Trustees of the Millwrights' Health & Welfare Trust Fund For Alberta

Plan Document Number: G0119848

Plan B: Retirees under age 65

Note: The above are the main numbers you should provide as a reference when contacting Your Administrator or Manulife. Be sure to record these numbers and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Plan Document Effective Date: February 1, 2020

Booklet Effective Date: February 1, 2020

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INTRODUCTION

The Millwrights Health and Welfare Trust Fund For Alberta was established in 1968. It was established in order to fund a benefit plan for union members of Millwrights Union Local 1460.

The Fund is controlled by Trustees who have the sole authority for all operations of the Fund and the Plan. Their actions are scrutinized and regulated by federal and provincial agencies dedicated to safeguarding your interests as a Plan member. This includes the handling of the personal information you provide for the creation of your Plan records. That personal information is used exclusively for the confidential administration of your benefit entitlements, and it may not be divulged for any other reason without your permission.

The Trustees, who are appointed by the participating employers and Union, are required, by law, to develop and maintain the Plan in a manner that is reasonable and even-handed, while protecting the financial well-being of the Fund.

The revenues of the Fund come from four sources:

- contributions made by contributing employers,
- reciprocal payments from benefit trusts in other union jurisdictions where members of Millwrights Union Local 1460 are working on “travel card”,
- self-payments from Plan members and retired Plan members, and
- earnings on Fund investments.

To a large extent, the size of these revenues cannot necessarily be predetermined by the Trustees. Therefore, the Fund revenues and assets must be prudently and carefully managed.

RETIREES

If you are a covered Member of the Plan in good standing with the Union and retire and commence your pension form the Millwrights Local 1460 Pension Plan, or another pension plan approved by the Trustees, you may be eligible to apply for retiree coverage from this Plan. The retiree coverage is based on your current age, and differs from the coverage provided to non-retired Members. If you are considering retirement, you should carefully review this retiree benefit booklet prior to making a retiree benefits decision.

Important information about your benefits:

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. Every effort has been made to describe the program accurately. However, should there be a question of interpretation, the terms outlined in the official plan documents will prevail.

Where required by law, you or any claimant under the Plan Document has the right to request a copy of any or all of the following items:

a) the sections of the Group Policy and/ or Plan Document that apply to you and your dependents;

b) your application for group benefits; and

c) any medical evidence you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Plan Document.

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

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

Plan Administrator: Prudent Benefits Administration Services

To contact a customer service representative at PBAS for assistance with your eligibility, please call 1-888-525-1460.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Adherence

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

Advisory Body

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

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by Manulife.

Collective Agreement

means the collective agreement between the Employer and the Union

Contributing Employer or Employer

means an employer who is a party to, or bound by, the Collective Agreement or as may be defined in the Collective Agreement, and who is required or permitted to make payments to The Trustees of the Millwrights Health and Welfare Trust Fund For Alberta, (hereinafter called the Fund) for the purpose of providing Coverage for Members, of such Contributing Employer or Employer, who are eligible to be covered under the Plan Document.

Contributions

means the cents per hour worked by you, which an Employer is bound to remit to the Fund under the Collective Agreement**.**

Coverage Costs

means the number of hours (currently 120) in your Hour Bank account, which are required to maintain Coverage for one Month under the Fund.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your Dependents before benefits are payable by Manulife.

Explanation of Commonly Used Terms

Dependent

your Spouse or Child who is covered under the Provincial Plan.

- Spouse

your legal Spouse, or a person continuously living with you in a role like that of a marriage partner for:

a) if single or living common-law prior to the new cohabitation, 12 months; or

b) if married or separated but not divorced prior to new cohabitation, 36 months.

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

- Child

your natural or adopted Child, or stepchild, who is:

a) unmarried;

b) under age 22, or under age 26 if a full-time student;

c) not employed on a full-time basis; and

d) not eligible for coverage as a Member under this or any other Group Benefit Program.

A newborn Child shall become eligible from 14 days old.

A stepchild must be living with you to be eligible.

A Child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible Dependent. However, the Child must have been covered under this Benefit Program immediately prior to that date.

A Child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on you for support, maintenance and care, due to a mental or physical handicap.

Manulife may require written proof of the Child's condition as often as may reasonably be necessary.

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.

Explanation of Commonly Used Terms

Due Diligence

a process employed by Manulife to assess new Drugs, existing Drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an Advisory Body.

Eligibility Requirements

means the rules, regulations and procedures established from time to time by the Trustees for determining the eligibility of Members for health and welfare benefits provided under the Fund.

Exclusive Distribution

Manulife-approved vendors.

Experimental or Investigational

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

Hour Bank Account

shall mean the record of the number of hours reported and accumulated on your behalf to determine eligibility. Contributing Employers will make contributions to the Fund on your behalf for each hour worked, in accordance with the Collective Agreement.

Hour Bank System

means a system used by the Fund to determine your eligibility.

Immediate Family Member

you, your Spouse or Child, your parent or your Spouse's parent, your brother or sister, or your Spouse's brother or sister.

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.

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.

Explanation of Commonly Used Terms

Lower Cost Alternative

if two or more Drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate Drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife as effective, appropriate and essential treatment of an illness or injury. Manulife has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered under the Plan Document.

Patient Assistance Program

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

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical Drugs, clinical services or supplies. 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.

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.

Provincial Plan

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

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;

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

c) the maximum price established by law.

Retirement

means the date you retire in accordance with the constitution and by-laws of the Millwrights' Health & Welfare Trust Agreement or as defined in the Collective Agreement.

Ward

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

Eligibility and General Provisions

Eligibility

Member Eligibility

You will be eligible for coverage as set out in the Benefit Schedule if you:

a) are in good standing with the Union;

b) have met the eligibility requirements;

c) are a member of an eligible class;

d) are younger than the Termination Age; and

e) are residing in Canada.

Dependent Eligibility

Your Dependents are eligible for coverage on the date you become eligible or the date you first acquire a Dependent, whichever is later. You must apply for coverage for yourself in order for your Dependents to be eligible.

Your dependents must be residing in Canada in order to be covered under this Plan.

Medical Evidence

Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

In all cases, medical evidence can be submitted by completing the Evidence of Good Health form, available from your plan administrator, or at www.manulife.com/groupbenefits. Further medical evidence may be requested by Manulife**.**

Eligibility and General Provisions

Effective Date of Coverage

Effective Date of Member Coverage

An application for retiree coverage from this Plan must be made no later than three months after your retirement date, and prior to the date your Plan coverage would otherwise cease. If approved, your first retiree self-payment must be made prior to the date your Plan coverage would otherwise cease.

You must meet the eligibility requirements for plan benefit coverage to become effective.

Please refer to your Plan Administrator for self-payment details.

Effective Date of Dependent Coverage

Your Dependent's coverage becomes effective on the date the Dependent becomes eligible, or the date any required medical evidence on the Dependent is approved by Manulife, whichever is later.

Your Dependent's coverage will not be effective prior to the date your coverage becomes effective.

Eligibility and General Provisions

Provision for Self-Pay

Please refer to your Plan Administrator for Self-Payment details.

Maximum Accumulated Hour Bank Account

The number of hours you may accumulate in your Hour Bank Account may not exceed what is required to provide for 6 months of Coverage Costs. Any hours in excess of this maximum will be credited to the general reserve of the Trust Fund.

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The Claims Process

Submitting a Claim

To submit a claim, you can do one of the following:

Submit Online (if applicable)

Sign up to use Manulife's Plan Member Secure Site at www.manulife.com/groupbenefits.

If your health care service provider cannot send Manulife electronic claim transmissions, you can still submit your claim electronically to us online, right from the Plan Member Secure Site.

For fast, easy and secure claim payments, we encourage you to sign up for direct deposit and electronic claim statements when you set up your access on the Plan Member secure site. Even if you mail us your claims, by providing your banking and email information, your claim payments can be deposited quickly to your bank account and you will receive an email notification, including a link to manulife.ca, where you can sign in to view your electronic claim statement.

By Mail

You must complete an applicable claim form and mail it to Manulife. Mailing instructions are included on the claim form.

Claim forms are available at www.manulife.com/groupbenefits, or from your plan administrator.

Submission Requirements

Claims, available at www.manulife.com/groupbenefits, must be submitted within the following timeframes:

a) 12 months from the date the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while coverage under the plan is in force. Upon termination of a person's coverage 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 coverage.

For Extended Health Care, complete the Extended Health Care form. Visit the forms section at www.manulife.com/groupbenefits to determine which claimed expenses can be submitted via the website.

For Dental Care, claims can be submitted either electronically by your dentist, or by paper, using a standard dental claim form.

The Claims Process

Co-ordination of Extended Health Care and Dental Care Benefits

Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and (briefly) here's how it works:

If you have a claim for yourself: then submit to Manulife first. For any unpaid balances, send a copy of your Manulife claim statement and the other insurance carrier's claim form to the other insurance company for processing.

If you have a claim for your Spouse: then submit the claim to your Spouse's insurance company. For any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing.

If you have a claim for a dependent Child: then send the claim to the insurance carrier of the parent whose birthdate falls earliest in the calendar year first. Submit any unpaid balance to the other insurance company.

For complete details, please go to www.manulife.com/groupbenefits.

Naming a Beneficiary

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

Manulife does not accept beneficiary designations for any benefits under this Plan.

Termination of Coverage

Termination of Member Coverage

Your coverage under this Plan terminates on the earliest of the following dates:

a) the date this Plan terminates or coverage on the classification to which you belong terminates;

b) the date the you fail to meet the required monthly Coverage Costs as determined by the rules of the Fund, including the provisions made for self-pay;

c) the date you reach the Termination Age as shown in the applicable Benefit section;

d) the date of your death;

e) the date coinciding with the end of the period for which the required premium for your coverage was last paid to Manulife Financial;

f) the date you are suspended from the Union; or

g) the date you are eligible to be enrolled under another group contract with similar coverages.

Military Service: Employment will be deemed to terminate as of the date upon which you commence active duty in the armed forces of any country, state or international organization.

Your Dependents' coverage terminates on the date your coverage terminates or the date the Dependent ceases to be an eligible Dependent, whichever is earlier.

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Extended Health Care

Your Extended Health Care Benefit is provided directly by The Trustees of the Millwrights' Health & Welfare Trust Fund For Alberta. Manulife has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and in the Benefit Plan for the Trustees of the Millwrights' Health & Welfare Trust Fund For Alberta.

If you or your Dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - $10.00 per prescription

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs (Drug Dispensing Fee)
- Vision (other than Visual Training and Laser Eye Surgery)
- Medical Services and Supplies (Private Duty Nursing, Accidental Dental, Medical Forms, Ambulance)

80% for
- Drugs (other than Drug Dispensing Fee)
- Professional Services
- Medical Services and Supplies (Wigs, Surgical Stockings, Surgical Brassieres, Orthopaedic Shoes and Orthotics, Breast Prosthesis, Glucose Monitor)

75% for
- Vision (Visual Training)

50% for
- Vision (Laser Eye Surgery)
- Medical Services and Supplies (Hearing Aids, Medical Equipment, CPAP Machine, Myoelectric Arms, Patient Lifters, Wheelchair Ramps, TENS, Extremity Pumps)

Termination Age - Member's age 65

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary, as determined by Manulife, provided they are:

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

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

d) not covered under the Provincial Plan or any other government-sponsored program;

e) legally covered;

f) used as prescribed or recommended by a physician; and

g) associated with any Drug, supply or service that was subject to the Due Diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by Manulife and shared with the Plan Sponsor as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this 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.

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 using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include as a covered expense, 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 or prescribing guidelines recommend alternative Drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

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

Manulife has the right to ensure you or your dependents 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 you or your Dependents to apply to and participate in any Patient Assistance Program to which you or your Dependents are entitled. Manulife reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance you or your Dependents are entitled to receive under a Patient Assistance Program.

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife.

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.

- 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 your 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 your physician and pharmacist.

Hospital Care

a) charges, in excess of the hospital's public Ward charge, for private accommodation, provided:

   i) the person was confined to hospital on an in-patient basis, and

   ii) the accommodation was specifically elected in writing by the patient

b) private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of $25 per day

c) charges for any portion of the cost of Ward accommodation, utilization or co-payment* fees (or similar charges) are not covered

   * Charges for copayment fees will be covered for accommodation in a nursing home.

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your Drug benefit.

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist:

a) Drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist;

b) oral contraceptives;

c) injectable medications;

d) non-prescription injectable vitamins;

e) Life-Sustaining Drugs;

f) preventive vaccines and medicines (oral or injected); and

g) standard syringes, needles and diagnostic aids, required for the treatment of diabetes.

Charges for the following expenses are **not** covered:

a) charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment;

b) charges made by a practitioner or physician to administer injectable medications;

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

d) prescription vitamins;

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

f) anti-obesity Drugs; or

g) intrauterine devices and diaphragms.

- Drug Maximums

Fertility Drugs - $5,000 per lifetime

Anti-smoking Drugs - $500 per lifetime

Drugs used in the treatment of a sexual dysfunction - $500 per calendar year

All other covered Drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered Drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for Drugs and any maximum.

Covered Expenses for any prescribed Drug will not exceed 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.

Manulife 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.

- No Substitution Prescriptions

If your prescription contains a written direction from your 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.

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.

Payment of your covered Drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for Drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered Drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible Dependents will not incur out-of-pocket expenses for the full cost of the prescription.

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:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase; and

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

You will be required to pay the full cost of the prescription at time of purchase if:

a) you cannot locate a participating Pay Direct Drug pharmacy;

b) you do not have your Pay Direct Drug Card with you at that time; or

c) the prescription is not payable through the Pay Direct Drug Card system.

For details on how to receive reimbursement after paying the full cost of the prescription, please see your plan administrator.

Vision Care

a) eye exams, up to $100 per 2 calendar years;

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $400 per 12 consecutive months for persons under age 18 and $400 per 2 calendar years for persons age 18 and over;

c) if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 2 calendar years;

d) elective laser vision correction procedures, $600 per eye per lifetime; and

e) visual training, unlimited.

Professional Services

Services provided by the following licensed practitioners:

a) Chiropractor - $400 per calendar year

b) Naturopath - $400 per calendar year

c) Osteopath - $400 per calendar year

d) Physiotherapist - unlimited

e) Podiatrist/Chiropodist - $400 per calendar year

f) Psychologist - $400 per calendar year combined for services of a psychologist and social worker

g) Social Worker - $400 per calendar year combined for services of a psychologist and social worker

h) Speech Therapist - $400 per calendar year

Recommendation by a physician for Professional Services is not required.

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

Note: 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 a maximum of $10,000 every 3 calendar years.

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, nursing home, or similar institution; or

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

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

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

Medical Equipment

Rental or, when approved by Manulife, 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, up to a maximum of $10,000 per 3 calendar years.

Non-Dental Prostheses, Supports and Hearing Aids

a) external prostheses. Breast prostheses will be subject to the limit of one per 12 months. Myoelectric arms will be subject to the limit of $10,000 per prosthesis.

b) surgical stockings, up to a maximum of 2 pairs per calendar year;

c) surgical brassieres, up to a maximum of 2 every 12 months;

d) braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;

e) custom-made shoes which are 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, up to 1 pair per calendar year to a maximum of $500 (must be constructed by a certified orthopaedic footwear specialist);

e) casted, custom-made orthotics, up to a maximum of 2 pairs per 2 calendar years to a maximum of $300 for Dependent children under age 19, and 1 pair per 2 calendar years to a maximum of $300 for any other person; and

f) cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $1,000 per ear every 4 calendar years.

Other Supplies and Services

a) ileostomy, colostomy and incontinence supplies;

b) medicated dressings and burn garments;

c) wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $250 per lifetime;

d) oxygen;

e) CPAP machine and supplies, up to $2,500 per 3 calendar years;

f) mechanical or hydraulic patient lifters, up to $2,000 per lifter, once every 5 years;

g) outdoor wheelchair ramps, up to $2,000 per lifetime;

h) blood-glucose monitor machines, one every 4 years;

i) Transcutaneous Nerve Stimulators (TENS), up to $700 per lifetime;

j) extremity pumps for lymphedema, up to $1,500 per lifetime;

k) microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec; and

l) charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing, up to a maximum of $2,500 per lifetime.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Extended Health Care benefits are payable for expenses related to:

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

b) committing or attempting to commit an assault or criminal offence;

c) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;

d) an illness or injury for which benefits are payable under any government plan or workers' compensation;

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

f) services or supplies provided by an employer's medical or dental department;

g) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

h) services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage;

i) services or supplies which are not permitted by law to be paid;

j) services or supplies which are required for recreation or sports;

k) services or supplies which would have been payable by the Provincial Plan if proper application had been made;

l) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

m) medical or surgical care which is cosmetic;

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

o) services or supplies which are provided while confined in a hospital on an in-patient basis; or

p) services or supplies which are not specified as a covered expense under this benefit.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

If you and your Dependents reside in Quebec, the following provisions apply to your Drug benefit coverage.

Covered Expenses

The following expenses are covered:

a) Drugs that are on the Quebec Basic Prescription Drug Insurance Plan 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 Quebec Basic Prescription Drug Insurance Plan List; and

c) Drugs that are listed as a Covered Expense in this Benefit Booklet, but are not on the Quebec Basic Prescription Drug Insurance Plan List.

Coverage for Drugs on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services published for private plans

The following provisions apply to the coverage of Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act. Coverage for all other Drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered Drug expenses payable will be:

i) for any Drugs on the Quebec Basic Prescription Drug Insurance Plan List which are not otherwise covered under the terms of the plan, the percentage 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, the percentage payable is as set out by the then applicable Legislation.

iii) for any Drug on the Quebec Basic Prescription Drug Insurance Plan List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage stated under The Benefit, 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 Drug expenses payable under this benefit 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 you and your Spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are

i) Deductible amounts, and

ii) the portion of covered Drug expenses that is paid by a covered person, when the percentage of Covered Expenses payable under this benefit is less than 100%, and

iii) covered pharmacy services that are performed by pharmacists for Drugs on the Quebec Basic Prescription Drug Insurance Plan List.

The annual out-of-pocket maximum for you and your 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 Quebec Basic Prescription Drug Insurance Plan List paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your Spouse, those portions of covered Drug expenses and covered pharmacy services paid for your 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) for the Drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the Deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to Drugs on the Quebec Basic Prescription Drug Insurance Plan List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services that are performed for Drugs on the Quebec Basic Prescription Drug Insurance Plan 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**

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

i) the age specified in this Benefit Booklet (please refer to definition of Child under Explanation of Commonly Used Terms), and

ii) age 26.

Drug coverage and covered pharmacy services provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services performed for a Drug on the Quebec Basic Prescription Drug Insurance Plan 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 you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age as specified under the benefit is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered,

ii) only covered pharmacy services related to a Drug on the Quebec Basic Prescription Drug Insurance Plan 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.

Coverage for Drugs that are listed as a Covered Expense in this Benefit Booklet but are not on the Quebec Basic Prescription Drug Insurance Plan List

Coverage for Drugs that are listed as a Covered Expense under this Benefit but not on the Quebec Basic Prescription Drug Insurance Plan List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care Benefit

Your Dental Care Benefit is provided directly by The Trustees of the Millwrights' Health & Welfare Trust Fund For Alberta. Manulife has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and in the Benefit Plan for the Trustees of the Millwrights' Health & Welfare Trust Fund For Alberta.

If you or your Dependents require any of the dental services specified under Covered Expenses below, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses below.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide - 2019 Alberta Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

75% for Level III - Dentures

75% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I

$3,000 per calendar year combined for Level I, Level II, Level III and Level IV

$4,000 per lifetime for Level V

Termination Age - Member's age 65

Covered Expenses

The following expenses are covered if they:

a) are incurred for the necessary dental care of a covered person while covered under this benefit;

b) 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;

c) are reasonable as determined by Manulife, taking all factors into account; and

d) do not exceed the fees recommended in the Dental Fee Guide, or Reasonable and Customary charges as determined by Manulife, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, Manulife will pay benefits as if the least expensive course of treatment were used. Your 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 every 36 months

b) full mouth x-rays, one every 36 months

c) panoramic x-rays, one every 36 months

d) recall examinations, twice per calendar year

e) bitewing x-rays

f) routine diagnostic and laboratory procedures

g) one unit of light scaling and one unit of polishing, twice per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing), twice per calendar year, when the service is performed in Quebec

h) fluoride treatment, twice per calendar year

i) oral hygiene instruction, once every 6 months

j) space maintainers (excluding appliances placed for orthodontic purposes), for Dependent children under age 15

k) appliances to control harmful habits

l) 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 24 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..

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

n) pre-fabricated crowns, for Dependent children under age 15

o) minor surgical procedures and simple extractions

p) complicated extractions including impacted and residual roots

q) consultation, anaesthesia, and conscious sedation

r) denture repairs, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

s) denture relines, once per 36 months, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

t) denture rebases, once per 36 months, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

u) 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:

   i) root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime.

   ii) re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Level III - Dentures

a) initial provision of full or partial removable dentures;

b) replacement of removable dentures, provided the dentures are required because:

   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, or

iii) the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation.

Expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable.

Level IV - Major Restorative Services

a) crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;

b) replacement of crowns or onlays, provided the replacement due to one of the following:

   i) for crowns, the existing crown is at least 5 years old and cannot be made serviceable

   ii) for onlays, the existing onlay is at least 60 months old and cannot be made serviceable

c) inlays, covering at least 3 surfaces, provided the tooth cusp is missing;

d) initial provision of fixed bridgework;

e) replacement of bridgework, provided the new bridgework is required because:

   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, or

   iii) the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation.

Expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable.

Level V - Orthodontics

Orthodontic services.

Late Entrant Limitation

If you or your Dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $125 for each covered person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered Expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

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

b) committing or attempting to commit an assault or criminal offence;

c) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;

d) dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit;

e) anti-snoring or sleep apnea devices;

f) broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms;

g) services which are payable by any government plan;

h) services or supplies provided by an employer's medical or dental department;

i) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

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

k) replacement of removable dental appliances which have been lost, mislaid or stolen;

l) laboratory fees which exceed Reasonable and Customary charges;

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

n) 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 plan 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;

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

p) services or supplies which are not specified as a covered expense under this benefit.

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, Manulife will continue the Extended Health Care and Dental Care benefits without requiring any contribution from you, until the earliest of:

a) the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms);

b) the date similar coverage is obtained elsewhere;

c) the date which is 24 months from your death; or

d) the date the Plan Document terminates.

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.