



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

Plan Document Number: G0119848

Group Policy Number: G0119847

Plan: A – Active Members

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

Group Policy Effective Date: February 1, 2020

The Plan described is up to date as at: February 1, 2022

This booklet produced: January 12, 2022

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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.

Important Information about your Benefits

Important information about your benefits:

The information provided here is an overview of the coverage and services that The Millwrights Health and Welfare Trust Fund For Alberta 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 Group Policy and/or 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 Evidence of Insurability 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 Group Policy and/or Plan Document.

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

RETIREES

If you are a covered Member of the Plan in good standing with the Union and retire and commence your pension from 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 request a copy of the retiree benefit booklet prior to making a retiree benefits decision.

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 coverage self-payment must be made prior to the date your Plan coverage would otherwise cease.

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

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.

Accident

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

Actively at Work

means you are working for a Contributing Employer or are available for work as determined by your name appearing on the out-of-work list of the Union.

Adherence

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

Administrator

Manulife.

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 your employer.

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 & 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 Group Policy or 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.

Explanation of Commonly Used Terms

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 your employer.

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.

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

Explanation of Commonly Used Terms

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 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; or
- 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.

Explanation of Commonly Used Terms

Licensed, Certified, Registered

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

Life-Sustaining Drugs

non-prescription Drugs which are necessary to sustain life.

Lower Cost Alternative

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

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.

Non-Evidence Limit

you must submit satisfactory medical evidence to Manulife for Benefit Amounts greater than this amount.

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.

Qualifying Period

a period of continuous Total Disability, starting with the first day of Total Disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

Explanation of Commonly Used Terms

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.

Take Home Pay (Net Earnings)

your Earnings, less deductions normally made for federal and provincial income tax.

Total Disability or Totally Disabled

For Weekly Income

a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

The availability of work will not be considered by Manulife in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

For Life Insurance and Long Term Disability

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

- a) your own occupation, during the Qualifying Period and the 3 years immediately following the Qualifying Period; and
- b) any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 3 years specified above.

The availability of work will not be considered by Manulife in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

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

Who Qualifies for Coverage?

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) are working for a contributing employer;
- c) are compensated for services by the contributing employer;
- d) performing work within the jurisdiction of the Union;
- e) have met the eligibility requirements;
- f) are a member of an eligible class;
- g) are younger than the Termination Age; and
- h) 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.

Who Qualifies for Coverage?

Effective Date of Coverage

Effective Date of Member Coverage

Effective Date: The date upon which you become covered under this Plan is the later of the following dates:

- a) the first day of the Month following accumulation of the number of hours needed to provide for 3 consecutive Months of Coverage Costs in your Hour Bank Account: or
- b) the date that Manulife Financial approves the evidence of good health, where evidence of good health is required.

You must meet the eligibility requirements and be actively at work for plan benefit coverage to become effective.

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.

Who Qualifies for Coverage?

Provision for Self-Pay

If at the end of any given month, if you fail to meet the required monthly coverage cost as determined by the rules of the Trust Fund, you will be notified by the administrator before your coverage is terminated and given the opportunity of contributing the necessary amount of money so that you may continue to be covered.

Under this provision, self-payments may be made on the following basis:

- a) Monthly payments equal to the Coverage Costs may be made for a maximum of 3 consecutive Months. After that, your coverage will be cancelled unless you have sufficient hours in your hourbank to continue your Plan coverage. If you choose not to make a self-payment when you are eligible to do so, your Plan coverage will be cancelled. In that case, you will need to store at least 360 hours in your hourbank, over any period of time, before your Plan coverage can re-commence.
- b) you may not make self-payments to continue Short Term Disability or Long Term Disability Coverages (where provided under this Plan).

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.

How the Hourbank Works

All of your 360 (or more) hours worked for contributing employers, during your initial, not-more-than-four consecutive month eligibility period, and any subsequent hours, are deposited to your hourbank. Those hours create an hourbank balance, before any deduction of hours to provide you with Plan coverage.

For example: if you work 390 hours in May, June and July (i.e. not-more-than-four consecutive months) and you meet the other initial eligibility requirements, those hours are deposited to your hourbank, and become your initial hourbank balance, before the deduction of hours for Plan coverage.

390 Hours Worked In May, June and July and meet initial eligibility requirements → Hours deposited to Hourbank

All hours worked in one month are reported to the Administrator during the following month and credited to your hourbank. If you have already met the initial eligibility requirements, then on the first day of the next following month, 120 hours are deducted from your hourbank to provide you with that month's benefit coverage.

For example: if you work 150 hours in July, in August those hours are reported to the Administrator and are credited to your hourbank. On September 1st, 120 hours are deducted from your hourbank to provide you with September Plan coverage.

150 July Worked Hours → Deposited to Hourbank in August → 120 Hours deducted to provide September coverage

Each subsequent month, additional worked hours will be deposited to, and deducted from, your hourbank to provide you with future months of Plan coverage.

The monthly hourbank deduction is 120 hours. If you work more hours than are needed for immediate coverage, those extra hours will be stored in your hourbank for later use. Those extra hours will provide you with additional Plan coverage during vacations, temporary breaks in employment, and other voluntary absences.

Who Qualifies for Coverage?

For example: if you work 165 hours in August, in September those hours are reported to the Administrator and are credited to your hourbank. On October 1st, 120 hours are deducted from your hourbank to provide you with October coverage. The remaining 45 hours are stored in your hourbank for later use.

165 August Worked Hours → Deposited to Hourbank in September → 120 Hours deducted to provide October coverage → 45 extra hours stored in hourbank for later use

You may store a maximum of 720 hours, being the equivalent of six months of future coverage, in your hourbank for later use. If you work fewer or no hours during some months, the Administrator will deduct hours previously stored in your hourbank to continue your coverage.

For example: if you worked 100 hours in September, in October those hours are reported to the Administrator and credited to your hourbank. On November 1st, 120 hours are deducted from your hourbank – 100 from your September worked hours, and 20 from the hours previously stored in your hourbank.

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 must be submitted within the following timeframes:

- a) 90 days from the date of the loss, for claims for Life and Accidental Death and Dismemberment benefits;
- b) 180 days from the end of the Qualifying Period, for claims for disability benefits, or when applying for waiver of premiums; and
- c) 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 Life and AD&D claims, complete the Life Claim form.

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.

For Disability claims, complete the STD/LTD Member's statement. A corresponding LTD Physician's statement (for Long Term Disability) or Waiver Physician's statement (for Waiver of Premiums) must be completed by your attending physician.

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 other than Member Life Insurance and Accidental Death and Dismemberment

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Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against Manulife less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitation of Actions Act (NB)
Civil Code of Quebec (QC)

Termination of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- a) the date you cease to be an eligible Member;
- b) the date you cease to be actively at work, unless the Group Policy or Plan Document allows for your coverage to be extended beyond this date;
- c) the date your employer terminates coverage;
- d) the date you enter the armed forces of any country on a full-time basis;
- e) the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates;
- f) the date you are suspended from the Union;
- g) the date you reach the Termination Age; or
- h) the date of your death.

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

Your Group Benefits

Life Insurance Benefit (Member Life, Dependent Life)

Benefit Details

Member Life

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

Benefit Amount - \$100,000

Non-Evidence Limit - \$100,000

Benefit Reduction - your benefit amount reduces to \$10,000 at age 70

Termination Age - your benefit amount terminates upon your retirement.

Qualifying Period for Waiver of Premium - 112 days

For Your Dependents:

If one of your dependents dies while insured, the amount of this benefit is paid to you.

Benefit Amount - \$20,000 Spouse; \$10,000 each dependent Child

Termination Age - Member's retirement

Qualifying Period for Waiver of Premium - same as Member Life

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your plan administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;
- b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and
- c) you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife.

Your Group Benefits

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

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- c) the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife;
- d) the date you do not attend an examination by an examiner selected by Manulife;
- e) the date of your death; or
- f) the date of your 65th birthday.

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

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

Conversion Privilege

If your or your Spouse's Group Benefits terminate or reduce, you and your Spouse may be eligible to convert your Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife within 31 days of the termination or reduction of your Life Insurance. If you or your Spouse die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your plan administrator. Provincial differences may exist.

Your Group Benefits

Accidental Death and Dismemberment Benefit

Benefit Details

For You:

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

Accidental Death and Dismemberment

Benefit Amount - \$100,000

Benefit Reduction - your benefit amount reduces to \$10,000 at age 70

Termination Age - your benefit amount terminates upon your retirement.

Qualifying Period for Waiver of Premium - 112 days

Schedule of Losses

A loss shown in this schedule is covered provided it:

- a) is a direct result of the accidental injury;
- b) occurs within 365 days from the date of the accidental injury; and
- c) is total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of the Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%

Your Group Benefits

- Loss of or Loss of Use of One Arm and One Leg on different sides of the body - 100%
- Loss of or loss of use of both arms or both hands - 100%
- Surgical Reattachment of a Lost Limb* - 50%
- Loss of or Loss of Use of One Hand or One Foot - 66.67%
- Loss of Sight of One Eye - 66.67%
- Loss of Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

* **Note:** Concerning Surgical Reattachment: If you suffer the loss of a limb that is surgically reattached, Manulife will pay 50% of the amount that would have been payable had the loss been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

No more than 100% will be paid for all losses due to any one accidental injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while the insured person is living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which the insured person was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If the insured person disappears after a conveyance in which he was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if the insured person's body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife will pay incurred expenses, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife; and
- b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of \$10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Your Group Benefits

Repatriation Expenses

If the insured person dies as a direct result of an accidental injury which occurs while travelling 150 kilometres or more from his place of residence, Manulife will pay for expenses incurred for the preparation and transportation of the insured person's body to his place of residence.

The amount payable is subject to a maximum of \$10,000.

Family Transportation Expenses

If, as a direct result of an accidental injury, the insured person suffers a loss specified in the Schedule of Losses and is confined to a hospital located 150 kilometres or more from the insured person's place of residence, Manulife will pay the hotel and travel expenses incurred by an Immediate Family Member, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife;
- b) for hotel accommodations in the vicinity of the hospital; and
- c) for transportation by the most direct route to the hospital, including return fare.

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of \$0.20 per kilometre travelled.

The amount payable is subject to a maximum of \$2,000 per accident.

Dependent Education Expenses

If you die as a direct result of an accidental injury, Manulife will pay the tuition for each Child who is enrolled as a full-time student:

- a) in a school for higher learning above the secondary school level; or
- b) at the secondary school level, but who enrolls as a full-time student in a school for higher learning within 365 days after your death.

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionnel (CEGEP), community college or trade school.

The maximum payable each year for each Child is the lesser of:

- a) 5% of your Accidental Death and Dismemberment benefit amount; or
- b) \$5,000.

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- a) tuition expenses incurred prior to your death; or
- b) room and board expenses, or other living, travelling or clothing expenses.

Your Group Benefits

Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your Spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Manulife will pay for expenses incurred by your Spouse, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife; and
- b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of \$10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Seat Belt Benefit

If the insured person dies as a direct result of an accidental injury sustained while driving or riding in an automobile, Manulife will pay an additional amount equal to 10% of your Accidental Death and Dismemberment benefit, provided the insured person was wearing his seat belt and it was properly fastened at the time of the accidental injury.

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife will pay day-care expenses for each Child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 90 days from the date of your death.

The maximum payable each year for each Child is the lesser of:

- a) 5% of your Accidental Death and Dismemberment benefit amount; or
- b) \$5,000.

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- a) expenses incurred prior to your death; or
- b) room and board expenses, or other living, travelling or clothing expenses.

Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, the insured person:

- a) suffers a loss of, or loss of use of, both feet or both legs; or
- b) becomes a hemiplegic, paraplegic, or quadriplegic;

and requires the use of a wheelchair to be ambulatory, Manulife will pay for incurred expenses, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife;
- b) incurred within 3 years from the date of the accidental injury;

Your Group Benefits

- c) for alterations to the insured person's home for the purpose of making it wheelchair accessible; and
- d) for modifications to one motor vehicle for the purpose of making it wheelchair accessible.

The amount payable is subject to a maximum of \$10,000.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your plan administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Waiver of Premium

If, while the Group Policy is in force, your Insurance premium is waived because you are Totally Disabled, the premium for this benefit will also be waived. (See Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the Group Policy terminates.

Exclusions

No Accidental Death and Dismemberment benefits are payable if the loss results from:

- a) suicide or self-inflicted injuries;
- b) war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion;
- c) an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity;
- d) riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew;
- e) riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer;
- f) committing or attempting to commit an assault or criminal offence; or
- g) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol.

Your Group Benefits

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 your employer's Benefit Plan.

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)

90% for

- Drugs (other than Drug Dispensing Fee)

80% for

- 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 retirement

Your Group Benefits

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 insurable;
- 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 the Administrator and shared with your employer 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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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;
- e) visual training, unlimited; and
- f) safety glasses, \$300 every 2 calendar years, for Members only

Professional Services

Services provided by the following licensed practitioners:

- a) Acupuncturist - \$400 per calendar year
- b) Chiropractor - \$400 per calendar year
- c) Massage Therapist - \$400 per calendar year
- d) Naturopath - \$400 per calendar year
- e) Osteopath - \$400 per calendar year
- f) Physiotherapist - unlimited
- g) Podiatrist/Chiropodist - \$400 per calendar year
- h) Psychologist - \$1,000 per calendar year combined for services of a psychologist and social worker
- i) Social Worker - \$1,000 per calendar year combined for services of a psychologist and social worker
- j) 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.

Your Group Benefits

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. On January 1st coinciding with or immediately following the date the Member attains age 70, the amount payable will be a lifetime maximum of \$10,000, less any amount paid out in the previous 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

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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

Your Group Benefits

- 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.

Your Group Benefits

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.

Your Group Benefits

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 your employer's Benefit Plan.

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 - 2022 Alberta Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

90% for Level I - Basic Services

90% 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 retirement

Your Group Benefits

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 your employer or 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 your employer or 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, your employer 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.

Your Group Benefits

- 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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer 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 2 years from your death plus the number of hours remaining in your Hour Bank Account; or
- d) the date the Plan Document terminates.

Weekly Income (Short Term Disability)

If you become Totally Disabled while covered and meet the Entitlement Criteria for this benefit, your employer will pay a disability benefit.

The Benefit

Benefit Amount - \$547

Qualifying Period - none, if the disability is due to an Accident;
7 calendar days, if the disability is due to a sickness

If hospitalized due to sickness prior to the end of the Qualifying Period, benefits are payable from the first day of hospitalization.

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

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period. Otherwise, benefits are not payable until the date you are first treated by your physician.

Maximum Benefit Period - 16 weeks

Termination Age - retirement

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- a) you must be continuously Totally Disabled throughout the Qualifying Period;
- b) your employer or Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and
- c) you must be receiving from a physician, regular, ongoing care and treatment for your disabling condition.

Periods for Which You are Not Entitled to Benefits

Your Group Benefits

You are not entitled to benefit payments for any period that:

- a) you are not receiving from a physician, regular, ongoing care and treatment for your disabling condition;
- b) you do not supply your employer or Manulife with medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- c) after you fail to participate and cooperate in a medical, psychiatric, psychological and/or functional examination or evaluation by a medical examiner selected by your employer or Manulife;
- d) you are receiving Employment Insurance maternity or parental benefits;
- e) you are making self-payments during which you become Totally Disabled;
- f) you are on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;
- g) you are engaged in employment for wage or profit, except as provided for under the Rehabilitation Assistance provision; or
- h) you are incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any amount you receive:

- a) for the same or related disability:
 - i) from Workers' Compensation or similar coverage;
 - ii) from any provincial motor vehicle plan or motor vehicle insurance policy that does not take into account disability benefits payable under the Employment Insurance program; and
 - iii) from your employer-sponsored salary continuance or wage loss replacement plan; and
- b) as earnings from your employer, including severance and vacation pay as set out in the Employment Insurance Program.

Benefit Calculation Rules

Your employer or Manulife will apply the following rules in determining your disability benefit:

- a) benefits payable from other sources which began before the commencement of your current disability will not be taken into account
- b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by your Employer
- c) for benefits payable other than on a weekly basis, a weekly equivalent of such benefit will be estimated by your employer or Manulife.

Your Group Benefits

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, your employer will request that you complete a subrogation reimbursement agreement when you submit your Weekly Income claim.

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 disability benefits that your employer paid to you, exceed 100% of your lost income.

Tax Status of Benefits

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

Payment of Disability Benefits

Disability benefit payments will be made weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.

The amount of each payment will be based on the number of scheduled shifts you were unable to work during that week, due to total disability.

Your employer must provide Manulife with a copy of your shift schedule at the time a claim for Weekly Income benefits is submitted.

Rehabilitation Assistance

Once your employer or Manulife determines that you are Totally Disabled, if appropriate, and at your employer or Manulife's discretion, you may be offered rehabilitation to assist you in returning to work.

In considering whether Rehabilitation Assistance is appropriate for you, your employer or Manulife will take into account:

- a) the nature, extent and expected duration of your disability
- b) your level of education, training or experience
- c) the nature, scope, objectives and cost of a Vocational Plan.

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to work.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you, your employer or Manulife will provide a structured Vocational Plan that will prepare you for a return to work with your employer.

Your Group Benefits

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings; net earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, your employer or Manulife will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- b) the date on which benefits have been paid up to the Maximum Benefit Period for this benefit;
- c) the date you retire; or
- d) the date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 2 weeks from the end of the period for which Weekly Income benefits were paid, the disability will be treated as a continuation of your previous disability.

You will not be required to satisfy any applicable Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 2 weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

Exclusions

No benefits are payable for any disability related to:

- a) any illness or injury which arises out of or in the course of employment, unless Workers' Compensation denies your claim;
- a) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- c) medical or surgical care which is performed solely for cosmetic purposes, except if due to an illness or injury;

Your Group Benefits

- d) the committing of a criminal offence;
- e) injuries sustained while operating a motor vehicle under the influence of drugs or alcohol as prohibited by law; or
- f) abuse of drugs or alcohol, unless you are participating in an in-patient medical treatment program for substance abuse.

Salary Continuation (Long Term Disability)

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Manulife will pay a disability benefit.

The Benefit

Benefit Amount - \$1,800

Non-Evidence Limit - \$1,800

Qualifying Period - 112 days

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

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Maximum Benefit Period - 3 years, but not beyond age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;
- b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and
- c) you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife.

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

Your Group Benefits

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- a) not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife;
- b) receiving Employment Insurance maternity or parental benefits;
- c) on lay-off during which you become Totally Disabled;
- d) on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;
- e) receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan;
- f) working in any occupation, except as provided for under the Rehabilitation Assistance provision;
or
- g) incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- a) Workers' Compensation or similar coverage;
- b) Canada or Quebec Pension Plans, excluding dependent benefits; and
- c) any government motor vehicle automobile insurance plan or policy, unless prohibited by law.

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross Earnings (net Earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

- a) any group, association or franchise plan;
- b) any retirement or pension plan;
- c) earnings or payments from any employer, including severance payments and vacation pay;
- d) self-employment;
- e) any government plan, excluding Employment Insurance Benefits; and
- f) Canada or Quebec Pension Plans' dependent benefits.

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Your Group Benefits

Benefit Calculation Rules

Manulife will apply the following rules in determining your disability benefit:

- a) benefits payable from other sources which began before the commencement of your current disability will not be taken into account;
- b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife;
- c) subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;
- d) benefits payable under individual disability income insurance will not be taken into account;
- e) for benefits payable, other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife; and
- f) if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife and assumed to be paid.

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, Manulife will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife those amounts you recover which, when added to the disability benefits that Manulife paid to you, exceed 100% of your lost income.

Tax Status of Benefits

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

Payment of Disability Benefits

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

Rehabilitation Assistance

Once Manulife determines that you are Totally Disabled, if appropriate, and at Manulife's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife will take into account:

- a) the nature, extent and expected duration of your disability;
- b) your level of education, training or experience; and
- c) the nature, scope, objectives and cost of a Vocational Plan.

Your Group Benefits

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife will provide a structured Vocational Plan that will prepare you for a return to work, either:

- a) with your employer;
- b) with an alternate employer; or
- c) in a self-employed capacity.

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross Earnings; net Earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;
- c) the date you do not attend an examination by an examiner selected by Manulife;
- d) the date on which benefits have been paid up to the Maximum Benefit Period for this benefit; or
- e) the date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, Manulife will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period again. The benefit payable to you will be based on your Earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

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

Your Group Benefits

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

Waiver of Premium

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

Exclusions

No benefits are payable for any disability related to:

- a) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- c) medical or surgical care which is not medically necessary;
- d) the committing of or the attempt to commit an assault or criminal offence;
- e) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;
- f) abuse of addictive substances, including Drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife; or
- g) a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which Drugs were prescribed, within 90 days prior to the effective date of your coverage.

