INTRODUCTION

This information booklet has been prepared to give you an informal summary of the main features of your group insurance program as of September 1, 2022.

This booklet is not an insurance policy, and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policy and by applicable law.

Your Accidental Death and Dismemberment, and Permanent Total Disability Insurance are underwritten by Chubb Insurance Company; your Critical Illness benefit is underwritten by AIG. These benefits are described in a separate document. All other coverage is underwritten by Manulife Financial.

This booklet is for your reference. Please read it carefully and keep it for future use.

This booklet produced: August 19, 2022

TABLE OF CONTENTS

TRUSTEES OF LOCALS 2330 & 1620 IBEW BENEFIT PLAN TRUST FUND

Policy Number: 901729

GENERAL INFORMATION

The Group Insurance is administered by a Board of Trustees representing the Locals 2330 and 1620 I.B.E.W. and employers participating in the Plan. Such employers are called "Contributing Employers" in this booklet.

An account is kept by the Administrator of the Fund for each member which shows hours worked for a Contributing Employer for which contributions have been made for the purchase of group insurance. This account is called an Hour Bank Account.

Each month 144 hours will be deducted from your Hour Bank Account. The number of hours in your Hour Bank Account may never exceed 864 hours (enough to provide 6 months of coverage even though you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

If a member who is not insured has no contributions credited to his account during a 12 month period, any hours in his account will be credited to the general reserves of the Fund.

ELIGIBILITY

Who May Be Insured

This Plan is for members of the Locals 2330 and 1620 I.B.E.W who work for Contributing Employers.

When You Become Insured Initially

You and your eligible dependents will become insured on the first day of the second month following accumulation of 432 hours in your Hour Bank Account, provided you are actively at work or available for work on the day you would ordinarily become insured. Should you not be working or available for work on the day your insurance would ordinarily start, the insurance for you and your dependents will be delayed until you return to work or are available for work.

Reinstatement

If your insurance has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the first day of the second month in which you have accumulated 288 hours in your Hour Bank Account. If reinstatement does not occur within 12 months of your insurance terminating, your hour bank account credit will be zero.

Should you not be working or available for work on the day your insurance would ordinarily become reinstated, the insurance for you and your dependents will be delayed until you return to work or are available for work.

Termination of Insurance

The insurance for you and your eligible dependents will terminate:

1. The last day of the month in which you have less than 144 hours in your Hour Bank Account. However, you may arrange to have your insurance continued on a contributory basis. See Self-Pay Provision below.

2. If you cease to be a member in good standing of the Union.

3. If you enter Military Service.

4. If the Group Policy terminates.

5. If you discontinue any required contributions.

6. If you retire, and have insufficient hours in your Hour Bank Account.

7. the date outlined in the Summary of Benefits.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Self-Pay Provision

Should you be notified by the Plan Administrator that your coverage is terminating because you have insufficient hours in your Hour Bank Account to maintain coverage, you have the right (provided you are under age 65) to self-pay as noted below. Please contact your Plan Administrator for Self-Pay procedures.

For Active Members: Under this provision, self-payments may be made, but not beyond age 65, for the first 6 months to maintain coverage for all benefits. After this first 6-month period, self-payments may be made, but not beyond age 65, to maintain coverage for all benefits except for the Weekly Disability Income benefit.

For Retired Members: Under this provision, self-payments may be made, but not beyond age 65, to maintain coverage for all benefits except the Weekly Disability Income benefit.

For Retired Members over age 65 (Closed), self-payments may be made to maintain coverage for only the Prescription Drug benefit.

For Disabled Members: Under this provision, self-payments may be made, but not beyond age 65, to maintain coverage for all benefits except the Weekly Disability Income benefit.

Eligible Dependents

- Unmarried children who are under age 21 (over 14 days of age with respect to Dependent Life Insurance), or under age 25 if attending an accredited school, college, or university as a full time student. Dependent children must be dependent on you for support and not employed at a regular full-time job. With respect to Dependent Life Insurance, dependent children must be over 14 days of age.

- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.

- A child of your spouse provided:
  i) he/she is also your biological child; or
  ii) your spouse is living with you and has custody of the child.

- Your spouse as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose.

  Divorced or separated spouses (with or without a court order or separation agreement) are not eligible for coverage.

SUMMARY OF BENEFITS

FOR ACTIVE MEMBERS AND EARLY RETIREES UNDER 65 WHO CHOOSE TO SELF-PAY

LIFE INSURANCE

You are eligible for an amount of insurance equal to $100,000.

Coverage terminates on the date you retire and exhaust your Hour Bank Account (subject to the fact that if you retire early you can choose to self-pay to age 65), and as outlined under "Termination of Insurance".

DEPENDENT LIFE INSURANCE

Spouse	➢	$10,000
Each Child Over 14 days and Under 6 Months of Age	➢	$500
Each Child 6 Months of age and Over	➢	$2,500

Coverage terminates on the date your life insurance terminates, and as outlined under "Termination of Insurance".

SUPPLEMENTARY HEALTH EXPENSE

Deductible	➢	Nil
Coinsurance	➢	100% for all eligible expenses.
Lifetime Maximum Benefit	➢	Unlimited

Calendar Year
Maximum Benefit ➢ Unlimited

Coverage terminates at retirement and exhaustion of Hour Bank Account, and as outlined under "Termination of Insurance" (unless you retire early and decide to self-pay this coverage to age 65. Retired Members over age 65 (Closed) are only eligible for Prescription Drug Expenses.)

DENTAL EXPENSE

Deductible ➢ Nil

Coinsurance ➢ 80% for Minor Procedures
80% for Major Procedures

Calendar Year
Benefit Maximum ➢ $1,500 combined for Basic and Major Procedures.

Fee Guide - Benefits are paid in accordance with the current year minus one year Fee Guide in effect in the Province of Newfoundland and Labrador. Please see the Dental Expense section for a list of eligible expenses.

Coverage terminates at retirement and exhaustion of Hour Bank Account, and as outlined under "Termination of Insurance"

FOR RETIRED MEMBERS OVER AGE 65 (CLOSED)

SUPPLEMENTARY HEALTH EXPENSE (DRUGS ONLY)

Deductible ➢ Nil

Coinsurance ➢ 100%

Lifetime
Maximum Benefit ➢ Unlimited

Calendar Year
Maximum Benefit ➢ Unlimited

Coverage terminates upon death and as outlined under "Termination of Insurance".

FOR ACTIVE MEMBERS ONLY

WEEKLY DISABILITY INCOME

Your benefit is equal to 70% of weekly earnings, rounded to the nearest dollar, up to the E.I. Benefit Maximum at start of Disability. Benefits begin on the 1st day of a disability due to an accident and on the 8th day of a disability due to sickness (1st day of hospital confinement). The maximum duration of benefits is 26 weeks.

No benefits are payable by the Insurer during the 15 week period commencing with the date Employment Insurance Act benefits would normally commence, unless you provide proof you are not eligible for such benefits.

Coverage terminates on the date you attain age 65 or earlier retirement, and as outlined under "Termination of Insurance"

Note: If a member is on temporary layoff and becomes disabled, the benefit period will commence on the date the member receives notice that work is available.

MEMBER LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your 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 FOR DISABILITY (for active members only)

If you become totally disabled for 6 consecutive months before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first.

To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation, and you must submit proof of your continuing disability as may be required by the Insurer.

Note: In order to qualify for the Waiver of Premium benefit you must notify the Insurer of your disability within one (1) year of your last active day at work, and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

CONVERSION PRIVILEGE

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member 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.

DEPENDENT LIFE INSURANCE

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you.

CONVERSION PRIVILEGE

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

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

WEEKLY DISABILITY INCOME

In the event that you become totally disabled due to a non-occupational injury or sickness you will receive a disability benefit, provided you are under the continual treatment of a qualified and licensed physician.

Benefits for any one disability are payable from the 1st day of disability for injury resulting from an accident and the 8th continuous day of disability for sickness. Your benefit will be payable for not more than 26 weeks during any one period of disability.

No benefits are payable during the 15 week period during which Employment Insurance Act benefits are paid or payable to you unless you provide proof that you are not eligible for these benefits.

If following a period of disability, you return to active work for at least two weeks, a recurrence of this disability will be considered a new period of disability.

EXCLUSIONS

Benefits are not payable for the following:

- for the portion of a period of disability during which the member is not under treatment by a physician;
- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- disabilities arising from voluntary participation in a war, riot or insurrection;
- for the portion of a period of disability during which you are:
  a) imprisoned in a penal institution; or
  b) confined in a hospital, or similar institution, as a result of criminal proceedings;

- any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet. This plan will, however, pay benefits for the post-natal recovery period of maternity leave in accordance with Manulife Financial's claim practices, for Members in provinces where an Employment Standards Act or similar legislation requires it.

SUBROGATION

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

SUPPLEMENTARY HEALTH EXPENSE

MEMBER AND DEPENDENT COVERAGE

In the event that you incur in a calendar year any of the Eligible Expenses listed below, you will be paid a percentage of such expenses. The percentage (coinsurance) is specified in the Summary of Benefits.

LIFETIME MAXIMUM BENEFIT

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

EXTENSION OF SUPPLEMENTARY HEALTH COVERAGE

Supplementary Health Expense coverage for dependents will continue without premium payment following your death up to a maximum of twelve (12) months from the date of your death or to the date the policy or benefit terminates, whichever is earlier.

ELIGIBLE EXPENSES

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account

- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan 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 policy will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This policy will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife Financial using the due diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments, or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

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

Manulife Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife Financial may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Manulife Financial reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital.

Prescription Drug Expenses

Reasonable and customary charges incurred for medically necessary drugs and medicines which:

1) are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and; and

2) are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either:

    a) drugs requiring the prescription of a physician in accordance with the Food and Drugs Act, Canada; or

    b) other specified drugs and medicines which have been identified by the Insurer as covered expenses and are by convention usually not dispensed without a physician's prescription; or

    c) injectable preparations identified by the Insurer, insulin preparations and supplies, and allergy serums.

Note:

1) Smoking cessation aids which require a physician's prescription are covered, subject to a lifetime maximum benefit of $600 per individual.

2) Erectile Dysfunction drugs are covered to a calendar year maximum of $500. A physician’s prescription is required advising of medical necessity.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Charges for the following expenses are not covered:

- the administration of injectable medications;
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis; and
- drugs determined to be ineligible as a result of due diligence.

Outside Canada Expenses

Only insured individuals under age 65 are eligible for coverage. Coverage is limited to a period of 60 days from the date the insured leaves the province of residence. Coverage is not available during a leave of absence.

If, while travelling outside Canada, hospitalization or medical treatment is required due to a medical emergency and nonelective reasons, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan:

1) reasonable and customary charges for semi-private accommodation; and
2) reasonable and customary charges for the services of a physician.

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

i) a sudden, unexpected injury which occurs or a new medical condition which begins while a covered person is travelling outside his province of residence; or

ii) a previously identified medical condition that was Stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

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

If an insured is referred by a physician to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by any provincial medical plan, the expenses listed above in excess of any provincial government plan allowance are covered.

Out of Province Expenses (Inside Canada)

If, while travelling outside the insured's province of residence but inside Canada, hospitalization or medical treatment is required due to a medical emergency and non-elective reasons, the following expenses in excess of any government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan:

1) reasonable and customary charges for ward accommodation. (Coverage for charges in excess of the ward rate is specified under the Preferred Accommodation in Canadian Hospital);

2) reasonable and customary charges for the services of a physician.

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

i) a sudden, unexpected injury which occurs or a new medical condition which begins while a covered person is travelling outside his province of residence; or

ii) a previously identified medical condition that was Stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

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

If an insured is referred by a physician to a hospital outside the insured's province of residence but inside Canada for medically necessary treatment which is unavailable in the insured's province of residence and for which there is no medically sufficient alternate treatment available in the insured's province of residence, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the charges listed above in excess of any government plan allowance are covered. However, charges for ward accommodation are subject to a maximum benefit of $25.00 per day when the insured is referred by a physician.

Extended Health Expenses

- Charges for semi-private or private accommodation in a licensed Rehabilitation Hospital, subject to a maximum benefit of $10 per day for not more than 120 days of confinement per disability. Confinement must begin following a minimum of 3 consecutive days of hospital confinement and prior to the insured's 65th birthday;

- Charges for the services of the following licensed, registered or certified paramedicals are covered:

  (a) Charges for a Speech Therapist, Chiropractor, Podiatrist, Osteopath, Naturopath, Clinical Psychologist* or Masseur**, up to a maximum benefit of $500 per calendar year per individual;

  *the maximum does not apply for diagnosis and assessment

  **Physician's referral is required

  (b) Charges for a Physiotherapist up to a maximum benefit of $500 per calendar year per individual;

- Charges for the services (excluding custodial care) of a Registered Nurse (R.N.), which are rendered while the insured is not confined to a hospital provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform;

- Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer;

- Charges for rental (or, at the Insurer's option, purchase) of braces and crutches and the purchase of prostheses;

- Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 6 months of the accident to be considered a covered medical expense;

- Charges for professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment;

- Charges for one set of orthopedic shoes (including repairs) or orthotics every 24 consecutive months, which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

  i) a diagnosis, including a list of symptoms and the primary complaint;
  ii) a description of the physical findings from the clinical examination;
  iii) a brief description of the abnormal walking pattern associated with the diagnosis; and
  iv) confirmation that the product has been custom-made.

  Your orthopedic shoes and orthotics must be prescribed on an annual basis. For information on eligible prescribing and dispensing providers, please contact your Benefits Administrator for a copy of the plan member information sheet provided by the Insurer Manulife Financial.

- Charges for laboratory tests and x-rays not covered by any provincial government plan, subject to a maximum benefit of $500 per calendar year per individual;

- Charges for purchase of hearing aids (excluding batteries), provided by a certified clinical audiologist and subject to a lifetime maximum benefit of $300 per person provided the member did not have a hearing aid prior to becoming insured under this coverage. Charges for replacement or repair are not covered;

- Charges for the following out-patient care services made by a hospital, provided that no benefit shall be payable with respect to charges made by a resident physician or intern of a hospital:

  (a) use of an examination or operating room;
  (b) drugs, dressings or casts;
  (c) anaesthesia in connection with the performance of a surgical procedure.

Vision Care Expenses

Charges for vision care as follows:

- Refractive eye examinations performed by a qualified optometrist in any period of 24 consecutive months (12 consecutive months for dependent children under 19 years of age);

- one set of lenses and frames for eyeglasses, safety eyeglasses or contact lenses not covered below, subject to a maximum benefit of $400 per person in any period of 24 consecutive months (12 consecutive months for dependent children under 19 years of age);

- Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity cannot be improved to at least the 20/40 level by spectacle lenses, subject to a lifetime maximum benefit of $250.00;

- Laser eye surgery to a lifetime maximum benefit of $1,000 per person.

EXCLUSIONS

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

- charges which are considered an insured service of any provincial government plan;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- charges for general health examinations, and examinations required for use of third party;
- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- charges for medical treatment or surgical procedure by a physician other than as provided under Outside Canada or Out of Province Expenses;
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges not specified in the foregoing list of eligible medical expenses;
- charges which the Insurer is not permitted, by any law or regulation, to cover;
- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;

- charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;

- charges which would not normally have been incurred but for the presence of this insurance or for which you are not legally obligated to pay;

- charges for dental work where a third party is responsible for payment for such charges;

- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;

- for Out-of-Province/Out-of-Canada only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness;

- charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;

- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;

- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies;

- charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under the Outside Canada Expenses or Outside Canada Referral sections, where provided under the Supplementary Health Expense.

DENTAL EXPENSE

MEMBER AND DEPENDENT COVERAGE

As the wording of this dental coverage is technically oriented Manulife Financial suggests you take this booklet with you when you visit your dentist.

In the event you incur in a calendar year any of the eligible expenses listed below, you will be paid a percentage of such expenses as specified in the Summary of Benefits.

MAXIMUM BENEFIT

The total benefits payable are subject to the maximums specified in the Summary of Benefits.

EXTENSION OF BENEFITS

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Master Policy or after your insurance under this coverage ceases.

ALTERNATE BENEFITS AND SUBMISSION OF TREATMENT PLAN

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, The Plan Administrator reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, The Plan Administrator will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your employer, including pretreatment x-rays if the proposed treatment involves crowns or bridgework.

ELIGIBLE EXPENSES

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide for General Practitioners of the Dental Association as outlined in the Summary of Benefits. Further details may be found in the Master Policy.

MINOR PROCEDURES

Diagnostics: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- oral examinations limited to once every 9 months, complete oral exam and diagnosis is covered only once every 24 months;
- x-rays: single diagnostic x-rays; complete series or equivalent once every 24 months;
- study casts: once per year;
- consultations.

Preventive Therapy: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- 1 unit of time for polishing every 9 months, 8 units of time for scaling and/or root planing in any calendar year, topical fluoride limited to once every 9 months;
- passive space maintainers, those that do not move the teeth, for dependent children only.

(One unit of time = 15 minutes)

Note: Scaling limits include all periodontal scaling and root planing services.

Basic Restorative Dentistry: The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic restorations (fillings) or prefabricated full coverage restorations for primary teeth and white fillings on molars. In addition, sedative dressings are covered.

Extractions: Uncomplicated removal of teeth.

Endodontics: Endodontic procedures and root canal therapy.

Periodontics:

- Adjunctive Services as follows: Root planing (Note: Periodontal Scaling and Root Planing are subject to the scaling limits described under Preventive Therapy), Acute infections, Occlusal Adjustment, Provisional splinting;
- Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- Special Periodontal Appliances.

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

Anaesthesia: Anaesthesia where reasonably and customarily required in connection with other covered procedures.

Repairs, Relining, and Rebasing of Dentures: Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

MAJOR PROCEDURES

Installation of Dentures: The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date of coverage for Minor Procedures.

Replacement of existing dentures is not covered except if:

- The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan for Minor Procedures; or

- The replacement is more than 12 months after the individual became insured under this coverage, and the existing dentures are at least 5 years old and no longer serviceable.

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

Extensive Restorative Dentistry: Those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. The replacement of inlays, onlays and crowns are covered only if such replacement is more than 12 months after the individual became insured under this coverage, and the existing inlay, onlay, or crown is at least 5 years old and no longer serviceable. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration. Extensive Restoration is subject to the pre-existing condition limitation on teeth fractured prior to the effective date of coverage for Minor Procedures.

Bridgework: The initial installation of bridgework subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date of coverage for Minor Procedures.

Recementing and replacement of the facing or veneer of the bridge.

The replacement of existing bridges is not covered except if:

- The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan for Minor Procedures; or

- The replacement is more than 12 months after the individual became insured under this coverage, and the existing bridge is at least 5 years old and no longer serviceable.

EXCLUSIONS AND LIMITATIONS

Payments will not be made for any dental procedure in respect of any injury or dental disease for which the Member or dependent was advised to receive treatment or for which treatment first began before the Member or dependent became insured for that dental procedure. Payments will not be made for any dental procedure in respect of teeth extracted, missing, or fractured before the Member or dependent became insured for that procedure except for appliance replacement as specifically stated under Eligible Expenses.

No benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing, extracted or fractured after becoming insured under this plan for prosthetic devices.

No benefit is payable for the following:

- Services or supplies that are primarily for cosmetic dentistry;

- Charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;

- Services or supplies which are not furnished by a legally qualified dentist, hygienist or denturist acting within the scope of his or her license;

- services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;

- Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;

- Any services covered in whole or in part by any government plan, services for which no charge is made, or services which Manulife Financial is not permitted by law to cover;

- any charges which would not normally have been made but for the presence of this insurance or for which you or your dependent are not legally obligated to pay or were furnished while you or your dependent were not insured under this plan;

- Any hospital charges for board and room and related services and supplies;

- Any dental examinations required by a third party;

- charges which were considered an insured service of any provincial government plan at the time this policy/benefit was issued and subsequently were modified, suspended or discontinued;

- Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;

- Diagnostic procedures in connection with any benefit categories excluded as eligible expenses;

- Services or supplies for implantology.

GENERAL PROVISIONS

DEFINITIONS

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

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

Disease Management Programs means 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 means a medication that has been approved for use by Health Canada and has a Drug Identification Number.

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

Earnings means the amount of money, based on the number of hours in the regular work week, as per the Collective Agreement multiplied by the hourly wage rate for each particular member in the wage rate classification to which he belongs.

Exclusive Distribution means Manulife approved vendors.

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

Leave of Absence shall mean a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal law.

Life-Sustaining Drugs means non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative means 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 means 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 Policy.

Patient Assistance Program means 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 means 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 means 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.

Rehabilitation Hospital shall mean a licensed, extended hospital care facility or institution, or chronic care facility or institution, which is regularly engaged in the care of sick persons during the rehabilitation stage of an illness or injury. Such institution must provide 24-hour nursing service and regular medical supervision. The term rehabilitation hospital as used in this policy shall not include a home for the aged, health spa or hotel, an establishment providing custodial care or an institution for the care and treatment of alcoholism or drug addiction, tuberculosis or mental illness.

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

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

i) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination, or

ii) experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the insured/covered person has been seen by a medical professional in relation to the symptoms, or

iii) been prescribed or recommended a change in treatment or medication related to the medical condition by a Physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, or

iv) been admitted to or treated at a hospital for the medical condition, or

b) did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

COORDINATION OF BENEFITS

Payment of Supplementary Health and Dental Expense benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, the Insurer has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

CHANGE IN AMOUNTS OF INSURANCE

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively-at-work.

CHANGE IN GOVERNMENT SPONSORED PROGRAMS

The medical, dental and hospital benefits under this group insurance plan are provided in conjunction with government sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the group insurance plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

HOW TO CLAIM

In order to quickly process a claim, the following information is required:

- **your full name and address.**
- **the name of your Employer.**
- **your Certification (Identification) Number.**
- **your Group Policy Number. (901729)**

Contact your Plan Administrator who will supply you with the proper forms with instructions for completion.

All claims should be forwarded to the Plan Administrator:

Benefit Plan Administrators (Atlantic) Limited
38 Solutions Drive, Suite 100
Halifax, Nova Scotia
B3S 0H1

Phone: 902-455-2479
Toll Free: 1-888-426-4433

TIME LIMITATIONS

A claim for disability income benefits must be submitted within 6 months of the end of the qualifying disability period.

A claim for a waiver of premium benefit must be submitted within 12 months of the date disabled.

A claim for any other loss must be submitted within 12 months following the date the loss is incurred. However, in the event of termination of insurance, a claim must be submitted within 90 days following the date of termination of your insurance or the date following termination of a coverage or the policy.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined above. Every action or proceeding against Manulife Financial for the recovery of money payable under this plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

BENEFICIARY

For member death benefits, 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.

ACCESS TO PLAN DOCUMENTS

With respect to benefits covered by Manulife Financial, you or any of your covered dependents have the right to request a copy of any or all of the following items from your plan administrator:

- the sections of the Group Policy and/ or Plan Document that apply to you and your dependents;
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

Benefit Plan Administrators (Atlantic) Limited reserves the right to charge you for such documentation after your first request.

PLAN ADMINISTRATOR:

BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
38 SOLUTIONS DRIVE, SUITE 100
RAVINE CENTRE TWO
HALIFAX, NOVA SCOTIA
B3S 0H1

All benefits (except Accidental Death and Dismemberment, Permanent Total Disability and Critical Illness) are underwritten by:

MANULIFE FINANCIAL

POLICY #901729