A SUMMARY PLAN DESCRIPTION

FOR THE

ASBESTOS WORKERS' INSURANCE BENEFIT TRUST FUND OF ALBERTA

Revised: January 2011

"The Weekly Disability, Supplementary Health and Dental Benefits described in this book are integrated with benefits for which the Trust Fund has a liability. This liability is limited to the level of deposits required to be made to The Manufacturers Life Insurance Company for coverage. The Manufacturers Life Insurance Company is liable for all benefits in excess of the level of deposits providing they are covered under the terms of the Insurance Policy."

This booklet is for your general information only and is not the Insurance Policy. The booklet provides you with a brief description of the benefits to which you and your family are entitled; the rules governing eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim. The final determination, however, of any claim, question or problem, which may arise, will be governed by the Trust Agreement and the Insurance Policies issued by The Manufacturers Life Insurance Company and the Industrial Alliance Pacific Life Insurance Company.

ASBESTOS WORKERS' INSURANCE BENEFIT TRUST FUND OF ALBERTA

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ASBESTOS WORKERS' INSURANCE
BENEFIT TRUST FUND OF ALBERTA

9335 – 47 Street
Edmonton, Alberta
T6B 2R7

To all Eligible Employees:

This revised booklet has been published to give you an up-to-date description of the benefits provided by the Fund, as of January 1, 2011.

The booklet provides a description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits, and the procedure that should be followed when making a claim.

We have tried to explain the benefits in this booklet using straightforward language while still making every effort to be accurate. However, if there is any conflict between this booklet and the insurance policies or trust agreement, the wording of the insurance policies and trust agreement shall govern.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits which are available to you and your dependants. While it is our hope that you and your family will enjoy good health, it is comforting to know that these benefits are available when needed.

Because of the ever changing economic environment, the benefits provided in this booklet cannot be guaranteed for the future. In order to protect the Fund, the Trustees have the right to amend, delete, add or change the Plan's benefits and eligibility rules as they apply to all current and future members and retirees, including the right to add or delete benefits, monetary or otherwise, as circumstances may warrant.

If at any time you have any questions about the benefits, or would like assistance in filing a claim, please do not hesitate to contact the Administrator where a member of the staff will be pleased to assist you.

Sincerely,

BOARD OF TRUSTEES

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THIS BOOKLET CONTAINS IMPORTANT INFORMATION AND SHOULD BE KEPT IN A SAFE PLACE FOR FUTURE REFERENCE.

SCHEDULE OF BENEFITS
ACTIVE MEMBERS

MEMBERS ONLY

Life Insurance	$75,000
Accidental Death and Dismemberment Insurance	$75,000
Critical Illness	$25,000
Weekly Disability Income 1st day accident 8th day sickness	$413 per week for a maximum of 41 weeks of disability integrated with E.I.

DEPENDANTS ONLY

Dependant Life	$15,500 Spouse $15,500 Each Child

MEMBERS AND DEPENDANTS

Supplementary Heath Care	80% of eligible generic drug and medication expenses (reimbursement of dispensing fees limited to $5 per prescription), Foot Care expenses; 100% of other eligible expenses; $10,000 per individual lifetime maximum for private duty nursing expenses; $1 million lifetime maximum for out of province expenses; $750 per 12 months Vision Care expenses.
Dental Expenses *	100% of Routine, 80% of Dentures and 60% of Crowns and Bridgework; $2,500 per calendar year combined maximum per individual. Limited coverage for dental implants and over-dentures
Orthodontia (Dependent Children age 19 and under) *	50% of eligible expenses; $5,000 lifetime maximum per individual.

* The Dental Fee Guide used to reimburse Dental Expenses is updated each January 1st to provide reimbursement based on the Dental Fee Guide for the immediately preceding year, i.e. the 2010 Dental Fee Guide will be used to pay claims for 2011.

THE ABOVE IS A SUMMARY OF BENEFITS ONLY. YOU SHOULD REFER TO THE RELEVANT SECTION OF THE BOOKLET TO DETERMINE WHETHER YOU OR YOUR DEPENDANTS QUALIFY FOR THE BENEFITS BASED ON THE ELIGIBILITY REQUIREMENTS FOR EACH BENEFIT.

SCHEDULE OF BENEFITS
RETIRED MEMBERS

MEMBERS ONLY

Life Insurance	$20,000
Accidental Death and Dismemberment Insurance	$20,000

MEMBERS AND DEPENDANTS

Supplementary Heath Care	80% of eligible generic drug and medication expenses (reimbursement of dispensing fees limited to $5 per prescription), and Foot Care expenses; 100% of other eligible expenses; $10,000 per individual lifetime maximum for private duty nursing expenses; $1 million lifetime maximum for out of province expenses; $750 per 12 months Vision Care expenses
Dental Expenses *	80% of Routine, 80% of Dentures and 60% of Crowns and Bridgework; $2,500 per calendar year combined maximum per individual.

* The Dental Fee Guide used to reimburse Dental Expenses is updated each January 1st to provide reimbursement based on the Dental Fee Guide for the immediately preceding year, i.e. the 2010 Dental Fee Guide will be used to pay claims for 2011.

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

WHO MAY BE ELIGIBLE FOR BENEFITS

1. Any employee for whom his employer is obligated to contribute to the Fund by an applicable Collective Bargaining Agreement.

2. Any full time salaried officer or employee of any applicable Local for whom coverage under this Plan has been approved by the Trustees.

3. Any employee of the Trustees for whom coverage under this Plan has been approved by them.

4. Any other employee of certain employers for whom coverage under this Plan has been approved by the Trustees.

   Contributing Employer means any employer who is obligated or permitted to contribute to the Fund.

ELIGIBLE DEPENDANTS

A Member's eligible dependants are:

1. the employee's spouse, and

2 unmarried children, stepchildren or legally adopted children, in respect of whom the employee is eligible for deduction for the purpose of calculating taxable income under the *Income Tax Act* (Canada) who are:

   (a) from live birth and under the age of twenty-one years, or

   (b) at least twenty-one years of age but under twenty-five years of age and attending an accredited educational institute, college or university on a full time basis, or

   (c) at least twenty-one years of age and dependent upon the employee by reason of mental or physical incapacity, provided the infirmity commenced while the child was insured as a dependant. (Please refer to Continuation of Supplementary Health Care and Dental Care Benefits for Certain Incapacitated Children on Page 31 for further details)

   "Spouse" means either:

   (a) a person who, as of the time in question, is legally married to the employee, or

   (b) a person living with the employee who is publicly represented as the employee's "spouse" and is designated by the employee on his or her Registration Form as his or her "spouse", provided, however that if such designated person is not legally married to the employee, the employee must have been living with him or her for at least one continuous year prior to the incurring of the covered expense or service in question, so as to qualify him or her as a "spouse" for the purpose of the payment of such expense or service.

   The Administrator may (but is not obligated so to do) require from such employee or such employee's designated "spouse" a statutory declaration or other evidence sufficient to satisfy the Administrator of his or her qualification or otherwise for such payment.

If a person qualifies under (a) and another person qualifies under (b), then of the two persons so qualified, the one who has been designated to receive the benefit or benefits in question by an instrument in writing, signed by such employee and received by or filed with the Trustees or the Administrator, or in the absence of such designation the person qualified under (a), shall be deemed the "spouse" for the purpose of this plan.

EFFECTIVE DATE OF COVERAGE

Effective date of coverage for any employee (or dependant) is the date on which the employee qualified for the coverage in accordance with the following rules—except that no payments are to be made for services rendered prior to that date.

HOW AN EMPLOYEE BECOMES ELIGIBLE

Hours worked for contributing employers, for which contributions have been received, will be credited to the employee's reserve account.

New employees will become eligible for benefits after accumulating a minimum of 300 hours for work performed for contributing employers in not more than three consecutive months. The following month is a waiting period and eligibility will commence on the first day of the month following the waiting period. Also, you must be at work or available for work and not disabled on the day you become eligible for benefits.

CONTINUATION OF ELIGIBILITY

Hours worked for contributing employers, for which contributions have been received, will be credited to the individual's "reserve account". One hundred hours of work credit will be deducted from each eligible employee's "reserve account" for each month of insurance coverage, and employees will continue to remain eligible as long as their reserve accounts contain at least 100 hours of work credit.

In this connection employees, **who are members of the Union,** will be allowed to accumulate excess hours in their reserve accounts, up to a maximum of 600 hours.

CONTINUATION OF ELIGIBILITY WHILE DISABLED

Whenever an eligible employee is disabled and is receiving Workers' Compensation benefits or Fund Weekly Disability or Employment Insurance Sickness and Accident benefits for such disability for at least two weeks in any calendar month, no deduction will be made from his reserve account for that month. In other words, his reserve accumulation will be "frozen". The maximum period for which such employees' hours will be frozen under this rule for any one continuous period of disability will be twelve months.

If you receive Workers' Compensation benefits or Employment Insurance Sickness and Accident benefits, you must notify the Administrator of the duration of your disability so that your reserve accumulation may be frozen for the period described above. WCB or EI Sickness stubs must be provided to the Administrator along with your request to have your hours frozen. A "Request for Freezing of Hours" form may be obtained at your Local Union Office.

TERMINATION OF BENEFITS

An employee's eligibility under this Plan will terminate at the end of the month in which the work credits in his reserve account fall below 100 hours, after deduction of 100 hours for the current month's coverage.

REINSTATEMENT

An employee whose eligibility has terminated will again become eligible if his reserve account shows a total of at least 100 hours within the four-calendar-month period subsequent to the termination of his eligibility. Such reinstatement will be effective on the first day of the second month, which follows the month in which this requirement is met. If the employee is not reinstated within a four-calendar-month period, any reserve hours in his account will be forfeited. Such an employee will again become eligible for insurance upon completion of the initial eligibility requirements.

EXTENSION OF COVERAGE BY SELF-PAYMENT

An employee who is a member in good standing with the Union and whose eligibility terminates, may continue coverage for himself (excluding the Weekly Disability Benefit) and his dependants from month to month provided he is available for work with a contributing employer as determined by the Local Union Office. Coverage may be continued by making self-payments to the Administrator (up to a maximum of 12 consecutive payments) provided the member remains in good standing with the Union.

The first payment must be made prior to the termination of eligibility; payments must be continuous so long as the employee is eligible to make them, and must be made in advance of the month for which coverage is desired.

CHANGES IN ELIGIBILITY RULES

These rules may be altered by the Trustees from time to time without the necessity of prior notice being made to those affected thereby.

DECEASED EMPLOYEE—LENGTH OF DEPENDANT COVERAGE

In the event of any employee dying while he is eligible for Health and Welfare benefits under the eligibility rules, the Supplementary Health and Dental Care benefits payable under the Plan applicable at the time of death for such deceased employee's dependants shall continue for either the three calendar months immediately following the date of death or until the deceased employee's bank hours run out in the normal course, whichever is later. However, coverage will not be provided beyond the date that the dependant would have ceased to qualify as an eligible dependant, if the employee was still living.

PARTICIPATION OF NON-BARGAINING EMPLOYEES OF CONTRIBUTING EMPLOYERS AND EMPLOYEES OF THE UNION

Employers may insure themselves and any members of their organizations who are not covered by a Collective Bargaining Agreement by making the required payments to the Fund as stipulated by the Trustees from time to time.

Non-Bargaining employees may become and remain eligible provided they meet prescribed non-bargaining eligibility rules. The Board of Trustees reserves the right to amend theses rules at any time and to require proof that all conditions and requirements are being met. Full information concerning participation of non-bargaining employees can be obtained by contacting the Administrator.

ELIGIBILITY RULES FOR RETIRED MEMBERS

INITIAL ELIGIBILITY

To be eligible for benefits under the Retired Members Benefit Plan the member must meet all of the following requirements:

<u>Members with 15 Years or Less of Union Affiliation* at Date of Retirement</u>

1. He must be a member in good standing of the International Association of Heat & Frost Insulators and Allied Workers Local 110 (and its predecessors) (the Union) on the date he retires from employment with participating employers (the date of his retirement);
2. He must have worked at least 1,000 hours for participating employers in each of the five (5) years immediately preceding his date of retirement;
3. He must be in receipt of, or in the process of successfully applying for, a monthly retirement benefit commencing on his date of retirement from the Asbestos Workers Pension Plan of Alberta (the Pension Plan); and
4. He must have 12 continuous months of coverage as an Active Member under the Plan as of the date of his retirement.

<u>Members with More Than 15 Years of Union Affiliation* at Date of Retirement</u>

1. He must be a member in good standing of the Union on the date he retires from employment with participating employers (the date of his retirement);
2. He must have worked at least 500 hours per year for participating employers in 13 of the 15 years immediately preceding his date of retirement; or, he must have worked at least 1,000 hours for participating employers in each of the five (5) years immediately preceding his date of retirement;
3. He must be in receipt of, or in the process of successfully applying for, a monthly retirement benefit commencing on his date of retirement from the Pension Plan; and
4. He must have been covered as an Active Member under the Plan in the month immediately preceding the date of his retirement.

   *Union Affiliation means membership in the International Association of Heat & Frost Insulators and Allied Workers Local 110 (and its predecessors).

If a member does not elect to participate in the Retired Members Plan within 30 days of his effective date of coverage (as defined on page 11), he will not be allowed to participate later.

ELIGIBLE DEPENDANTS

A Retired Member's eligible dependants are:

1. the employee's spouse, and
2. unmarried children, stepchildren or legally adopted children, in respect of whom the employee is eligible for deduction for the purpose of calculating taxable income under the *Income Tax Act* (Canada) who are:
   (a) under the age of twenty-one years, or
   (b) at least twenty-one years of age but under twenty-five years of age and attending an accredited educational institute, college or university on a full time basis, or

(c) at least twenty-one years of age and dependent upon the employee by reason of mental or physical incapacity, provided the infirmity commenced while the child was insured as a dependant. (Please refer to Continuation of Supplementary Health Care and Dental Care Benefits for Certain Incapacitated Children on Page 31 for further details)

"Spouse" means either:

(a) a person who, as of the time in question, is legally married to the employee, or

(b) a person living with the employee who is publicly represented as the employee's "spouse" and is designated by the employee on his or her Registration Form as his or her "spouse", provided, however that if such designated person is not legally married to the employee, the employee must have been living with him or her for at least one continuous year prior to the incurring of the covered expense or service in question, so as to qualify him or her as a "spouse" for the purpose of the payment of such expense or service.

The Administrator may (but is not obligated so to do) require from such employee or such employee's designated "spouse" a statutory declaration or other evidence sufficient to satisfy the Administrator of his or her qualification or otherwise for such payment, and

If a person qualifies under (a) and another person qualifies under (b), then of the two persons so qualified, the one who has been designated to receive the benefit or benefits in question by an instrument in writing, signed by such employee and received by or filed with the Trustees or the Administrator, or in the absence of such designation the person qualified under (a), shall be deemed the "spouse" for the purpose of this plan.

REQUIRED CONTRIBUTIONS

Retired Members who receive a Normal Retirement benefit from the Pension Plan can currently become eligible for Retired Members coverage without making contributions.

Retired Members who receive another form of Retirement benefit from the Pension Plan can become eligible for Retired Members coverage by making monthly contributions at the required level and at the required time as determined by the Trustees. The monthly contributions are required on a consecutive basis until the earlier of a) termination of coverage and b) until the member reaches the Pension Plan's Normal Retirement benefit age. Thereafter, coverage currently can be continued without making contributions.

EFFECTIVE DATE OF COVERAGE

The effective date of coverage under this Plan for any Retired Member (or dependant) is the first day of the month immediately following the month in which Active Member coverage by the Asbestos Workers Insurance Benefit Trust Fund of Alberta (the Fund) ceases.

If a dependant is confined for medical care or treatment in any institution or at home when insurance would normally begin, the dependant will not be insured until given a final release by the licensed doctor (M.D.) from all such confinement. However, this provision is not applicable to dependants who were insured as an active employee's dependants as of the last day of active employee coverage.

TERMINATION OF ELIGIBILITY

Coverage as a Retired Member under this Plan will cease upon the earliest of:

1. The date the Retired Member ceases to be a member in good standing of the Union;
2. The date the Retired Member ceases to make the required monthly Plan contributions to the Administrator;
3. The date coverage commences as an Active Member under the Fund, due to the Retired Member's re-employment with a participating employer;
4. The date the Retired Member is re-employed in the industry by a non-participating employer;
5. The date the Retired Member has been covered as a Retired Member for 60 months (not necessarily consecutive) on or after the Retired Member's Normal Retirement date; and
6. The date of the Retired Member's death.

Important: If a Retired Member's coverage terminates for any reason other than Number 3 above, his coverage cannot be reinstated.

As noted in Number 3 above, should a member become eligible for coverage as a Retired Member and subsequently become eligible as an Active member under the Fund, his eligibility as a Retired Member will cease. If, after that, he terminates eligibility as an Active Member, he will again become eligible as a Retired Member provided he meets all of the Initial Eligibility rules (with respect to his date of re-retirement) except for Number 2. (Rule Number 4. Of the Initial Eligibility rules will be adjusted to the number of months he was covered as an Active Member, if it was less than 12 months.)

CHANGES IN ELIGIBILITY RULES

The eligibility rules may be amended by the Trustees at any time without the necessity of prior notice being provided to those individuals affected thereby, including Retired Members covered by this Plan and those not yet eligible for coverage as of the effective date of any such amendment.
The Trustees expressly reserve the right to terminate any or all of the benefits or coverage provided for Retired Members and their dependants, and expressly reserve the right to provide different benefits to Retired Members or Dependants than the benefits being provided to other members, employees, dependants or beneficiaries of the Fund. The Trustees also expressly reserve the right to require contributions to be made by all Retired Members participating in the Plan, and to change the amount of the contributions from time to time.

GENERAL INFORMATION

WHEN YOUR DEPENDENCY STATUS CHANGES

If you marry or have children, a new Registration Form must be completed and forwarded to the Administrator each time you acquire a new dependant.

CHANGE OF ADDRESS

If you should have a change of address, it is important that you notify the Administrator immediately by completing a new Registration Form.

LIFE INSURANCE FOR MEMBERS AND DEPENDANTS

The Life Insurance is payable in the event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum to the beneficiary or beneficiaries designated by you. The beneficiary or beneficiaries may be changed whenever you wish in accordance with Provincial Laws. Dependant Life Insurance is payable in the event of your dependants' (spouse or each child's) death from any cause at any time or place while you are insured. Payment will be made in a lump sum to you. (Dependant Life Insurance is not applicable to the Retired Members Plan.)

DISABILITY PROVISION (Not applicable to the Retired Members Plan.)

If an insured employee:

- becomes Totally and Permanently Disabled while insured;
- continues to be so disabled for the next 6 months; and
- is under age 65;

the Employees' Life Insurance Coverage at the time the employee becomes so disabled will continue while so disabled, but not beyond the employee's 65th birthday, subject to any reduction or termination indicated in the Schedule due to a change in class. The insured employee must submit proof satisfactory to Manulife Financial, within 12 months of the date of cessation of active work, that the employee is so disabled. Upon approval, no further premium will be required but from then on proof satisfactory to Manulife Financial must be submitted, as required, that the employee is still so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, an insured employee is, and will continue to be, unable to work at any occupation for which the employee is, or may reasonably become, fitted by education, training or experience.

If Employee Life Insurance is being continued, Dependant Life Insurance will also be continued with no further premium required.

CONVERSION PRIVILEGE

MEMBERS

If your Life Insurance terminates because your employment or class membership terminates or because you no longer qualify for coverage under the Disability Provision, then on or before your 65th birthday, you may convert up to 100% of the terminated amount, less any amount of group life insurance for which you may become eligible within 31 days of the date of the termination.

SPOUSES

If Dependant Life Insurance for your spouse terminates because your employment or class membership terminates or because of your death, then on or before your spouse's 65th birthday, your spouse may convert up to 100% of the terminated amount, less any amount of group life insurance for which your spouse may become eligible within 31 days of the date of the termination.

MEMBERS AND SPOUSES

Note: The conversion privilege does not apply to reduction of life insurance or termination of insurance which became effective at specified ages, or upon your retirement.

The individual policy may be:

- a permanent plan that the Insurance Company offers to the public at the time of conversion;
- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it in force to any plan described above.

In no event may the converted policy exceed $200,000, nor may it include disability or other added benefits.

You or your Spouse must apply, in writing, and pay the first premium to the Insurance Company within 31 days of the date insurance terminates. The premium rates will be based on age and class of risk at the time of conversion. No medical exam or health questionnaire will be required.

EXTENSION OF BENEFITS

If you or your dependant dies within 31 days of the date the Life Insurance terminates, the amount that could have been converted will be paid as a death benefit under this plan even if there was no application for conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT
BENEFIT FOR MEMBERS

COVERAGE

Coverage is provided for accidents which occur anywhere, at any time, on or off the job. You will be covered whether you are at home or travelling, including air travel as a passenger, pilot or crew member (some limitations apply) in any certified aircraft flown by a duly licensed pilot.

The plan provides benefits for injury resulting in a loss which occurs within one year after the date of accident. Benefit payments are based on a Principal Sum of $75,000 ($20,000 under the Retired Members Plan) and are payable in accordance with the following schedule:

SCHEDULE OF BENEFITS

The plan provides benefits for injury resulting in a loss which occurs within one year after the date of accident. Benefit payments are based on a Principal Sum of $35,000 ($20,000 under the Retired Members Plan) and are payable in accordance with the following schedule:

Loss	Benefit
Life	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum
Speech and Hearing	The Principal Sum
One Arm	Three-Quarters of The Principal Sum
One Leg	Three-Quarters of The Principal Sum
One Hand	Two-Thirds of The Principal Sum
One Foot	Two-Thirds of The Principal Sum
Entire Sight of One Eye	Two-Thirds of The Principal Sum
Speech or Hearing	Two-Thirds of The Principal Sum
Thumb & Index Finger of Either Hand or Four Fingers of One Hand	One-Third of The Principal Sum
Hearing in One Ear	One-Third of The Principal sum

PARALYSIS BENEFITS

Loss	Benefit
Quadriplegia (complete paralysis of both upper and lower limbs)	The Principal Sum
Paraplegia (complete paralysis of both lower limbs)	The Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of the body)	The Principal Sum

Only one of the amounts shown above (the largest applicable) will be paid for injuries to the same limb resulting from any one accident. Notwithstanding the amounts specified above, the maximum payable under this policy for all losses sustained by an Insured Person as a result of the same accident shall not exceed the Principal Sum.

If your insurance is terminated because of loss of eligibility, benefits are extended during the 31-day period following such termination.

DEFINITIONS

"Injury**"** means bodily injury caused by an accident occurring while the policy is in force with respect to the Insured Person for whom a claim is presented and resulting in loss covered by the policy.

"Loss**"** as above used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and finger means complete severance at or above the first phalange; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; and as used with reference to hearing means the total and irrecoverable loss thereof.

"Loss**"** as above used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

This policy is subject to an Aggregate Limit of Indemnity of $2,000,000.00 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident which results in an accumulation of losses exceeding $2,000,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

LIMITATIONS

The Plan does not cover any loss:

- resulting from suicide or from self-inflicted injury,
- resulting from war or any act of war (declared or undeclared)
- occurring while you are on active service in the armed forces,

Coverage is provided for air travel as a passenger on an aircraft which has a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license for such aircraft. However, there are coverage limitations applicable to air travel coverage, details of which can be obtained from the Administrator.

CRITICAL ILLNESS BENEFIT
(ACTIVE MEMBERS PLAN ONLY)

Only those active employees, under age 65 who are members in good standing with the Union (and including staff of the Union and Trust Fund employees), and who also have had continuous coverage in the Plan in each of the last three (3) years are eligible for the Critical Illness Benefit.

Retired Members, Dependants (of both Retired Members and Active Members), permit workers, and non-bargaining employees are not eligible for this benefit.

The Critical Illness benefit supplements your other Plan coverage by providing you with a lump sum payment should you become critically ill with one of the listed conditions. There is no requirement for loss of income or any incurred health care expenses, so you can use the Critical Illness benefit as you wish.

If, while you are insured for this benefit, you are diagnosed with one of the Critical Illness conditions below, you can submit a claim for a Critical Illness benefit. The following is only a list of the conditions that are covered. The Critical Illness Insurance Policy contains a detailed definition of each of the conditions and the Entitlement Criteria that must be satisfied in order to qualify for a Critical Illness benefit.

If all Entitlement Criteria are met, the Plan will pay you an amount of $25,000

- Cancer (Life-threatening)
- Heart Attack
- Stroke
- Coronary Artery Bypass Surgery
- Major Organ or Bone Marrow Transplant
- Major Organ or Bone Marrow Failure or on Waiting List
- Occupational HIV Infection
- Alzheimer's Disease
- Coma
- Parkinson's Disease
- Heart Valve Replacement
- Kidney Failure
- Loss of Limbs
- Loss of Speech
- Motor Neuron Disease
- Benign Brain Tumor
- Multiple Sclerosis
- Aortic Surgery
- Blindness
- Deafness
- Paralysis
- Severe Burns

ENTITLEMENT CRITERIA

Manulife Financial will apply the following criteria in determining your entitlement to Critical Illness Benefits:

- A completed claim form, including medical evidence documenting your diagnosis of a covered Critical Illness condition, must be submitted within ninety (90) days of the diagnosis of your Critical Illness;

- The diagnosis of any Critical Illness is made by a physician, practicing medicine in Canada in a specialty relating to the applicable Critical Illness (you may be required to submit to an independent medical examination or evaluation by an examiner selected by the insurance company);

- You must survive the initial diagnosis by thirty (30) days.

EXCLUSIONS

No benefits are Payable for any Critical Illness related to:

- A pre-existing condition incurred or diagnosed during the twenty-four months prior to the effective date of coverage or latest reinstatement (whether or not you were aware of your condition);

  A pre-existing condition is an illness or injury for which you have exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or have been prescribed medication – or where treatment would have been received by a prudent individual – during the 24 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness Benefit.

- Self-inflicted injuries or illnesses;

- Abuse of addictive substances, including drugs and alcohol;

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

- The committing of or the attempt to commit an assault or criminal offence;

- Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if your blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury;

- Intentionally taking a poisonous substance or inhaling toxic gasses or fumes;

- Any specific exclusion(s) associated with a given condition set out in the Critical Illness policy.

TERMINATION OF BENEFITS

Your eligibility for coverage under this benefit will terminate on the earliest of:

- The date you lose eligibility under the Plan:
- Your 65th birthday:
- The date of your retirement;
- The date your Critical Illness benefit is paid out;
- The date of your death.

For more complete information about what is and is not a covered Critical Illness, please contact your Plan Administrator.

WEEKLY DISABILITY BENEFIT
(ACTIVE MEMBERS PLAN ONLY)

The plan pays you a weekly benefit of $413 for disability absences which prevent you from working, and are a result of a non-occupational accidental bodily injury or sickness which occurs after your effective date of coverage. Your benefit will commence on the first day of disability due to injury and on the eighth day of disability due to sickness and is payable for a maximum of 41 weeks during any one period of disability.

Benefits from the Fund will cease when Employment Insurance (E.I) Sickness and Accident benefits would normally begin. When E.I. Sickness and Accident benefits terminate, additional benefits from the Fund will be paid for a total maximum benefit payment from the Fund and E.I. of 41 weeks. If you are not eligible for E.I Sickness and Accident benefits, the Fund will provide benefits for a maximum of 41 weeks.

Be sure to apply to Employment Insurance for Sickness and Accident benefits in the first week of your disability. Failure to do so may affect your disability benefits from the Fund.

If you are entitled to pregnancy or parental leave of absence, no benefits are payable for the period during which you would be away from work on pregnancy or parental leave of absence, except where benefits are provided during the post-natal recovery period.

THIRD PARTY LIABILITY

If you receive benefit payments under this plan for loss of income for which there may be cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will enable Manulife Financial to be reimbursed for any amount(s) including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to Manulife Financial of payment by a third party of any judgment or settlement, further disability payments under this plan will terminate until Manulife Financial has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

WHAT IS NOT COVERED

1. Any period of disability during which you are not under the care of a legally qualified physician or surgeon; no period of care shall be considered to have started until the employee has been seen and treated personally by the physician or surgeon.

2. Disability resulting from (a) injuries sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, or (b) sickness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.

3. Any period of disability for which you are eligible, qualified or entitled to receive a benefit under the *Employment Insurance Act.*

4. Any day of disability on which you are performing work of any kind, anywhere, for compensation or profit.

5. Where permitted by law, any day for which you receive disability benefits under any Provincial Automobile Insurance Act.

Successive periods of disability which are separated by less than one week of active work, or availability for active work, shall be considered as one period of disability unless the subsequent disability is due to injury or sickness entirely unrelated to the causes of the previous disability. Disabilities arising from different and unrelated causes will be considered as a new disability providing they commence after you return to full-time work, or availability for active work, for at least one full day. Disabilities arising from the same or a related cause will be considered as a new disability provided you returned to regular, full-time work, or availability for active work, for a period of at least one week.

NOTE: DISABILITY CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS FOLLOWING COMMENCEMENT OF DISABILITY.

SUPPLEMENTARY HEALTH CARE FOR MEMBERS AND DEPENDANTS

DESCRIPTION OF BENEFITS

If you incur Class I Covered Expenses the plan will pay 80% of such expenses, subject to a $5 per prescription or refill dispensing fee limit.

If you incur Class II Covered Expenses the plan will pay 100% of such expenses subject to applicable maximums.

The Maximum Lifetime Benefit for Out-of-Province Expenses is $1 million for each insured family member and for private duty nursing services is $10,000 for each insured family member.

COVERED EXPENSES

This section should be read in conjunction with the section entitled "Exclusions".

Covered Expenses included under the plan are the charges which you are required to pay for the following services and supplies received while you are insured, for the treatment for non-occupational injuries and illness, vision care or for pregnancy.

NOTE: Covered Expenses are limited to reasonable and customary charges. A Reasonable and customary charge shall mean a charge made by the provider of care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

CLASS I EXPENSES

DRUGS AND MEDICINES (excluding smoking cessation products available over-the-counter and all medications for treatment of erectile dysfunction) obtainable only upon a physician's or dentist's prescription (or other professional authorized by provincial legislation to prescribe drugs) and dispensed through a registered pharmacist or physician legally authorized to dispense such drugs, plus drugs that regardless of their legal status are not normally sold by a pharmacist except on such prescription.

Coverage is provided based on generic drugs and medicines. Full coverage (that is 80%) of brand name drugs and medicines will only be provided if a generic equivalent does not exist. If a generic drug does exist and a brand name is purchased, you will be required to pay all expenses in excess of 80% of the cost of the generic equivalent.

Reimbursement for vaccines limited to $250 per insured per calendar year.

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

FOOT CARE: These are the charges for:

(1) orthopedic shoes (including repairs) to a maximum benefit of $350 every two calendar years, each calendar year for insured persons under age 18, and

(2) orthotics to a maximum benefit of $350 every two calendar years, each calendar year for insured persons under age 18.

These products must have been specially designed and molded for the insured person and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- a description of the physical findings from the clinical examinations;
- a brief description of the gait abnormality associated with the diagnosis; and
- confirmation that the product has been custom-made.

In order to be eligible for reimbursement, orthopedic shoes and orthotics must be prescribed, on an annual basis, by providers with the following professional qualifications:

- Medical General Practitioner or Specialist (MD); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M); or
- Chiropractor (DC); and

must be dispensed by one of the following provider types:

- Medical General Practitioner or Specialist (MD); or
- Orthodontist Co(c) or CPO(c); or
- Pedorthist C Ped (C) or C Ped (MC); or
- Podiatrist (DPM): or
- Chiropodist (D CH or D Pod M); or
- Chiropractor (DC).

CLASS II EXPENSES

Expenses incurred in the individual's normal province of residence for:

DIABETIC SUPPLIES, that is, syringes and test strips. (These items can be obtained by using your Pay-Direct Drug Card.)

HOSPITAL BOARD AND ROOM AND OTHER NECESSARY SERVICES AND SUPPLIES up to the difference between the hospital's daily charge for ward and semi-private accommodations. The General Provisions section contains a definition of a hospital. Charges for ward to semi-private accommodation incurred for palliative care in an extended care facility/nursing home, with a lifetime maximum reimbursement of $2,500.

LOCAL AMBULANCE SERVICE for transportation in a vehicle regularly used for professional ambulance service to or from a hospital in the local area; but limited to one trip to and one trip from the hospital for any one hospital confinement.

EMERGENCY TRANSPORTATION beyond the local area if:

(a) necessary because of any emergency arising while the insurance is in force; and if

(b) by professional ambulance, or by scheduled airline or railroad to and from the nearest hospital qualified to provide needed treatment.

OUT-PATIENT HOSPITAL SERVICES AND SUPPLIES (during a period for which the hospital makes no charge for board and room) in connection with use of an examination or operating room, drugs, dressings or casts, anesthesia in connection with the performance of a surgical procedure, but not charges made by a resident physician or intern of a hospital.

PRIVATE DUTY NURSING SERVICES BY A REGISTERED GRADUATE NURSE (R.N.) VICTORIAN ORDER NURSE (V.O.N.) AND LICENSED PRACTICAL NURSE (L.P.N) while the patient is not confined to a hospital up to a lifetime benefit maximum of $10,000. The nursing service must have been ordered by a physician as medically necessary and requiring the specialized training of an R.N., V.O.N. or L.P.N. The nurse must not ordinarily reside in the employee's home or be a member of the family.

CONVALESCENT/REHABILITATION HOSPITAL BOARD AND ROOM AND OTHER NECESSARY SERVICES AND SUPPLIES up to the difference between the hospital's daily charge for ward and semi-private accommodations for as many as 120 days during any one period of disability provided the individual is admitted to the convalescent/rehabilitation hospital within 7 days following discharge from a hospital in which the member was confined for at least 5 consecutive days. All confinements in a convalescent/rehabilitation hospital will be considered as one period of disability unless confinements are separated by at least 90 days. The General Provisions section contains a definition of a convalescent /rehabilitation hospital.

TREATMENTS BY A PROVINCIALLY LICENSED CHIROPRACTOR OR ACUPUNCTURIST up to $400 per calendar year per type of practitioner. However, no benefit will be paid while the individual is entitled to similar benefits under any Provincial Health Plan other than chiropractor charges, regardless of whether the Provincial Plan pays all or only part of such charges.

TREATMENTS BY A PROVINCIALLY LICENSED OSTEOPATH, NATUROPATH, PODIATRIST, OR CHRISTIAN SCIENCE PRACTITIONER, limited to $400 per calendar year, per specialty. No benefit will be paid while the individual is entitled to similar benefits under any Provincial Health Plan, other than podiatrist charges, regardless of whether the Provincial Plan pays all or only part of such charges.

PHYSIOTHERAPY by a person duly qualified and registered and legally engaged in the practice of physiotherapy, provided such services, by duration and type, have been prescribed by a physician; however, any charges for occupational or recreational therapy will be disregarded. Reimbursement will be limited to $400 per calendar year.

MASSAGE THERAPY by a person duly qualified and registered and legally engaged in the practice of massage therapy up to a maximum of $400 per calendar year will be made, provided treatment is prescribed by a physician.

DIAGNOSIS AND ASSESSMENT BUT NOT TREATMENT BY A PERSON DULY QUALIFIED AND REGISTERED AND LEGALLY ENGAGED IN THE PRACTICE OF PSYCHOLOGY on the written recommendation of a physician. In the case of a dependent child, diagnosis and assessment shall include one consultation by the psychologist with the parents and one consultation by the psychologist with the family doctor.

TREATMENT BY A PERSON DULY QUALIFIED AND REGISTERED AND LEGALLY ENGAGED IN THE PRACTICE OF PSYCHOLOGY provided that if such services are for psychiatric testing, they are rendered in conjunction with medically necessary psychotherapeutic treatment. Reimbursement will be limited to $1,000 per calendar year. Treatment must have been prescribed by a physician.

OUT-OF-PROVINCE EMERGENCY TREATMENT as described in (1) and (2) below incurred in connection with emergency treatment while the individual is travelling or vacationing outside the province in which he normally resides for periods of not more than 90 days.

(1) Charges by a general practitioner or specialist in excess of the amount allowed under the Provincial Hospital and Medical Plans in the individual's normal province of residence provided such charges are reasonable and customary in the area in which they were incurred.

(2) Charges for hospital confinement including ancillary or miscellaneous expenses in excess of the allowance for ward accommodation payable by the Provincial Hospital Plan in the individual's normal province of residence. No charges will be considered unless all or part of the daily charge is payable under such Provincial Hospital Plan nor for any type of accommodation for which the individual would not have been covered under this plan had he been hospitalized in his normal province of residence.

Note: The maximum reimbursement available for these expenses is $1 million during the lifetime of each insured person (a separate maximum applies for you and for each of your insured dependants). If you, or your family, travel outside Canada you may want to obtain additional coverage for medical emergencies outside Canada.

The Supplementary Health Care benefit includes an Emergency Travel Assistance (ETA) benefit. This benefit provides you and your dependants with a 24-hour, toll-free telephone number to call in the event that you encounter a medical emergency while traveling outside of the country. The ETA coverage is limited to trips of 90 days or less.

RENTAL OF IRON LUNG OR OTHER DURABLE MEDICAL OR SURGICAL EQUIPMENT, (please contact Manulife Financial for pre-approval prior to an expense being incurred).

ARTIFICIAL LIMBS AND EYES, CRUTCHES, SPLINTS, CASTS, TRUSSES, AND BRACES FOR BACK, NECK, ARM, OR LEG including replacement due to a change in physical condition when prescribed or ordered by the attending physician.

DENTAL WORK performed by a dentist for the prompt repair of sound natural teeth required as a result of a non-occupational, accidental injury, external to the mouth, occurring while insured.

ANESTHESIA, OXYGEN, BLOOD AND BLOOD PRODUCTS.

DIAGNOSTIC LABORATORY AND X-RAY EXPENSES.

HEARING AIDS IF NECESSARY ON ACCOUNT OF BODILY INJURY TO PHYSICAL ORGANS OR PARTS sustained in an accident which occurs or an illness which commences while this insurance is in force. Must be prescribed by an otolaryngologist. Any charges in connection with replacement or repair are excluded.

VISION CARE EXPENSES

Coverage is provided to a maximum of $750 for the purchase of prescription glasses, laser eye surgery for correction of visual acuity*, prescription sunglasses, or prescription safety goggles, or contact lenses, every 12 months. Non-corrective lenses (and frames for non-corrective lenses) are not covered.

*Unused Vision Care coverage (that is, $750 per year) can be accumulated towards reimbursement of laser eye surgery expenses only. If no Vision Care expenses have been claimed for a 24 consecutive month period, then up to $1,500 for laser eye surgery can be claimed; and if there have been no Vision Care expenses claimed for 36 consecutive months, up to $2,250 can be claimed. No accumulations beyond 36 months are permitted. During these accumulation periods, the individual must have been insured for at least 6 months for each of the 12-month accumulation periods.

NOTE: Retirees and their dependants are not eligible for laser eye surgery coverage.

Eye examination, including refractions, by an ophthalmologist or optometrist are covered if the individual is between 19 and 64 years of age inclusive. Eye exams are included in the $750 overall Vision benefit maximum in any 12 month period.

RESTORATION

On January 1 of each year, the amount which has been counted against any Maximum Lifetime Benefit of an insured family member and not previously restored or reinstated will be automatically restored up to $1,000. No evidence of good health is required for this automatic restoration but it is not available after insurance is terminated.

For example, if you receive $1,700 in Out-of-Province Benefit payments in one calendar year, your Maximum Out-of-Province Benefit will automatically be restored by $1,000 on the next January 1, and by the remaining $700 on the following January 1, assuming no further benefits have become payable in the meantime.

REINSTATEMENT

At any time that the Maximum Lifetime Benefit of a family member is reduced by at least $1,000 on account of benefits which have been collected, reinstatement of the maximum may be requested providing the family member is then in good health. It will be necessary to submit medical evidence of the good health of such member to the Insurance Company at your own expense. The new maximum becomes effective on the date the Insurance Company acknowledges the evidence as satisfactory.

MATERNITY BENEFITS

All Supplementary Health Care Benefits described on the preceding pages will also be payable for expenses incurred while insurance is in force due to pregnancies.

DENTAL CARE BENEFITS FOR MEMBERS AND DEPENDANTS

DESCRIPTION OF BENEFITS

If you incur covered Dental Expenses in any calendar year, this plan pays you 100%* of Routine expenses, 80% of Dentures and 60% of Crowns and Bridgework expenses, and 50% of Orthodontic expenses subject to applicable maximums. (Coverage provided under the Retired members Plan is 80% of Routine and Denture expenses and 60% of Crowns and Bridgework expenses. Orthodontic expenses are not covered under the Retired Members Plan.)

The maximum benefit for covered Routine, Dentures, Crowns and Bridgework incurred in any calendar year is $2,500 combined for each insured family member. The maximum for Orthodontic treatment is $5,000 per individual per lifetime. Only dependent children age 19 or less are eligible for Orthodontic coverage.

The Dental Fee Guide used to reimburse Dental Expenses is updated each January 1st to provide reimbursement based on the Dental Fee Guide for the immediately preceding year, i.e. the 2010 Dental Fee Guide will be used to pay claims for 2011, the 2011 Dental Fee Guide will be used to pay claims for 2012, and so on.

*NOTE: Retirees and their dependants have their Routine expenses covered at 80% coinsurance.

ALTERNATIVE SERVICES

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

DENTAL IMPLANTS

Implant-related treatment will be covered up to the maximum that would have been paid for prosthodontic treatment such as bridgework or a partial denture. Charges for implant-related periodontic or oral surgery will not be an eligible expense.

ADDITIONAL COVERAGE FOR DENTAL IMPLANTS AND OVER-DENTURES

If you are an active employee and have had coverage in the Plan in each of the last three (3) years, and are in good standing with the Union (and including staff of the Union and Trust Fund employees), you are entitled to additional coverage for dental implants and over-dentures.

Retired Members, permit workers, and non-bargaining employees are not eligible for this coverage.

The Plan will provide 50% reimbursement on eligible claims up to a calendar year maximum reimbursement of $25,000 per family for the two types of procedures combined.

Employees should obtain confirmation of coverage from the Administrator before proceeding with such procedures.

PREDETERMINATION OF BENEFITS

When dental treatment involving significant expenses is proposed for you or one of your covered dependants, it is recommended that a Predetermination of Benefits be submitted to Manulife Financial before any of the services are performed.

A Predetermination of Benefits is a plan of dental treatment (including x-rays if required) showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the dentist and the cost of the proposed treatment. After reviewing the proposed course of treatment, the Administrator will notify both you and your dentist of the estimated payment. Failure to file a Predetermination of Benefits for any course of treatment which will exceed $300 **may** result in benefit payments in a lesser amount than would otherwise have been payable, because of the difficulty of determining the necessity for the types of services involved, after they have been performed.

The submission of a Predetermination of Benefits is intended to avoid any misunderstanding as to the extent of coverage. It permits the review of the proposed treatment in advance and allows for resolution of any questions **before** rather than after the work has been done. Additionally, both you and the dentist will know in advance what is covered and payable under the plan. It is **not** intended to limit you in your choice of dentist, tell you or the dentist what treatments should be performed, or what fee should be charged.

COVERED DENTAL EXPENSES

Covered Dental Expenses included under the plan are the charges which you are required to pay for the following services and supplies, for the treatment of a non-occupational injury or disease, up to the amount specified in the 2007 Fee Guide. The Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide plus an inflationary adjustment as determined by Manulife Financial.

ROUTINE EXPENSES (PAYABLE AT 100%; 80% under Retired Members Plan)

- oral examinations, including scaling and cleaning of teeth, (limited to 10 units* of scaling per calendar year) but not more than one examination or one scaling and cleaning in any period of 12 consecutive months;

  * more than 10 units of scaling per calendar year will be considered an eligible expense provided prior approval is received from the Insurance Company.

- topical application of sodium or stannous fluoride;
- dental x-rays;
- extractions;
- oral surgery, including excision of impacted teeth;
- fillings;
- anesthetics administered in connection with oral surgery or other covered dental services;
- treatment of periodontal and other diseases of the gums and tissues of the mouth;
- endodontic treatment, including root canal therapy;
- space maintainers and pre-fabricated full coverage restorations for primary teeth;
- injections of antibiotic drugs by the attending dentist;
- repair or recementing of crowns, inlays, onlays, bridgework, or dentures, or relining of dentures;
- pit and fissure sealants on permanent teeth (for dependent children age 16 and under).

DENTURES (PAYABLE AT 80%)

(1) Initial installation of partial or full removable dentures and adjustments to such dentures but separate charges for adjustments will only be included if they are incurred more than three months after the initial installation; or the replacement or addition of teeth required to replace one or more additional teeth extracted after the existing denture was installed;

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

   (i) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture was installed and while the family member is covered; or

   (ii) the existing denture was installed at least five years prior to its replacement and that the existing denture cannot be made serviceable; or

   (iii) the existing denture is an immediate temporary denture replacing one or more natural teeth extracted while the family member is covered, and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.

CROWNS AND BRIDGEWORK (PAYABLE AT 60%)

(1) Inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments);

(2) Replacement of an existing fixed bridgework by a new bridgework, but only if evidence satisfactory to the Insurance Company is presented that

   (i) the replacement is required to replace one or more additional natural teeth extracted after the existing bridgework was installed and while the family member is covered; or

   (ii) the existing bridgework was installed at least five years prior to its replacement and that the existing bridgework cannot be made serviceable.

ORTHODONTIC EXPENSE (PAYABLE AT 50%), APPLICABLE ONLY TO ACTIVE MEMBERS PLAN AND TO DEPENDENT CHILDREN AGE 19 AND UNDER*

- the charges made for Orthodontic treatment (including the correction of malocclusion).

* Note: The dependants of Retirees are not eligible for orthodontic coverage.

OTHER PRACTITIONERS

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

- cleaning or scaling of teeth may be performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of such dentist, and

- installation, adjustments, repairs and relining of complete dentures may be made by a dental mechanic or denturist legally practicing within the scope of his license, but any charges in excess of the amount specified for such services and supplies in the dental mechanics' or denturists' tariff of the Province where such services and supplies are received will be disregarded.

Reasonable and customary charges by an anaesthetist for the administration of a general anaesthetic in connection with a covered dental procedure are covered.

NO BENEFITS ARE PAYABLE FOR:

- any dental procedure which is included under any other Medical Plan provided by any employer or government;
- prosthetic devices (including bridges and crowns), and the fitting thereof, which were ordered while the individual was not insured or was insured, but are finally installed or delivered to the individual more than 90 days after termination of insurance;
- replacement of a lost or stolen prosthetic device;
- personalization or characterization of dentures;
- services and supplies that are partially or wholly cosmetic in nature, except covered expenses necessary for the prompt repair of a non-occupational injury;
- supplies which were first prescribed or recommended prior to the date on which the individual would otherwise become insured hereunder for reimbursement in respect of such supplies;
- any hospital charges in connection with injuries or disease of a dental nature;
- charges for completion of claim forms;
- charges for nutritional counseling, for protective athletic appliance, or for oral hygiene instruction;
- charges for appointments broken without notice;
- services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.

GENERAL PROVISIONS APPLICABLE TO SUPPLEMENTARY HEALTH AND DENTAL CARE BENEFITS

COORDINATION WITH OTHER BENEFITS

If a person covered under this plan is also covered under another plan, benefits under all plans are adjusted so as to limit the combined payment to 100% of the total allowable expense.

The manner in which this is done is to determine which plan pays first (and thus determine where to submit the claim first) and which plan(s) pays next.

The plan that does not have a coordination of benefits provision pays before the plan that does (most, if not all, Insurance Company plans have such a provision).

The plan that covers the person as:

- an employee or member pays before the plan that covers such person as a dependant; or
- a dependent child of the parent, covered as an employee or member, whose birthday occurs first during the calendar year, pays first.

If both parents have their birthday on the same day, benefits under the plan will be shared in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Plan may:

- subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed, or
- pay to or recover from any other person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments will fully discharge the Plan from all liability under this plan.

Allowable expense means any necessary reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health or dental care coverage, or student accident insurance.

The exclusion of governmental benefits or services under this plan is described in the “Exclusions” section.

EXCLUSIONS

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

- Charges that would not have been made if no insurance existed or charges that neither the employee nor any of his dependants are required to pay; or

- charges for services or supplies which are furnished, paid for otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or

- charges for services or supplies which are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependants; or

- charges for services and supplies which are not necessary for treatment of the injury or sickness or are not recommended and approved by the attending physician or charges which are unreasonable; or

- charges of a physician or other person or agency in excess of the amount payable under any Provincial Health Plan are not covered except in the case of emergency treatment while travelling outside your normal province of residence; or

- charges for drugs or medicines when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under Out-of-Province.

No benefits are payable under this plan if the provision of such benefits is prohibited by law.

EXTENSION OF BENEFITS

If you or one of your insured dependants are totally disabled at the time insurance terminates, Supplementary Health Care benefits (except Dental Benefits) will be extended for the disabled individual during the uninterrupted continuance of such disability for a maximum of 12 months beyond the date on which insurance terminates, but in no event beyond the date the disabled person becomes covered under any other group-type plan providing similar benefits.

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

- an employee – is unable because of sickness or injury to engage in his regular occupation and is not working for any kind of compensation.

- a dependant – is prevented because of sickness or injury from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Dental benefits for installation or delivery of prosthetic devices (including bridges and crowns), which were ordered while the individual was insured will be extended 90 days from the date of termination of insurance.

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

CONTINUATION OF SUPPLEMENTARY HEALTH CARE AND DENTAL CARE BENEFITS FOR CERTAIN INCAPACITATED CHILDREN

If a dependent child is incapable of earning his own living because of physical or mental incapacity, and is chiefly dependant on the employee for support, and is covered under the Plan on the date such coverage would otherwise terminate because the child attained the limiting age, benefits for such a child can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. Proof of incapacity must be furnished to Manulife Financial within thirty-one days after the child has reached the limiting age, and thereafter as requested.

DEFINITIONS

HOSPITAL

To be recognized as a hospital for insurance purposes, an institution must keep patients regularly overnight, have full therapeutic facilities for the care of the injured, sick, or chronically ill and be placed under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24 hour nursing service by registered graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, rest homes and places for the aged, drug addicts or alcoholics do not qualify as hospitals.

CONVALESCENT/REHABILITATION HOSPITAL

The term "convalescent/rehabilitation hospital" means an institution (or distinct part of a hospital or other institution) which has in effect a transfer arrangement with one or more hospitals and which is regularly engaged in providing – for compensation from its patients and on an in-patient basis – skilled nursing care during the convalescent/rehabilitation stage of an injury or disease and whose charges for ward care normally are reimbursed by the provincial hospital plan, or similar legislation, of the province or territory in which the family member resides: in particular, whose charges for ward care for the particular covered family member involved are being reimbursed by the applicable hospital plan. In no event however, shall the term convalescent/rehabilitation hospital be deemed to include any institution or part thereof which is used principally as a hospital, a rest facility, a facility for the aged, a facility for the care of drug addicts, a facility for the care of pulmonary tuberculosis, a facility for the care of mental illness, a facility for the care of mental retardation, or a facility for custodial care.

PHYSICIAN

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

POLICIES

This booklet describes the principal features of the Group Insurance Plan. The complete terms of the Group Insurance coverage are set forth in Group Insurance policies issued by the Insurance Companies. These policies are the governing documents in any questions of interpretation. Detailed information about benefits or other provisions of the policies or copies of those provisions may be obtained from the Administrator.

CHANGE OR DISCONTINUANCE OF PLAN

It is hoped that this Plan will be continued indefinitely, but, as is customary in Group Insurance plans, the right of change or discontinuance at any time must be reserved.

HEALTH SPENDING ACCOUNT

From time to time, **on a completely discretionary basis**, the Board of Trustees may decide to deposit funds into the Health Spending Accounts of eligible employees. The first such deposit occurred on January 1, 2008 when eligible employees were credited with $500.

WHAT IS A HEALTH SPENDING ACCOUNT (HSA)

If you have any credits in your HSA, the credit may be used to reimburse health-related expenses not covered by the Benefit Plan provided you continue to be eligible for Benefit coverage (including through using bank hours or making self-payments).

Generally, any expense that would be considered deductible on your income tax return would be eligible for reimbursement. These could include charges such as co-payment amounts, orthodontia for adults, vision care expenses that exceed the Benefit Plan's maximum, and many other expenses.

The money credited to your HSA is not taxed either when it is deposited or when you receive your reimbursement. Reimbursements you receive from the HSA do not have to be claimed as income for income tax purposes. However, expenses which are reimbursed through the HSA also cannot be claimed as deductions on your tax return.

HOW THE HSA WORKS

When you have a health care expense, you pay the provider for the service or product -- just as you do now. Next, you submit your claim for reimbursement to any applicable insurance plan(s). Any amount that is not paid by the insurance plan(s) could then be eligible for reimbursement from the HSA. Reimbursements will be paid to you directly; they cannot be paid to providers of care.

You should note that any balance remaining in your HSA after the end of the year in which it was credited (December 31, 2011 for any amount remaining from the $500 deposit made on January 1, 2011) can be carried forward, for one year (to December 31, 2012 for balances carried from the 2011 year). In accordance with restrictions imposed by the Income Tax Act, any of these amounts that remain unused at the end of the second year (December 31, 2012) cannot be carried forward and will be forfeited at that time.

Please Note: If you lose eligibility for coverage under the Plan, any balance remaining in your HSA at that time will be permanently forfeited.

ELIGIBLE EXPENSES

Some expenses that will qualify for reimbursement from your HSA include:

- Deductibles
- Co-Payments
- Vision Care above Plan benefits
- Hearing Care above Plan benefits
- Dental expenses above Plan benefits
- Other medical and dental expenses not covered by the Plan as permitted by the Canada Revenue Agency

Expenses reimbursed may be for either you or your dependants. However, if the expense is for a dependant, he or she must be registered in the Plan for the expense to be considered eligible.

RECEIVING REIMBURSEMENT

On the claim forms that are provided for regular Benefit Plan expenses there is a box asking if you want unpaid expenses to be reimbursed from your HSA. If you do, you should tick this box. (See examples below).

All information required for a regular claim will also be required for a reimbursement from your HSA. That is, you should attach your original bill or receipt clearly indicating:

- The person receiving the service,
- The type of service or supply,
- The name and address of the person providing the service or supply,
- The amount charged and paid, and
- The date the service was provided.

Submit the claim and the supporting documentation to Manulife as you would normally. Keep a copy of everything you send for your own records.

Manulife will reimburse the expenses under the regular Benefit Plan coverage first. Any expenses not fully reimbursed will then be paid from your HSA account, up to the amount you have remaining in that account.

Example 1

> James is single and has $300 in his HSA on October 31, 2010. In November, he purchases a pair of prescription eyeglasses for $600. When he submits his claim and his receipt to Manulife, he "ticks" the box indicating that he wishes to have any portion of the claim which is not covered by the Plan to be paid from his HSA. Manulife processes the claim and determines that the Plan covers $500 of the expense. However James is eligible to be reimbursed for $600 as Manulife draws the remaining $100 from his HSA. The remaining balance in James' HSA account is $200 and he has up until December 31, 2011 to make use of this balance.

Example 2:

> Bob is married and has $250 in his HSA on December 31, 2010. Both he and his spouse have their own benefit plans. Bob's spouse has a medical condition requiring prescription drug treatments that cost $2,000 per year. After submitting their receipts to both plans, they have $250 remaining in unpaid costs (one plan covered $1,000 and the other covered $750). Bob subsequently submits another claim to Manulife and has the remaining $250 reimbursed from his HSA.

ADDITIONAL INFORMATION

If you require any assistance with the paperwork involved in applying for HSA benefits as described above, please feel free to attend the office of the Plan's Health and Welfare Administrator, and she will help you to complete it. She would also be pleased to answer any questions you may have concerning this benefit.

Throughout the year, if you want to check how much money there is remaining in your HSA, you can contact Manulife.

QUESTIONS AND ANSWERS

1. How do I become covered under the Active Members Plan?

Once hours that you have worked for a contributing employer have been reported to the Administrator and contributions have been received, an hour-bank reserve account is established for you.

A "Registration Form & Declaration of Beneficiary" must be completed immediately and returned to the Administrator. Blank Registration Forms are available at your Local Union Office or the Administrator.

2. What is the individual's Hour-Bank Reserve Account?

This is an account kept by the Administrator for each employee who works for a contributing employer. These employers report the number of hours worked by the employee and make the required contributions to the Administrator. Once this occurs, the hours are placed in the employee's reserve account.

This is similar to a bank account, with hours being deposited instead of dollars. In order to be eligible for coverage, an employee has hours deducted or withdrawn from his account.

For example: Let us have a look at the way a covered employee's account would operate, if he has 180 hours in his bank reserve account at the beginning of the month.

Month	Account Balance at Beginning of Month	Hours Credited for Month	Hours Deducted for Coverage*	Account Balance
1	180 hrs.	116 hrs.	100 hrs.	196 hrs.
2	196 hrs	185 hrs.	100 hrs.	281 hrs.
3	281 hrs.	75 hrs.	100 hrs.	256 hrs.
4	256 hrs.	Nil	100 hrs.	156 hrs.
5	156 hrs.	100 hrs.	100 hrs.	156 hrs.
6	156 hrs.	125 hrs.	100 hrs.	181 hrs.

* These are the hours worked in the two months preceding the current month. Hours are reported after the end of the month worked. (For example, hours worked in January, are reported in February and provide March eligibility)

Please note that due to employer payroll cut-off dates, there may be some monthly variances between the hours worked and the hours reported on your behalf.

3. Is a medical examination necessary to obtain initial coverage under the Plan?

No! All benefits for you and your dependants are available without any test of insurability.

However, medical evidence will be required to qualify for the payment of certain benefits, such as Critical Illness and Weekly Disability. The Fund will pay up to $150.00 for completion of the necessary medical forms.

4. When do my dependants get coverage under this plan? What benefits do they qualify for?

Your dependants become covered for Life Insurance (not applicable under the Retired Members Plan), Supplementary Health Care and Dental benefits at the same time you become eligible, or upon becoming your dependants, whichever is later. (Please refer to the Eligibility Rules for further details)

5. What happens to my coverage under the Active members Plan if I move from one Employer in the industry to another?

If you are a bargaining employee and your new Employer is required to make contributions to the Fund, your reserve account will continue to be credited with hours reported. Your benefits are portable within the industry in Alberta.

6. Once I am covered, how do I know if I have sufficient hours in my reserve account to pay for my coverage in future months?

The Administrator will have the latest hour-bank reserve account balances for each eligible employee.

NOTE: Each eligible employee is responsible for knowing what his reserve account balance is at any time.

7. Do I have to be under a Doctor's care in order to qualify for Weekly Disability benefits?

Yes! You must see a doctor as soon as possible if you have been injured or are sick enough to be unable to work. If you delay going to a doctor, your claim could be refused, reduced, or held up for further investigation.

8. Are any eligible benefits covered while traveling or vacationing outside Alberta?

Yes, coverage is provided for emergency treatment, as described in this booklet. You should have been provided with an Emergency Travel Assistance (ETA) wallet card. If you do not have a wallet card, please contact the Administrator.

The ETA card also includes phone numbers for Mondial Assistance in the event that you have an emergency medical situation. Please note the following procedures for submitting out-of-province/country emergency medical claims:

- If you incur emergency medical expenses **of $200 or less**, you are required to pay those costs yourself. Be sure to obtain detailed and itemized receipts and to keep all of the receipts. When you return to your province of residence, you will need to submit a claim to your Provincial Health Care Plan. (Be sure to keep a copy of your claim and of your receipts.) Once you have received payment from your Provincial Plan, you can submit any unpaid amounts to Manulife Financial for reimbursement. You must submit a copy of the Provincial Plan's payment details, and a copy of the receipts, with your claim to Manulife Financial.

- If you have a medical emergency that entails larger expenses, it may be possible for Mondial Assistance to guarantee payment to the medical facility so that you do not have to pay these expenses and then seek reimbursement. You can find this out by calling the Mondial Assistance toll free number when you have a medical emergency and provide them with details of your circumstances. (If you **do not** contact Mondial Assistance you will have to follow the same procedures as for claims under $200.)

It is recommended that you obtain additional medical insurance if you travel outside Canada.

CLAIM PROVISIONS

(SUBJECT TO ELIGIBILITY)

HOW TO CLAIM

Claim forms are available from the Local Union Office. To substantiate your claim, be sure to complete all forms fully and to attach original bills where applicable.

Health and Dental claims should be submitted to:

Manulife Financial
Group Operations – Health and Dental Claims
P.O. Box 2592, Station M
Calgary, Alberta T2P 5P4
Toll Free: 1-800-465-2071

Life and Critical Illness claims should be submitted to:

Manulife Financial
Group Operations – Life and Disability Claims
P.O. Box 1030
Halifax, Nova Scotia B3J 2X5
Toll Free: 1-866-447-4517

Weekly Disability claims should be submitted to:

Manulife Financial
Disability Benefits
P.O. Box 4217, Station C
Calgary, Alberta T2T 5N1
Toll Free: 1-800-561-1400

Accidental Death and Dismemberment Claims should be submitted to:

Industrial Alliance Pacific Life Insurance Company
Suite 2050, 777 – 8th Avenue, SW
Calgary, Alberta T2P 3R5
Telephone: (403) 266 – 7582

NOTE: Be sure that you indicate your Identification Number, Group Policy Number and complete name and address on all correspondence sent to the Insurance Companies.

The Group Policy Numbers are:

Life Insurance Benefit	30543
Accidental Death & Dismemberment Benefit	119 – 3394
Critical Illness Benefit	6091
Dental Implants and Over-Dentures	80147
All Other Benefits	80147

Please note that all Insurance Companies will investigate any and all claims to prevent fraud against the Plan. The Board of Trustees and the Administrator fully support the Insurance Companies and will assist them in this regard.

SECONDARY PAYER CLAIMS-SUPPLEMENTARY HEALTH, VISION, DENTAL

If you are applying for reimbursement of expenses for which this Plan is the secondary payer (see "Coordination with Other Benefits" in the General Provisions section of this booklet), you must submit those expenses to your Spouse's plan first. Keep a photocopy of each receipt and ask your Spouse's plan to return the original receipts to you once your claim has been settled. You should also receive an explanation outlining how the initial payment was calculated. Submit this explanation along with all necessary claim forms and receipts to Manulife Financial for payment of the balance of the allowable expenses.

PROOF 0F LOSS

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

- 24 months after the date of death under the Death Provision for Life Insurance Benefits;
- 12 months after the last date you were actively at work (regardless of the date you became disabled) under the Disability Provision for Life Insurance Benefits;
- 90 days after the date of the loss for Accidental Death and Dismemberment Benefits (or within 12 months if it was not reasonably possible to submit within 90 days);
- 6 months after the start of Disability for the Member Weekly Disability Benefit;
- 90 days of the date of diagnosis of the Critical Illness;
- 18 months after the date the expense was incurred, but not more than 6 months after the date coverage terminates, for Supplementary Health Care, Vision Care, and Dental Care Benefits.

Manulife Financial shall have the right and opportunity to examine any one person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pending period and payment period, if any, of such claim.

APPEALS POLICY

The Board of Trustees is committed to treating the employees, their families, dependants, and beneficiaries of the Fund with respect and consideration. Nevertheless, situations may arise where you feel that you have not been treated fairly. It is important that these matters are resolved in a timely and effective manner.

If you feel a claim has been improperly denied or adjudicated, the general process to resolve the matter is as follows:

Firstly, for all benefits other than the Accidental Death and Dismemberment Benefit you should contact the Claims Department of Manulife Financial as soon as you receive your denial and or explanation of benefits payment. The Claims Department will address the complaint according to the policies and procedures of Manulife Financial. In most circumstances this will resolve the situation properly and promptly.

- With respect to Supplementary Health Care and Dental Care Benefits please contact the Claims Department no later than 6 months from the date of denial or adjudication of your claim. You may be required to submit medical or other supportive documentation to support your appeal. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

- With respect to all other benefits, you must submit a written notice of appeal, outlining the reasons for your disagreement. This notice must be submitted to Manulife Financial within 60 days of the date of the denial/termination notice and be accompanied by additional evidence to support your position. Medical or other supportive documentation must be submitted to Manulife Financial no later than 6 months from the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

- If you are of the opinion that the Claims Department of Manulife Financial has not satisfactorily dealt with the situation, you may bring the matter to the attention of the Administrator. **<u>This appeal should be in writing</u>** and include any relevant information regarding the claim (e.g. prescription receipts, note(s) from your doctor, evidence of extenuating circumstances). The Administrator will review the appeal in accordance with the provisions of the Plan and determine if further discussion with Manulife Financial is warranted.

- As a final step, you may contact the Board of Trustees in writing and describe: the details of the decision you are appealing, the grounds for the appeal, the relevant information in support of the appeal and the decision you are seeking. You must also provide your consent for the Board of Trustees to discuss the matter with the Administrator. The Board of Trustees expects that contact with them should be made within 12 months of the time that the Claims Department has advised you of its decision. The Board of Trustees will then discuss the matter with the Administrator to ensure that all relevant information has been considered and determine if further discussion with Manulife Financial is warranted.

Please also be aware of the following:

- Contacting the Board of Trustees to intervene on your behalf is the final step in the appeals process, other than you initiating legal action to recover benefits. Any expenses incurred in connection with obtaining and securing legal counsel would be your responsibility.

- Under the Group Insurance Policy, there are time limitations on when a legal action must be commenced by a claimant, if the claim has been denied. Please remember to consult a lawyer about those time limitations. Those time limitations are not extended because you are waiting for a decision from the Manulife Financial Claims Department or from the Board of Trustees.

THE ABOVE IS A SUMMARY OF THE APPEALS POLICY OF THE FUND. A COMPLETE COPY OF THE APPEALS POLICY MAY BE OBTAINED FROM THE ADMINISTRATOR.