National Steel Car Limited

Divisional Description: Active Hourly Employees

Group Contract Numbers: GL 39817, ASO 84217 and ASO 84218

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefits Program

Group Division Effective Date: July 1, 2003

As a valued employee, you are entitled to the medical and financial security of your Group Benefit Program, provided by National Steel Car Limited in partnership with Manulife Financial.

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but also for the security they provide for you and your family, especially in case of unforeseen needs.

Your Plan Administrator can answer any questions you may have about your benefits, or how to submit a claim.

Schedule of Benefits

Schedule of Benefits

Employee Life Insurance

The Benefit

Employee Life Insurance - The Benefit

Benefit Amount - $29,000

Termination Age - At retirement, life insurance will terminate and you will have the option of a Paid Up Life Insurance policy.

Waiting period - The period before the date seniority is attained, as written in the Collective Agreement.

Qualifying Period for Waiver of Premium - 6 months

Extended Health Care

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Expenses are subject to an overall maximum of $10,000 per person per calendar year.

Deductible - Expenses incurred in Canada: $25 per person or $50 per family. Each family member may contribute any amount, not to exceed $25, toward the family maximum. Such deductible does not apply to Drug expenses.

Benefit Percentage (Co-insurance) - 100% for Drug expenses and 90% for all other expenses.

Termination Age - none

Waiting Period - The period before the date seniority is attained, as written in the Collective Agreement.

Vision Care - $200 per person every 24 months

Dental Care

The Benefit

Dental Care - The Benefit

Dental Fee Guide - General Practitioners Dental Fee Guide in effect one year prior to the date the claim is incurred in the province of treatment

Benefit Percentage (Co-insurance)

100% for Basic Services

Benefit Maximum - Unlimited

Termination Age - retirement

Waiting Period - The period before the date seniority is attained as written in the Collective Agreement.

Schedule of Benefits

Short Term Disability

The Benefit

STD - The Benefit

Benefit Amount - $486 per week

Qualifying Period - Benefits begin on the first regularly scheduled working day if the disability is due to an accident and on the sixth regularly scheduled working day, if the disability is due to a sickness.

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

Maximum Benefit Period - 52 weeks

Termination Age - The first day of the month coincident with or immediately following retirement

Waiting Period - The period before the date seniority is attained, as written in the Collective Agreement

Benefits Insured by ACE-INA Insurance - Basic Accident Insurance Plan

The Benefit

Basic Accident Insurance Plan - The Benefit

This coverage is insured by ACE-INA Insurance. You are eligible for a flat amount of insurance equivalent to your basic life benefit.

For a further description of the AD&D coverage, please see your Plan Administrator.

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

This booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

a detailed Table of Contents, allowing quick access to the information you are searching for,

an Explanation of Common Insurance Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,

a clear, concise explanation of your Group Benefits, and

information you need, and simple instructions, on how to submit a claim.

Important Note

Important Note

Your Extended Health Care, Dental and Short Term Disability Benefits are provided directly by National Steel Car Limited. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of National Steel Car Limited. The information in this booklet is a summary of the provisions of the Group Contract. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of National Steel Car Limited and Manulife Financial are governed by the paper version of the Group Contract (available from your Plan Administrator). In the event of a discrepancy between this booklet (paper or electronic version) and the Group Contract, the terms of the Group Contract will apply. No alteration of this booklet is permitted by any person, except by an authorized representative of Manulife Financial.

Possession of this booklet alone does not mean that you or your dependent(s) are covered. The Group Contract must be in effect and you must satisfy all the requirements of the Contract.

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

Explanation of Common Insurance Terms

Accident

Accident an unexpected or unforeseen happening or event involving an external force, causing loss or injury.

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance) the percentage of Covered Expenses which is payable by Manulife Financial.

Child(ren)

Child(ren) your natural or adopted child, or stepchild who is:

- unmarried;
- under age 19, or is a full-time student under age 24;
- not employed on a full-time basis; and
- not eligible for insurance as an employee under this or any other Group Benefit Program.

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

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

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

a stepchild must be living with you to be eligible.

a newborn child shall become eligible from the moment of birth.

Covered Expenses

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

Deductible

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

Dependent

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

Drug

Drug medications that have been approved for use by the Federal Government of Canada and have a Drug Identification Number.

Explanation of Common Insurance Terms

Experimental or Investigational

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Immediate family member

Immediate family member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Licensed, Certified, Registered

Licensed, Certified, Registered

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

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Life-Sustaining Drugs

Medically necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Medically necessary

Provincial Plan

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

Provincial Plan

Qualifying Period

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

Qualifying Period

Reasonable and Customary

Reasonable and Customary

within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

Spouse

Totally disabled

except for Short Term Disability, you are unable to work and earn an income due to sickness or bodily injury that leaves you wholly and continuously disabled.

Totally disabled

Explanation of Common Insurance Terms

Waiting Period

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

Ward

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

Why Group Benefits?

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by National Steel Car Limited, in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

Your Plan Administrator

Your Plan Administrator is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by submitting all required premiums, reporting all new enrolments, terminations, changes etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your Plan Administrator with the necessary information to perform such duties.

Your Plan Administrator is _____

Phone Number: (_____) _____- _____

Please record the name of your Plan Administrator and contact number in the space provided.

Applying for Group Benefits

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Reinstatement Application Form, available from your Plan Administrator.

Making Changes

Making Changes

To ensure that coverage is kept up-to-date for yourself and your dependents, it is vital that you report any changes to your Plan Administrator. Such changes could include:

- change in Dependent Coverage
- change of Beneficiary
- change in Name
- applying for coverage previously waived

To make such changes, you must complete the Application for Change Form, available from your Plan Administrator.

The Claims Process

How to Submit a Claim

How to Submit a Claim

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed. Remember, always provide your Group Contract Number and your Certificate Number to avoid any unnecessary delays in the processing of your claim.

Your Plan Administrator can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefits Program.

Payment of Extended Health Care and Dental Claims

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your Plan Administrator will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact your Plan Administrator.

Co-ordination of Extended Health Care and Dental Benefits

Co-ordination of Extended Health Care and Dental Benefits

If you or your dependents are covered for similar benefits under another Plan, Manulife Financial will take this into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

other Group Benefit Programs;

any other arrangement of coverage for individuals in a group; and

individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expense).

If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.

If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

– For Claims incurred by you or your Dependent Spouse:
  The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent. In situations where you or your Dependent Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

  ° The Plan where the person is covered as an active full-time employee, then

  ° The Plan where the person is covered as an active part-time employee, then

  ° The Plan where the person is covered as a retiree.

– For Claims incurred by your Dependent Child:
  The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
  However, if you and your Spouse are separated or divorced, the following order applies:

  ° The Plan of the parent with custody of the child, then

  ° The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then

  ° The Plan of the parent not having custody of the child, then

  ° The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

A claim for accidental injury to natural teeth will be determined under health care plans with accidental dental coverage before it is considered under dental Plans.

If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

If the covered person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

Submit all necessary claim forms and original receipts to the Primary Carrier.

Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you:

are a full-time employee and work at least the required number of hours,

are residing in Canada,

are younger than the Termination Age, and

have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please see the section entitled Your Group Benefits.

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

Required Number of Hours

Required Number of Hours

25 hours per week

Evidence of Good Health

Evidence of Good Health

Medical evidence is required for all benefits, except Dental insurance, when you make a Late Application for insurance on any person.

Medical evidence can be submitted by completing the Evidence of Good Health Formavailable from your Plan Administrator. Further medical evidence may be requestede Financial.

Late Application

Late Application

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

apply for insurance more than 31 days after the date benefits terminated under your spouse's plan; or

apply for insurance and benefits under your spouse's plan have not terminated.

Late Dental Application

Late Dental Application

If you apply for coverage for Dental insurance for yourself or your dependents late, insurance will be limited to $125 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

Effective Date of Coverage

If Evidence of good health is not required, your Group Benefits will be effective on the date you are eligible.

Who Qualifies for Coverage?

If Evidence of good health is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

For all benefits except dental: You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

Your dependent's insurance becomes effective on the date the dependent becomes eligible, or the date any required evidence of good health on the dependent is approved by Manulife Financial, whichever is later.

If one of your dependents (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital.

Your dependent's insurance will not be effective prior to the date your insurance becomes effective.

Termination of Insurance

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

the date you cease to be an eligible employee,

the date you enter the armed forces of any country on a full-time basis,

the date the Group Contract terminates,

the date you reach the Termination Age,

the date any required contribution is due but not paid,

the date any work stoppage begins, if you are on strike, or

the date you retire. However, coverage may continue under the retiree plan.

Your dependent's insurance terminates on the date your insurance terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Continuation of Coverage

Continuation of Coverage

If you are on lay-off, full coverage will continue until the end of the month following the month the lay-off began. If lay-off continues beyond this period, your employer will pay for $3,000 life insurance to a maximum of 12 additional months. You may choose the full amount of life insurance, provided you pay the required contribution on the remaining insurance up to a maximum of 12 additional months.

If you are absent due to suspension or an approved leave of absence, coverage shall continue until the end of the month following the month the suspension or leave of absence began, provided the required contributions are paid. You can choose to continue insurance coverage at your own expense for a maximum of one year.

Employee Life Insurance

Employee Life Insurance

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

The Benefit

Employee Life Insurance - The Benefit

Benefit Amount - $29,000

Termination Age - At retirement, life insurance will terminate and you will have the option of a Paid Up Life Insurance policy.

Waiting Period- The period before the date seniority is attained, as written in the Collective Agreement.

Qualifying Period for Waiver of Premium - 6 months

Submitting a Claim

Employee Life Insurance - Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim Form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form should be submitted as soon as reasonably possible.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

Waiver of Premium

Employee Life Insurance - Waiver of Premium

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

Definition of Total and Permanent Disability

Employee Life Insurance - Definition of Total and Permanent Disability

Total and Permanent Disability means any such disability due to bodily injury, illness or disease through unavoidable cause which:

prevents you from engaging in any occupation or employment whatsoever for remuneration or profit;

commenced on a date specified; and

will be permanent and continuous during the remainder of your lifetime.

Such disability shall be considered as created through unavoidable cause unless it:

was contracted, suffered or incurred while you were engaged in, or resulted from having been engaged in, a criminal enterprise, or

results from injuries willfully self-inflicted.

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

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

Entitlement Criteria

Employee Life Insurance - Entitlement Criteria

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

you must be continuously Totally and Permanently Disabled throughout the Qualifying Period. If you cease to be Totally and Permanently Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally and Permanently Disabled.

Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from engaging in any occupation or employment whatsoever for remuneration or profit.

you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial.

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

Termination of Waiver of Premium

Employee Life Insurance - Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

the date you cease to be Totally and Permanently Disabled, as defined under this benefit.

the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from engaging in any occupation or employment whatsoever for remuneration or profit.

the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial.

the date you do not attend an examination by an examiner selected by Manulife Financial.

the date of your 65th birthday.

the date of your death.

Installment Disability Benefit

Employee Life Insurance - Installment Disability Benefit

If you become Permanently and Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria specified for Waiver of Premium, 50% of your Life Insurance will be paid to you in a lump sum or in 60 monthly installments as long as you remain disabled. Installments will cease when you reach age 65 or return to work, whichever is earlier. You will then be insured for the difference between the original amount of insurance and the total installments paid.

In event of your death prior to the payment of the last installment, the amount of life insurance benefit will be equal to your amount of Basic Life Insurance less the total amount of the installments paid under this provision.

The portion of your Life Insurance not eligible to be paid in installments will be subject to a Waiver of Premium.

Recurrent Disability

Employee Life Insurance - Recurrent Disability

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

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

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

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

Conversion Privilege

Employee Life Insurance - Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee 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.

Extended Health Care (EHC)

Extended Health Care (EHC)

If you or one of your dependents incurs charges for any of the Covered expenses specified, your Extended Health Care benefit can provide financial assistance.

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

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

The Benefit

EHC - The Benefit

Overall Benefit Maximum - Expenses are subject to an overall maximum of $10,000 per person per calendar year.

Deductible

Expenses incurred in Canada: $25 per person or $50 per family. Each family member may contribute any amount, not to exceed $25, toward the family maximum. Such deductible does not apply to Drug expenses.

Benefit Percentage (Co-insurance) - 100% for Drug expenses and 90% for all other expenses.

Termination Age - none

Waiting Period - The period before the date seniority is attained, as written in the Collective Agreement.

Covered expenses

EHC - Covered 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 sickness or injury and recommended by a physician (except for paramedical practitioners' expenses under Professional Services)

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

Advance Supply Limitation

EHC - Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time, except for covered drug expenses.

Drug Expenses

The maximum quantity of drugs or medicines that will be payable for each prescription will be limited to the lesser of:

the quantity prescribed by your physician or dentist, or

a 34 day supply.

A quantity of up to a 100 day supply may be payable for long term therapy cases, where the larger quantity is recommended as appropriate by your physician or pharmacist.

Manuscript Prescription Drugs

EHC - Manuscript Prescription Drugs

Drugs or medicines dispensed by a licensed pharmacist, and which by law or convention require a written prescription of a physician or dentist.

Fertility drugs.

Oral contraceptives and intrauterine devices.

Norplant.

Injectable medications.

Life-sustaining drugs.

Non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment).

Preventive vaccines and medicines (oral or injected).

Charges for the following expenses are not covered:

The administration of serums, vaccines, or injectable drugs.

Drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home.

Drugs used in the treatment of a sexual dysfunction.

Vitamins, vitamin supplements, dietary supplements or diet foods.

Food and food products, including infant formula, infant foods, salt and sugar substitutes.

General products or any other product which can be sold at any retail outlet including, but not limited to, such items as contact lens care, skin protectors, emollients and soaps.

Any single purchase of drugs which would not be reasonably used within 90 days from date of purchase.

Drug Maximum

EHC - Drug Maximum

Anti-smoking drugs (legally requiring a prescription) - $500 per lifetime

All other covered drug expenses - Unlimited

Payment of Covered Expenses

EHC - Payment of Covered Expenses

Payment of your covered drug expenses will be subject to the Co-insurance as specified above.

Payment of Drug Claims

EHC - Payment of Drug Claims

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

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

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

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

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

you cannot locate a participating Pay Direct Drug pharmacy,

you do not have your Pay Direct Drug Card with you at that time, or

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

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

Hospital Care

EHC - Hospital Care

Charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:

- the person was confined to hospital on an in-patient basis, and
- the accommodation was specifically elected in writing by the patient

Charges, up to a maximum of $5 per day, in excess of semi-private accommodation for private accommodation.

Charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered.

Vision Care

EHC - Vision Care

eye exams, once per calendar year

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses

visual training, to a lifetime maximum of $200 per person

Benefit Amount - $200 per person every 24 months

Professional Services

EHC - Professional Services

Services provided by the following licensed practitioners:

- chiropractor and osteopath: to a maximum of 10 treatments per calendar year, more if recommended by a physician, after the provincial maximum has been attained.
- psychologist, to a maximum of $250 per calendar year
- the services of a physiotherapist, subject to reasonable and customary charges.

Recommendation by a physician for Professional Services is not required.

Medical Supplies and Services

EHC - Medical Supplies and Services

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Private Duty Nursing

EHC - Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

a registered nurse, or

a registered nursing assistant (or equivalent designation) who has completed an approved medications training program

Charges for the following services are not covered:

service provided primarily for custodial care, homemaking duties, or supervision

service performed by a nursing practitioner who is an immediate family member or who lives with the patient

service performed while the patient is confined in a hospital, nursing home, or similar institution

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

Pre-Determination of Benefits

Manulife Financial suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing services begin. Manulife Financial will then advise you of any benefit that will be provided.

Ambulance

EHC - Ambulance

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

Medical Equipment

EHC - Medical Equipment

Rental, or, when approved by Manulife Financial's, purchase of:

- Mobility Equipment: crutches, canes, walkers and wheelchairs
- Durable Medical Equipment: manual hospital beds, respirator and oxygen equipment and other durable equipment usually found only in hospitals.

Non-Dental Prostheses and Supports

EHC - Non-Dental Prostheses and Supports

External prostheses.

Surgical bras, up to a maximum of 2 pairs per person per calendar year.

Surgical stockings, up to a maximum of 2 pairs per person per calendar year.

Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints.

Casted, custom-made orthotics, 1 pair per 12 months, up to a maximum of $500 for dependent children and 1 pair per 24 months, up to a maximum of $500 for all other persons (recommendation of a physician, chiropodist or podiatrist is required).

Custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of $150 per calendar year (must be prescribed by a podiatrist, chiropodist or physician and constructed by a certified orthopaedic footwear specialist)

Other Supplies and Services

EHC - Other Supplies and Services

Ileostomy and colostomy supplies

Medicated dressings and burn garments

Wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of one per lifetime

OBUS form back support, up to a maximum of one per lifetime, when recommended by the written prescription of a physician

Oxygen

Microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec

Laboratory tests and x-rays, subject to a maximum of $500 per person per calendar year

Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result.

Prostate Specific Antigen (PSA) tests

Devices used for Sleep Apnea

Submitting a Claim

EHC - Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim FormClaim forms are available from your Plan Administrator.

All applicable receipts must be attached to the completed claim form when submitting it.

All claims must be submitted within 18 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Subrogation (Third Party Liability)

EHC - Subrogation (Third Party Liability)

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

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

Exclusions

EHC - Exclusions

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

Self-inflicted injuries.

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

Committing or attempting to commit an assault or criminal offence.

Injuries sustained while operating a motor vehicle while under the influence of any intoxicant including, but not limited to, alcohol.

An illness or injury for which the person is entitled to benefits under any workers' compensation act.

Charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms.

Services or supplies provided by an employer's medical or dental department.

Services or supplies for which no charge would normally be made in the absence of group benefit coverage.

Services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage.

Services or supplies which are not permitted by law to be paid.

Services or supplies which are required for recreation or sports.

Services or supplies which would have been payable by the Provincial Plan if proper application had been made.

Medical treatment which is not usual or customary, or is experimental or investigational in nature.

Medical or surgical care which is cosmetic.

Services or supplies which are:

- performed or provided by the covered person, an immediate family member or a person who lives with the covered person.
- services or supplies which are provided while confined in a hospital on an in-patient basis.
- services or supplies which are not specified as a covered expense under this benefit.

Prior to April 6, 2004, Vision Care.

Continuation of Coverage

EHC - Continuation of Coverage

If a person is disabled when insurance under the Extended Health Care benefit terminates, covered expenses related to treatment of the disability will continue to be payable by Manulife Financial, for up to 90 days. However, coverage will terminate if you become eligible for insurance under another group plan.

You will be considered disabled if you are eligible for disability benefits under any other provision of this Group Benefit Program.

Your dependent will be considered if he or she is receiving medical treatment from a physician and confined to a hospital or to his or her home.

Dental Care

Dental Care

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

The Benefit

Dental Care - The Benefit

Deductible - nil

Dental Fee Guide - General Practitioners Dental Fee Guide in effect one year prior to the date the claim is incurred in the province of treatment

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

Benefit Maximums - unlimited

Termination Age - retirement

Waiting Period - the period before the date seniority is attained as written in the Collective Agreement.

Covered expenses

Dental Care - Covered expenses

Covered expenses are those which are recommended as necessary by a physician or dentist and are not in excess of the Dental Fee Guide.

Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of his license.

There are several dental procedures which are covered by Provincial Health Plans up to certain maximums. If the dentist or dental surgeon chooses to charge more than the amount payable by the Provincial Plan, legislation in some provinces does not permit the excess charges to be eligible under this Plan.

Level I - Basic Services

Dental Care - Level I - Basic Services

The following services will be eligible for payment once every 6 months:

- Recall oral examinations.
- One unit of scaling and one unit of polishing.
- Topical fluoride treatment.
- Bite-wing x-rays.

Complete oral examinations, one every 2 calendar years.

Full mouth series of x-rays, one every 2 calendar years.

Routine diagnostic and laboratory procedures.

Initial oral hygiene instruction, plus one recall.

Fillings and retentive pins. Replacement fillings are covered provided:

– the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or

– the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam.

Pre-fabricated full coverage restorations (metal and plastic).

Passive space maintainers for dependent children only (appliances placed for orthodontic purposes are not covered).

Minor surgical procedures and post surgical care.

Extractions (including impacted and residual roots).

Consultations, anaesthesia and conscious sedation.

Injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery.

Level II - Supplementary Services

Dental Care - Level II - Supplementary Services

Surgical procedures not included in Level I (excluding implant surgery).

Periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

– scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year;

– provisional splinting; and

– occlusal equilibration, up to a maximum of 8 units per calendar year.

Endodontic services which include root canals and therapy, root amputation, apexifications and periapical services

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

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

Alternate Treatment

Dental Care - Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, Manulife Financial will pay benefits as if the least expensive course of treatment were used. Manulife Financial will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Late Entrant Limitation

Dental Care - Late Entrant Limitation

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

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim Form which is available from your Plan Administrator.

You have options on how to submit your dental claims as follows:

1. Submit the claim to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it.
2. When a dental expense is incurred and your dental office is equipped with EDI computer capability, your dental expenses can be electronically transmitted for consideration of payment.

All claims must be submitted within 18 months after the date the expense was incurred. However, upon termination of your insurance for any reason, all claims must be submitted no later than 90 days from the termination date.

Exclusions

Dental Care - Exclusions

No payment will be made for expenses resulting from:

Self-inflicted injuries.

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

The committing of or attempt to commit an assault or criminal offence.

Injuries sustained while operating a motor vehicle while under the influence of any intoxicant including, but not limited to, alcohol.

Dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit.

Anti-snoring or sleep apnea devices.

Broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms.

Services which are payable by any government plan.

Services or supplies provided by an employer's medical or dental department.

Services or supplies for which no charge would normally be made in the absence of group benefit coverage.

Treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction.

Replacement of removable dental appliances which have been lost, mislaid or stolen.

Laboratory fees which exceed reasonable and customary charges.

Services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person.

Implants, or any services rendered in conjunction with implants.

Treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.

Services or supplies which are not specified as a covered expense under this benefit.

Survivor Extended Benefit

Survivor Extended Benefit

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

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

the date similar coverage is obtained elsewhere,

the date which is 31 days from your death, or

the date the Plan Document terminates.

Short Term Disability (STD)

Short Term Disability (STD)

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

Definition of Totally Disabled

STD - Definition of Totally Disabled

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

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

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

The Benefit

STD - The Benefit

Benefit Amount - $486 per week combined with Employment Insurance benefits

Qualifying Period - Benefits begin on the first regularly scheduled working day if the disability is due to an accident and on the sixth regularly scheduled working day, if the disability is due to a sickness.

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

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

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

Maximum Benefit Period - During any one period of disability, your benefits will continue until you recover or have received a maximum of 52 weeks in benefits, whichever is earlier.

Termination Age - retirement

Waiting Period - the period before the date seniority is attained, as written in the Collective Agreement

Entitlement Criteria

STD - Entitlement Criteria

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

you must be continuously Totally Disabled throughout the Qualifying Period

your employer or Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation.

you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by your employer or Manulife Financial.

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

Periods for Which You are Not Entitled to Benefits

STD - Periods for Which You are Not Entitled to Benefits

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

not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by your employer or Manulife Financial

receiving Employment Insurance, maternity or parental benefits, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law

on lay-off during which you become Totally Disabled

on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law

receiving benefits under an employer-sponsored salary continuance or wage loss replacement plan, or receiving temporary disability benefits from Workers' Compensation

receiving earnings or payments from any employer, including severance payments and vacation pay

incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Amount of Disability Benefits Payable

STD - Amount of Disability Benefits Payable

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

Canada or Quebec Pension Plans, including dependent benefits

any government motor vehicle automobile insurance plan or policy which is considered an allowable exclusion under the Employment Insurance Premium Reduction Regulations, unless prohibited by law

Subrogation

STD - Subrogation

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

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

Tax Status of Benefits

STD - Tax Status of Benefits

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

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

Payment of Disability Benefits

STD - Payment of Disability Benefits

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

Termination of Benefits

STD - Termination of Benefits

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you work in any occupation for wage or profit
- the date you do not supply your employer or Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation
- the date you do not attend an examination by an examiner selected by your employer or Manulife Financial
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit
- the date you retire
- the date of your death

Recurrent Disabilities

STD - Recurrent Disabilities

If you become Totally Disabled again from the same or related causes within 3 months from the end of the period for which STD benefits were paid, the disability will be treated as a continuation of your previous disability.

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

If the same disability recurs more than 3 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

Submitting a Claim

STD - Submitting a Claim

To submit a claim, you must complete the Weekly Income Claim FormNwhich is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Manulife Financial within 180 days from the end of the Qualifying Period.

Exclusions

STD - Exclusions

No benefits are payable for any disability related to:

any illness or injury which arises out of or in the course of employment, unless Workers' Compensation denies your claim because your disability is not recognized as resulting from employment

self-inflicted injuries or illnesses

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

medical or surgical care which is not medically necessary

the committing of or the attempt to commit an assault or criminal offence

injuries sustained while operating a motor vehicle while under the influence of any intoxicant including, but not limited to, alcohol

abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in a medical treatment program for substance abuse which has been approved by your employer or Manulife Financial or you have an organic disease which would cause total disability even if drug and alcohol abuse ended