your Hour Bank balance at that time will be maintained. Your coverage will be continued for a maximum of 12 months from the date you were injured, or, until the date you no longer receive WSIB benefits, if earlier.

If you become disabled due to a work related injury but before you are eligible for benefits under the Plan, you will be credited with hours until you do become

eligible, at which time you will be provided coverage and your Hour Bank balance will be maintained. The maximum total period of protection (credited hours plus continued coverage) available under this provision for each injury is 12 months.

After the 12 month period noted above, deductions from your Hour Bank will resume, and your coverage will continue until the balance in your Hour Bank falls below 120 hours.

Important: If you become eligible for WSIB benefits, contact the Benefit Office immediately.

Termination of Eligibility

Coverage for you and your dependents will terminate on the earliest of:

- the end of the second month following the month when your Hour Bank falls below 120 credited hours after deduction of 120 hours for that month;
- the end of the month for which the required premium payments were made on your behalf;
- the date you enter the armed forces; and
- the date the Plan terminates.

Coverage may be extended beyond the normal termination date if you elect to make self-payments, as described later in this booklet.

Reinstatement

If your coverage terminates, you will again become eligible if your Hour Bank account shows a total of at least 120 hours within the twelve-calendar-month period subsequent to the termination of your eligibility.

Such reinstatement will be effective on the first day of the second month which follows the month in which this requirement was met. If you are not reinstated within this twelve-calendar-month period, any hours in your Hour Bank will be forfeited. You will again become eligible for coverage upon completion of the initial eligibility requirements.

Extension of Coverage by Self-Payment

If your hour bank balance falls below 120 hours, you will receive a notice that your coverage will terminate. Providing you are a member in good standing with Local 837 at the time your coverage terminates, you will be provided a one-time option to continue all coverage, except the Weekly Disability Benefit, from month to month, up to a maximum of 30 consecutive months. The first self-payment must be made to the Benefit Office by the 10th day of the month following, the date your coverage terminates; all subsequent payments must be continued on an uninterrupted basis and by the 10th day of the month for which coverage is applicable. If there is an

interruption, you cannot re-start self-payments at a later date.

All cheques being submitted should be made payable to Labourers' Local 837 Health and Welfare Trust Fund and must have your name and Social Insurance Number/ Identification Number printed on it so that the proper person will be credited with the payment.

Please contact the Benefit Office for further information concerning the amount of self-payments required and other requirements which must be met.

Deceased Members – Length of Dependent Coverage

If you should die prior to termination of eligibility, the benefits payable under the Plan applicable at the time of your death shall continue for your eligible dependents in the normal course, until your Hour Bank balance is less than 120 hours.

Surviving dependents of deceased members may make a self– payment for Health and Dental Coverage only and only for the one month following the termination of their coverage through the deceased member. The required payment must be made by the 10th day of the month for which coverage is applicable. Please contact the Benefit Office for further information concerning the amount of self-payment required.

Continuation of Dental Care and Supplementary Health Care Benefits for Incapacitated Children

Dental Care and Supplementary Health Care Benefits will continue beyond the date an unmarried child attains the limiting age for coverage, provided proof is submitted to the Benefit Office within 31 days after such date that such child:

- Is incapable of self-sustaining employment by reason of mental or physical handicap;
- Became so incapacitated prior to attainment of the limiting age and while insured; and
- Is chiefly dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to the Benefit Office, as required, but not more often than yearly.

Changes to Report

It is essential that you complete and send the Benefit Office a new enrolment form whenever you have any changes.
If you wish to change the beneficiary of your Life Insurance you must complete and send the Fund Office a new Appointment of Beneficiary form.

Similarly, if you should have a change of address, it is important that you notify the Benefit Office in writing immediately.

Changes in Eligibility Rules

The eligibility rules may be amended by the Trustees at any time without the necessity of prior notice being provided to those individuals affected thereby, including covered members and those not yet eligible for coverage as of the effective date of any such amendment.

The Trustees expressly reserve the right to change or terminate any or all of the benefits or coverage provided for members and their dependents. The Trustees also expressly reserve the right to change the amount of required contributions from time to time.

Definitions

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

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

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

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

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

Exclusive Distribution: Manulife Financial approved vendors.

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

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

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

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

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

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

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

Stable: Stable means a condition as pertaining to the Out-of-Province or out-of-Canada benefit, whereby an insured person:

a) has not in the 90 days before the departure date:
   - Been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination; or
   - Experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness diagnosed or undiagnosed if the insured/covered person has been seen by a medical professional in relation to the symptoms; or
   - 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
   - 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.

LIFE INSURANCE FOR MEMBERS

Benefits

The Life Insurance benefit of $100,000 is payable to your beneficiary in the event of your death from any cause at any time or place while you are insured under the plan.

Beneficiary

You may designate any person or persons you wish and your beneficiary may be changed whenever you wish in accordance with the applicable laws of your province of residence. Whenever you wish to change your beneficiary, you must complete and send a new Appointment of Beneficiary form to the Benefit Office. You should review your beneficiary designation to be sure that it reflects your current intent.

Waiver of Premium for Disability

If you become totally and permanently disabled while you are insured for Life Insurance coverage under the Plan, and before age 65, your Life Insurance will continue (even though you may lose eligibility for other benefits) for as long as you remain disabled, but not beyond your 65th birthday, subject to the following requirements:

1. You must be totally disabled for at least 6 months
2. Medical evidence must show that your disability is total and permanent
3. Written notice and proof of your disability must be given to the Insurance Company within 24 months following the date you cease active work due to disability. Subsequent proofs of disability must be furnished each year thereafter.

Totally and permanently disabled as used above means that due to illness or injury, you are unable to perform any occupation for which you are, or may reasonably become, fitted by training, education or experience.

Conversion Privilege

If your Life Insurance coverage 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. Details concerning who is eligible to convert, the type of policy and the amount of coverage that you may convert are described in the Contract issued to the Contract holder. Contact the Benefit Office for details. Written application together with the initial premium due must be submitted to Manulife Financial within 31 days of the date your Life Insurance coverage terminates.

Extended Benefits

If you should die within 31 days of the date your Life Insurance coverage 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.

LIFE INSURANCE FOR DEPENDENTS

Benefits

The Life Insurance benefit of $10,000 for spouse and $10,000 for each dependent child is payable to you in the event of the death of one of your eligible dependents from any cause, at any time or place, while insurance for that dependent is in force.

Waiver of Premium for Disability

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

Conversion of Dependents' Insurance

If Dependent Life Insurance for your spouse terminates because your Member 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. Details concerning who is eligible to convert, the type of policy and the amount of coverage that your spouse may convert are described in the Contract issued to the Contract holder. You or your spouse should contact the Benefit 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 Life Insurance coverage terminates.

Extended Benefits

If your dependent spouses dies within 31 days of the date your Dependent Life Insurance terminates, the amount your spouse could have converted will be paid as a death benefit under this plan even if your spouse did not apply for conversion.

ACCIDENTAL DISMEMBERMENT BENEFIT FOR MEMBERS

If you sustain a bodily injury caused by an accident while insured and if an insured loss occurs as a direct result, and within 1 year of the accident, an Accidental Dismemberment benefit is payable to you. The Accidental Dismemberment benefit is $30,000. Based on the loss incurred the following will be paid:

For Loss of	Amount Payable
Both hands or both feet	$30,000
Both arms or both legs	$30,000
Sight of both eyes	$30,000
Sight of one eye	$20,000
Speech, or hearing of both ears	$15,000
Thumb and index finger of one hand, or 4 fingers of one hand	$10,000
5 toes of one foot	$3,750

For loss of, or Loss of use of	
Arm or leg	$22,500
Hand or foot	$20,000

Only one of the amounts, the largest, is payable for all losses resulting from one accident.

Loss of an arm or leg means severance at or above the elbow or knee joint; loss of a hand or foot means severance at or above the wrist or ankle joint; loss of a thumb, finger or toe means severance of the entire digit; loss of sight, speech, hearing or loss of use means loss that is total, cannot be recovered, lasts at least one year and is deemed to be permanent.

Exposure

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

Limitations

No payment of Accidental Dismemberment benefits will be made for a loss that results, directly or indirectly, from:

- Illness or disease of any kind;
- Infection, unless the result of an accidental wound;
- Medical or surgical treatment of other than an accidental injury;
- War, whether declared or not;

- Insurrection, rebellion or participation in a riot or civil commotion;
- Suicide or attempt thereat, while sane or insane;
- Self-inflicted injury, while sane or insane;
- Your commission of, or attempt to commit, an assault or a criminal offence;
- An accident that occurs while you are in the care or control of a motor vehicle where your blood-alcohol level exceeds 80 mg. of alcohol in 100 ml. of blood.

WEEKLY DISABILITY BENEFIT FOR MEMBERS

You will be paid a benefit of $543 per week, if while insured, you become disabled due to an illness, and that due to that disability you are unable to perform your regular work. The benefit will commence on the first day of disability due to an accident, on the eighth day of disability due to an illness, or if you are hospitalized for at least 18 hours, on the first day of hospitalization if less than the eighth day.

If you are eligible for Employment Insurance (E.I.) sickness and accident benefits, the Plan's payments will be suspended while you are receiving E.I. benefits. If you continue to be disabled after exhaustion of your E.I. benefits, then the Plan will resume its payments to you for a maximum period of protection of 26 weeks of payments, including payments received from E.I.

If you are not eligible for E.I. benefits, the Plan's benefits will be payable for as long as you remain disabled, up to a maximum of 26 weeks from the date of disability.

Note: Be sure to apply for Employment Insurance accident and sickness benefits immediately upon becoming disabled.

You must apply for Weekly Disability benefits no later than 6 months after the date your disability starts. Please refer to the Claim Instructions outlined later in this booklet.

Successive Disabilities

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

a) The causes of the latest disability absence cannot be connected with the causes of any of the prior disability absences and the latest disability absence occurs after return to or availability for full-time active work for at least one day; or
b) A connection with prior disability absences can be established but between the last of the previous disability absences which are connected

and the latest one, you have returned to full-time active work for at least two consecutive weeks.

(a) Exclusions and Limitations

No benefits are payable for:

a) Any day on which you are not under the care of a licensed doctor (M.D.) or surgeon; no period of care shall be considered to have started until you have been seen and treated personally by a licensed doctor (M.D.) or surgeon;
b) The period of disability absence during which you are entitled to pregnancy or parental leave by reason of statute, contract or employment arrangement. This plan will, however, pay benefits for the post- natal recovery period of maternity leave;
c) Any day you are performing work of any kind, anywhere, for compensation or profit;
d) Any disability resulting from or contributed to by a motor vehicle accident; or a work related accident;
e) Any period of sickness or disability which commences while insurance is not in force.

DENTAL CARE BENEFITS

Description of Benefits

If you incur Covered Dental Expenses in excess of your Deductible in any calendar year, this plan pays you 100% of expenses for routine care; 80% of expenses for major restorative; and 60% of expenses for orthodontic treatment including correction of malocclusion.

The maximum benefit for all Covered Dental Expenses (excluding orthodontics) incurred in any calendar year is $2,500.00 for each covered family member.

The maximum benefit for orthodontic expenses is $3,000 per lifetime for each covered family member.

The Deductible

The deductible is the amount of Covered Dental Expenses which you pay, before Plan benefits are payable. The amount of your Deductible is $25 per person, but not more than $50 per family.

Covered Dental Expenses

Covered Dental Expenses are the reasonable and customary charges up to the amount shown in the Ontario Dental Association Fee Guide approved by the Trustees for needed dental care, services or supplies, as described below, and received while the person is covered, for either a disease or injury that is non-occupational.

Routine Care

- Oral examinations, including cleaning of teeth, but not more than one examination in any period of 6 consecutive months, and not more than one emergency examination in any 12 consecutive months;
- Scaling and root planing is limited to 10 units per calendar year for all procedures combined, however children under 13 years of age are limited to 1 unit every 6 months for all procedures combined;
- Occlusal equilibration is limited to 8 units per calendar year;
- Topical application of sodium or stannous fluoride (where such application is necessary for the maintenance of sound dental health), for patients 15 years of age and under, it is limited to 1 application every 6 consecutive months;
- Dental x-rays limited to: bitewing – once per 6 consecutive months; full mouth – once per 36 consecutive months or complete x-ray series – once per 36 consecutive months;
- Extractions;
- Oral surgery, including excision of impacted teeth;
- Fillings, including white fillings;
- Anesthetics administered in connection with oral surgery or other covered dental services;
- Occlusal guards in connection with periodontal treatment or bruxism;
- Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Endodontic treatment, including root canal therapy;
- Space maintainers and prefabricated full coverage restorations for patients 18 years of age and under;
- Injections of antibiotic drugs by the attending dentist.

Major Restorative

- Inlays, onlays, crowns, (and related work) and initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments) to replace one or more natural teeth extracted while the family member is covered;*
- Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the family member is covered and adjustments to such dentures, but separate charges for adjustments will only be included if they are incurred more than three months after the initial installation; *
- Replacement of an existing partial or full removable denture or fixed bridge work

by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, but only if evidence satisfactory to the Insurance Company is presented that:

a) The replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture was installed and while the family member is covered*; or
b) The existing denture or bridgework was installed at least 5 years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or
c) The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while the family member is covered, and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate temporary denture. *

- Dental implants included under the Alternate Benefit Clause up to the cost of a Bridge.
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining of dentures.

* The limitations applicable to natural teeth extracted while insured is not required for those members (and their dependents) who have been eligible and covered under this Plan for at least the past 12 consecutive months.

Accidental Dental

Dental work performed by a dentist for the prompt repair of sound natural teeth required as a result of non-occupational, accidental injury, external to the mouth, occurring while insured, will be covered at 100% but will not contribute to the calendar year maximum.

Orthodontics

Orthodontic treatment (including correction of malocclusion).

Other Practitioners

Services and supplies, in the case of each Dental Expense, must have been rendered and dispensed by a legally qualified dentist except that:

a) Cleaning or scaling of teeth may be performed by a licensed dental hygienist.
b) Installation, adjustment, repair and relining of complete dentures may be made by a dental mechanic or denturist legally practicing within the scope of his license.

The administration of a general anaesthetic in connection with a covered dental procedure may be performed by an anaesthetist. Any charges in excess of the mount

specified for such services in the Ontario Dental Association Fee Guide approved by the Trustees will be disregarded. If alternate services may be performed for the treatment of a dental condition, the amount included as a Covered Expense will be the amount specified for the least expensive service or supply which, as determined by the Insurance Company, will produce a professionally adequate result. For example, bonded fillings will be reimbursed based on the cost for non-bonded fillings.

X-rays may be required for crowns or bridgework, or orthodontics. X-rays will be returned promptly to your dentist.

Predetermination of Benefits: If dental expenses in connection with a course of treatment planned by a dentist for a covered family member will exceed $500, the proposed course of treatment should be filed with and approved by the Insurance Company prior to the commencement of treatment. Failure to file and obtain approval may result in benefits for the course of treatment in a lesser amount than would otherwise have been payable, because of the difficulty of determining the necessity for the types of services involved after they have been rendered. After reviewing the proposed course of treatment, the Insurance Company will notify both you and your dentist of the estimated payment.

No benefits are payable for:

- Any dental procedure which is included under any other Medical Plan provided by any employer or government;
- The initial installation of dentures and bridgework (including crowns, onlays and inlays forming the abutments), when such charges are incurred for replacement of teeth all of which were extracted while the individual was not a covered family member;
- Replacement of a lost or stolen prosthetic device;
- Personalization or characterization of dentures;
- Services and supplies that are partially or wholly cosmetic in nature, except covered expenses necessary for the prompt repair of a non-occupational injury;
- Supplies which were first prescribed or recommended prior to the date on which the individual would otherwise become covered hereunder for reimbursement in respect of such supplies;
- Any hospital charges in connection with injuries or disease of a dental nature;
- Charges for completion of claims forms;
- Charges for oral hygiene instruction, nutritional counseling or protective athletic appliances;
- Charges for pit and fissure sealants;
- Charges for missed/cancelled appointments;
- Charges for gold fillings;

- Services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.

SUPPLEMENTARY HEALTH CARE

Description of Benefits

If you incur Covered Expenses, this plan pays 100% of all expenses except foot care expenses. The plan pays 50% of foot care expenses (orthopedic shoes, arch supports, molds or orthotic devices).

Covered Expenses

This section should be read in conjunction with the section entitled "Exclusions". Before incurring any major expenses, you may submit details to the Insurance Company which will inform you what benefits, if any, are available under the plan.

Covered Expenses included under the plan are the reasonable and customary charges which you are required to pay for the following services and supplies received while you are covered, for the necessary treatment of non- occupational injuries and diseases, or for pregnancy.

Expenses shown below are covered if they are:

a) Medically Necessary for the treatment of an illness or injury of an insured person and are recommended by a Physician; and
b) Incurred for the care of a person while he is insured 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's Due Diligence process.

These Expenses are covered to the extent that:

a) They are Reasonable and Customary, as determined by Manulife; and
b) They are not insured under the Provincial Plan or any other government-sponsored program; and
c) They can legally be insured; and
d) Due Diligence for the Drug, supply or service has been completed where required.

All Extended Health Care Benefits are paid as if the insured 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 Policy will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This Policy will not automatically assume eligibility for all Drugs, services and supplies prescribed. New Drugs, existing Drugs with new indications, services and supplies are reviewed by Manulife using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife 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, a person may be required to have tried an alternative treatment.

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

Manulife has the right to ensure insured persons access Manulife's Exclusive Distribution channels where applicable when purchasing a Drug, service or supply. Manulife 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 may require an insured person to apply to and participate in any Patient Assistance Program to which the insured person is entitled. Manulife reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance the insured 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.

DRUGS AND MEDICINES prescribed by a licensed doctor (M.D.) or licensed dentist or other professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or licensed doctor (M.D.) legally authorized

to dispense such drugs and medicines, that regardless of their legal status are not normally obtainable except by a prescription from a licensed doctor (M.D.) or licensed dentist. Charges for drugs and medicines will not be reimbursed for more than a 3 month supply at any one time. Reimbursement of dispensing fees is limited to $8.00 per prescription or refill. Any other charges by a licensed doctor (M.D.), such as professional fees, are not covered.

Drugs for the treatment of Erectile Dysfunction are limited to reimbursement of $400 per insured person per calendar year.

Drugs for the treatment of infertility are limited to a lifetime maximum of $6,000 per insured person.

Medical Marijuana covered up to a maximum of $2,500 per calendar year through Starseed Medicinal Inc.

Drugs or medications for smoking cessation are limited to a $500 lifetime reimbursement per insured person.

Vaccinations are payable under the Drug Plan.

Annual drug Maximum of $25,000 per isured, per calendar .

When you become eligible for coverage you will be sent a Manulife Financial Drug Card.

Expenses for Drugs and Medicines can be obtained using your Manulife Financial Identification Card. If you have your prescription filled at a pharmacy that does not participate in the Manulife Financial program, you must pay for the cost of the prescription and submit the receipt in accordance with the claim instructions detailed later in the booklet.

AMBULANCE SERVICE: Charges in excess of the amount payable under the covered person's Provincial Health Plan for professional licensed ambulance service, including air or rail ambulance service subject to prior approval of Manulife Financial, to transport the covered person:

- From the place of injury (or where illness struck) to the nearest hospital where treatment is available;
- Directly from the first hospital where treatment is given to the nearest hospital for needed specialized treatment not available at the first hospital; or
- From a hospital to a rehabilitation hospital

PRIVATE DUTY NURSING: Charges are covered up to a Lifetime maximum of $10,000 per eligible dependent.

Charges for home nursing care must be by a registered nurse (R.N), registered nursing assistant (R.N.A.), licensed practical nurse (L.P.N.) and Victorian order nurse (V.O.N) and cannot be a member of your family and does not normally live in

your home. Must be ordered by a licensed doctor (M.D.) as medically necessary for a disability that requires the specialized training of an R.N., R.N.A., L.P.N. and V.O.N.

PSA TEST: Reimbursement will be provided for reasonable and customary charges for one Prostate Specific Antigen (PSA) test per calendar year

VISION CARE EXPENSES for the following supplies when recommended by a legally qualified ophthalmologist or optometrist.

- Corrective glasses or contact lenses, up to a maximum benefit of $500, per insured person every 12 consecutive months.
- Charges for one routine eye examination every 24 months, for insured persons age 20 to 64, subject to a maximum benefit of $50.
- Prescription safety glasses, up to a maximum benefit of $200, per insured person every 24 consecutive months.
- Laser Eye Therapy at 100% co-insurance to a lifetime maximum of $1000. No benefits are payable for non-corrective glasses.

TREATMENTS BY A PROVINCIALLY LICENSED **CHIROPRACTOR, PHYSIOTHERAPIST, DULY QUALIFIED MASSAGE THERAPIST** and **CHIROPODIST OR PODIATRIST** and for diagnostic x-ray examinations ordered by a chiropractor, but not more than $1,000 per calendar year for all such charges. However, no benefit will be paid while the individual is entitled to similar benefits under any provincial health plan regardless of whether the provincial plan pays all or only part of such charges. Treatment for a qualified massage therapist must be prescribed by a physician.

HEARING AID charges for the cost and installation of a hearing aid or aids when provided by a certified, clinical audiologist. Any charges in excess of $400 for all such expenses with respect to a family member during a 60-month period shall be disregarded. Includes any charges in connection with replacement or repair. Excludes any charges in connection with batteries.

ORTHOPAEDIC SHOES (CUSTOM/MODIFIED), ARCH SUPPORTS, MOLDS OR ORTHOTIC DEVICES, but not for sports, on the written recommendation and dispensed by a licensed doctor (M.D.), podiatrist, pedorthist, othotist or chiropodist which states the need and diagnosis. Reimbursement will be made for 50% of eligible incurred expenses limited to $600 combined per insured person per 12 consecutive months.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

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 1 pair per lifetime); and
- Splints, casts, catheters, and hypodermic needles;

But excluding personal comfort, convenience, exercise, safety, self-help or environmental control 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 the Insurance Company 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.

EAP/COUNSELLING

Counselling services provided by Social Workers, Marriage/Family Therapists, Clinical Counsellors or Manulife EAP Resilience Programme (see enclosed brochure) are covered at 100% up to $1,000 per insured person and each eligible dependent per calendar year.

HEALTH CARE SPENDING ACCOUNT (HCSA)

This account provides you with the flexibility to cover unexpected health and/or dental expenses your standard benefits plan may not cover. Each insured members' family is eligible for $1,000 per calendar year. Any unused portion may be rolled over to the next calendar year to a maximum account balance of $2,000.

OUT-OF-PROVINCE/OUT-OF-CANADA

The termination age for Out-of-Province/Canada and ETA is age 70.

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

a) Treatment required as a result of a medical emergency which occurs during the first 60 days while temporarily outside of residence, provided

the insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

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

i. A sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your dependent) is travelling outside of his province of residence, or
ii. A previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

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

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

If, while outside of Canada on referral for medical treatment, the insured 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.

These charges are subject to the maximums shown in the Benefit Schedule.

For all treatment given out of Canada, other than emergency medical treatment, Manulife Financial:

a) Requires that it be recommended as necessary by a Physician practicing in Canada, and
b) Suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

Manulife Financial will then advise the Employee of any benefit that will be provided.

Charges for the following are payable under this expense:

- Physician's services
- Hospital room and board at standard ward rates
- The cost of special hospital services

- Hospital charges for out-patient treatment
- Licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- 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 Province 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 an insured person when required as a result of a Medical Emergency during the first 60 days while travelling outside such person's province of residence. The services are available during the period that the person is covered for the Out-of-Province or out-of-Canada expense, provided under this Benefit.

MEDICAL EMERGENCY ASSISTANCE

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

- A sudden, unexpected injury or a new medical condition which begins while an insured person is travelling outside of his province of residence, or
- A previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

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

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 Insurance coverage, is provided.

c) Claims Payment Service

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

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

d) Medical Care Monitoring

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

e) Medical Transportation

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

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

f) Return of Dependent Children

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

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

g) Trip Interruption/Delay

If a trip is interrupted or delayed due to an illness or injury of an insured person, one-way economy transportation will be arranged to enable each insured 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 insured person, and whose fare for transportation and accommodation was pre-paid at the same time as the insured person's fare.

If the insured 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 an insured 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 an insured 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 1) 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 an insured person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the administrator.

j) Vehicle Return

If an insured person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person's home or nearest appropriate rental agency will be paid, up to a maximum of $1000. (Canadian).

k) Identification of Deceased

If an insured 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 an insured person, the necessary authorization 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 an insured person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) Legal Referral

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

d) Interpretation Services

Telephone interpretation service in most major languages is provided.

e) Message Service

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

f) Pre-trip Assistance Service

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

HEALTH ADVICE AND ASSISTANCE

The following services are available for an insured 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 insured person.

c) Link to 911

If necessary, an insured 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 insured person, the registered nurse will follow-up with the insured person within 24 hours after the medical advice is provided.

Exceptions

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

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

How to Access Emergency Travel Assistance – Your Emergency Travel Assistance Card

Your Emergency Travel Assistance card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your I.D. number and plan document number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have an Emergency Travel Assistance Card, please contact your Plan Administrator.

Exclusions

No benefits are payable under this plan for the charges listed below, and the amount of any such charges will be deducted from the individual's expenses which are covered under this plan and from his allowable expenses before the benefits of this plan are determined.

i. Charges that would not have been made if no insurance existed or charges that neither the member nor any of his dependents are required to pay; or
ii. Charges for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or
iii. Charges for services or supplies which are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian members and their dependents; or
iv. Charges for services and supplies which are not necessary for treatment of injury or disease, or are not recommended and approved by the attending licensed doctor (M.D.), or charges which are unreasonable; or
v. Charges incurred for care, treatment, services or supplies as a result of any group or employer-sponsored treatment, inoculation or examination; or
vi. Charges incurred for drugs, medicines, or injectable drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis.

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

- War, whether declared or not;
- Insurrection, rebellion or participation in a riot or civil commotion;
- The covered person's commission of, or commit, an assault or a criminal offence.

No benefits are payable under this plan if the provision of such benefits is 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 the same age and sex.

GENERAL PROVISIONS APPLICABLE TO DENTAL CARE AND SUPPLEMENTARY HEALTH CARE BENEFITS

COORDINATION 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 coordination 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 priority cannot be established in the above manner, the benefits shall be prorated 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, Manulife Financial 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 Manulife Financial 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.

EXTENSION OF BENEFITS

If you or one of your covered dependents are totally disabled at the time insurance terminates, Supplementary Health Care benefits (except dental benefits) will be extended for the disabled individual during the uninterrupted continuance of such disability for a maximum of three months beyond the date on which insurance terminates, but in no event, beyond the date the disabled person becomes covered under any other group-type plan providing similar benefits.

An individual will be considered to be totally disabled at the time insurance terminates if:

- a member - is unable because of disease or injury to engage in his regular occupation and is not working for any kind of compensation.
- a dependent - is prevented because of disease or injury from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Dental Benefits for installation or delivery of prosthetic devices (including bridges and crowns), which were ordered while the individual was covered will be extended ninety days from the date of termination of insurance. No other dental benefits will be extended.

Any extended benefits payable is subject to the provisions and limitations of the plan.

CLAIM INSTRUCTIONS

To assist you in filing a claim with the Benefit Office, you will find below an outline of the procedures that should be followed.

Send the original copy of all completed forms to the insurance company.

For Supplementary Health Care and Dental benefit claims, you should keep a photocopy of the claims. You will need these if you file for additional payments that may be available from another insurance plan through coordination of benefits.

LIFE INSURANCE

1. The beneficiary should notify the Benefit Office immediately to obtain the necessary forms.
2. As well as a completed claim form, you will be asked for the Provincial Death Certificate or a Funeral Home Certificate. Original documents are required but will be returned to you upon request.

ACCIDENTAL DISMEMBERMENT

For dismemberment loss, you should notify the Benefit Office immediately to obtain the necessary claim forms.

WEEKLY DISABILITY BENEFIT

1. Obtain the proper claim forms from the Benefit Office.
2. Complete your part of the claim forms.
3. Ask your doctor to complete the physician's portion of the claim form. Any charges made by the doctor for completion of this report (or any other medical information) is the responsibility of the member.
4. Send the completed forms to the Benefit Office.
5. From time to time other forms may be sent to you for completion. Ensure they are completed as required and return them to the Benefit Office.

SUPPLEMENTARY HEALTH CARE BENEFITS

1. When you or your dependents have incurred covered expenses, obtain the appropriate claim form from the Benefit Office or Insurance Company.
2. Complete the form and return it to the Insurance Company along with all necessary bills and receipts. Only original bills and receipts will be accepted and should clearly indicate the name of the individual involved.

All bills must be paid in full before reimbursement can be made.

We suggest you avoid frequent submissions of small claims, but any large claims should be submitted promptly. Claims should be submitted when you have accumulated a reasonable number of bills and receipts. All claims must be submitted within 18 months of the date the expense was incurred, but not more than 6 months after the date your coverage terminates or the Benefit is discontinued.

DENTAL BENEFITS

Dental claims can be submitted electronically with your Manulife Benefit card or your dental office may submit claims manually to the Insurance Company with a completed and signed standard dental claim form.

PROOF OF LOSS

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

- 12 months after the date of death for Life Insurance;
- 24 months after the date the member ceases active work because of total and permanent disability under the disability provision for Life Insurance;
- 6 months after the date of the loss for Accidental Dismemberment Benefits;
- 6 months after the start of disability for the Weekly Disability Benefit; and
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Dental Care and Supplementary Health Care Benefits.

Legal action to recover benefits under this plan must begin within 2 years (3 years for Life Insurance) of the date of loss.

The Insurance Company 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.

The benefits described under this plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the policies or copies of those provisions may be obtained from the Benefit Office.

Notes

Head Office:
44 Hughson Street South | Hamilton ON | L8N 2A7
T: 905.529.1116 | F: 905.529.2723 | Toll Free: 1.866.548.6283

Niagara Region:
267 Carlton Street | St. Catharines ON |L2N 1B7
T: 905.227.1837 | F: 905.227.0165

Cambridge Office:
330 Industrial Road | Cambridge ON | N3H 4R7
T: 519.653.3333 | F: 519.653.8086 | Toll Free:1.800.981-6181

www.liunalocal837.com