Plan Document - Appendix A

Employer: ***FortisBC Energy Inc.***

Plan Number: ***G0086264A***

Plan Effective Date: ***October 1, 2011***

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The Extended Health Care and Dental Care Benefits are being provided directly by FortisBC Energy Inc. which has contracted with the Employer or the Administrator to adjudicate and administer the claims for these benefits following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this Plan Document and the Employer's Benefit Plan.

This Plan Document produced April 24, 2012.

2 Group Benefits Schedule

Employer: FortisBC Energy Inc.

Plan Number: G0086264A

Plan Effective Date: October 1, 2011

Class Number(s)

024 Customer Service COPE employees (Plan F)

503 Customer Service C.O.P.E Employees (FortisBC Electric) (Plan F)

Plan Number(s)

F Customer Service COPE employees

Effective Date for Increases in Plan Benefits

When first eligible for the increase

Associated Companies

FortisBC Energy Inc.

FortisBC Energy (Vancouver Island) Inc.

FortisBC Energy (Whistler) Inc.

FortisBC Holdings Inc.

FortisBC Inc.

4 Group Benefits Schedule – Plan F

Extended Health Care

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under this Plan Document to covered persons who reside in Quebec will be administered as outlined in the Plan Document Addendum - Drug Benefit For Covered Persons Who Reside In Quebec.

Classifications Eligible for Plan Benefits

Employees in Plan F

Dependents of Employees in Plan F are also covered for this Benefit.

Overall Plan Maximum

$500,000 per lifetime

Deductible

Nil

Drug Dispensing Fee Maximum

Not applicable

Benefit Percentage (Co-insurance)

80% for

- Hospital Care
- Drugs
- Vision Care
- Professional Services
- Medical Services and Supplies
- Out-of-Province Emergency Medical Treatment

Termination Age

Employee’s retirement

Survivor Extended Benefit

subject to the Employee's Termination Age for the Extended Health Care Benefit

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Plan Document Effective Date

first of the month following 3 months of continuous service

For Employees hired after the Plan Document Effective Date

first of the month following 3 months of continuous service

Covered Expenses and Maximums (per covered person)

The maximums shown below for Covered Expenses are subject to the Overall Plan Maximum.

Hospital

Semi-Private: Unlimited

Chronic Care

Semi-Private: Unlimited

Provincial Drug Plan 1

Prescription Drugs:

All Covered Drug Expenses: $1,500 per calendar year

Professional Services

Chiropractor: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Podiatrist/Chiropodist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Massage Therapist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Naturopath: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Osteopath: Not covered

Speech Therapist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Physiotherapist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Psychologist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Acupuncturist: $400 per calendar year combined for services of a chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, psychologist and acupuncturist. Charges for x-rays, appliance and tray fees are not eligible.

Dietician: Not covered

Vision Care

Prescription Glasses or Elective Contact Lenses: $150 per 24 months

Contact Lenses (where medically necessary): Not covered

Medical Services and Supplies

Private Duty Nursing: $2,000 per calendar year

Orthopaedic Shoes: $1,000 per calendar year combined for orthopaedic shoes, custom-made orthotics, hearing aids and wigs and hairpieces

Custom-Made Orthotics: $1,000 per calendar year combined for orthopaedic shoes, custom-made orthotics, hearing aids and wigs and hairpieces

Out-of-Province Maximum: Included in Overall Benefit Maximum

Hearing Aids: $1,000 per calendar year combined for orthopaedic shoes, custom-made orthotics, hearing aids and wigs and hairpieces

Surgical Stockings: Not covered

Surgical Brassieres: $150 per calendar year

Wigs and Hairpieces: $1,000 per calendar year combined for orthopaedic shoes, custom-made orthotics, hearing aids and wigs and hairpieces

All other Medical Services and Supplies: Unlimited

Dental Care

Classifications Eligible for Plan Benefits

Employees in Plan F

Dependents of Employees in Plan F are also covered for this Benefit.

Deductible

Nil

Benefit Percentage (Co-insurance)

90% for Basic Services - Level I

90% for Supplementary Basic Services - Level II

60% for Dentures - Level III

60% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Maximums

$2,500 per calendar year combined for Level I, Level II, Level III and Level IV

$3,000 per lifetime for Level V

Dental Fee Guide

Current Fee Guide for General Practitioners approved by the Provincial Dental Association in the Province where the Employee resides

If the Employee resides in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by the Administrator.

Termination Age

Employee’s retirement

Survivor Extended Benefit

subject to the Employee's Termination Age for the Dental Care Benefit

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Plan Document Effective Date

first of the month following 3 months of continuous service

For Employees hired after the Plan Document Effective Date

first of the month following 3 months of continuous service

8 Definitions

Actively at Work

at work for the Employer or any Associated Company shown in the Benefit Schedule on a Full-time basis at the Employee's usual place of work.

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Administrator

the organization which the Employer may from time to time appoint for purposes of performing services for the Plan.

Annual Enrolment Date

the date every year on which the Employee is permitted to make changes to his flexible benefits coverage.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the Employer.

British Columbia Drug Benefit Formulary (Formulary)

a listing of all drug products which qualify for payment under the British Columbia Drug Benefit Program.

The Formulary, compiled and maintained by the British Columbia Ministry of Health, includes all drug products eligible for reimbursement, available strengths and dosage forms, the drug identification numbers, and the cost for each product.

British Columbia Drug Benefit List of Non-Formulary Benefits

a listing compiled by the British Columbia Ministry of Health of drug products which are eligible for reimbursement under the British Columbia Drug Benefit Program when prescribed for the conditions or circumstances specified by the British Columbia Ministry of Health.

British Columbia Drug Benefit Program

a British Columbia government prescription drug program which provides essential prescription drug products and non-prescription drug products to British Columbia residents who meet the program's eligibility requirements, as specified by the British Columbia Ministry of Health.

Change in Life Event

a Change in Life Event occurs when:

a) an Employee acquires a Dependent;

b) an Employee has a change in marital status;

c) an Employee's Spouse's coverage ceases;

d) any Dependent ceases to qualify as a Dependent; or

e) any Dependent dies.

Chronic Care Facility

a legally licensed institution including the chronic care beds of a Hospital which is eligible to receive payments under a provincial hospital plan and which:

a) operates primarily to provide care for the chronically ill;

b) requires that every patient be under the care of a Physician;

c) provides 24-hour nursing services by registered nurses;

d) is not primarily operated as a maternity home a nursing home or a place for rest or for the care and treatment of the aged, the blind, the deaf, the mentally ill, Drug addicts, or alcoholics; and

e) is not primarily providing custodial care.

Dentist

a doctor of dentistry, licensed to practice dentistry in the place where the services are provided.

Dependent

an Employee's Spouse or Child who is covered under the Provincial Plan.

- Spouse

the Employee's legal Spouse, or the person who has, for at least 12 months, been continuously living with the Employee in a role like that of a marriage partner.

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

- Child

an Employee's natural or adopted child, or stepchild, who:

a) is unmarried;

b) is not employed on a full-time basis;

c) is not eligible for insurance as an employee under this or any other group policy; and

d) is either under 19 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.

A child insured under this Policy, who is incapacitated due to a mental or physical disability on the date he reaches the age when he would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this Policy.

A child is considered incapacitated if he 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 Dependent's condition as often as may reasonably be necessary.

A stepchild must be living with the Employee to be an eligible Dependent.

Disability or Disabled

the state of being Totally Disabled.

Drug

a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number

Drug Dispensing Fee

of the total prescription drug cost, that portion charged for the pharmacist's professional services for filling a prescription.

Drug Dispensing Fee Maximum

the maximum amount that is covered under this Plan Document for a Drug Dispensing Fee.

Employee

a person who:

a) is directly employed by the Employer on a permanent and Full-time basis;

b) is compensated for services by the Employer; and

c) is residing in Canada.

Employer

FortisBC Energy Inc. or any Associated Company shown in the Benefit Schedule.

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.

Full-time basis

For Full-time Employees: the Employer is responsible for determining eligibility surrounding the minimum number of hours worked

For Part-time Employees: the Employer is responsible for determining eligibility surrounding the minimum number of hours worked

Full-time as used in this policy can also mean and include Employees working on a Part-time basis or active temporary Employees working on a seasonal basis, whenever the context requires it.

Hospital

a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;

b) provides organized facilities for diagnosis, major surgery or rehabilitation;

c) provides 24-hour nursing service by registered nurses and has a Physician in regular attendance;

d) is not primarily operated as a nursing home or a place for rest or for the care and treatment of the aged, the blind or deaf; and

e) is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill, unless the institution is eligible to receive payments under a provincial hospital plan.

For the purpose of this Plan, the chronic beds of a Hospital are not considered to be part of that Hospital.

Immediate Family Member

a person who is:

a) the Employee;

b) the Employee's Spouse or Child;

c) the Employee's or Spouse's parent; or

d) the Employee's or Spouse's brother or sister.

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

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.

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

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.

12 Definitions

Parental Leave of Absence

the period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Physician

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

Prior Plan

a previous Group Plan which covered all or some of the persons covered under this Plan, and which terminated within 31 days prior to the Effective Date of this Plan.

Provincial Plan

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

Reasonable and Customary

the lowest of:

a) the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial;

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

c) the maximum price established by law.

Temporary Lay-Off

a period during which the Employee is laid off work and for which there is a fixed recall date.

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for coverage.

Ward

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

Eligibility for Plan Benefits

Employee

An Employee is eligible for plan benefits under this Plan if he:

a) is a member of a Classification which is eligible for plan benefits, as set out in the Benefit Schedule;

b) is younger than the Termination Age shown in the Benefit Schedule; and

c) has continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

Re-hired Employees

If an Employee is re-hired within 6 months of termination of coverage under this Plan due to termination of employment, he must re-apply for coverage under this Plan, but will not be required to satisfy another Waiting Period.

Dependent

An Employee's Dependent becomes eligible for plan benefits at the same time that the Employee does. However, the Employee must apply for the Employee coverage in order for the Dependent to be eligible. A person who becomes a Dependent after the Employee becomes covered is eligible on the date that person becomes a Dependent.

Amount of Plan Benefit Coverage

The amount of coverage for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

How to Become Covered

To become covered under this Plan Document, an eligible Employee must apply in writing on forms approved by the Employer. Coverage for Dependents must also be applied for on approved forms.

14 Effective Date of Insurance

Effective Date of Plan Benefits

Once an application for Employee or Dependent plan benefits has been completed, coverage becomes effective as follows, if the Employee is then Actively at Work:

a) for all plan benefit coverage which does not require evidence of good health, on the date the Employee or Dependent becomes eligible for this coverage; and

b) for all plan benefit coverage which does require evidence of good health, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when plan benefit coverage would otherwise take effect, this coverage will take effect on the next day on which he is again Actively at Work.

An Employee who is not Actively at Work on the Effective Date may still be eligible for plan benefits under this Plan through a Transfer of Benefits from the Prior Plan.

Dependent plan benefits will not take effect prior to the Effective Date of the Employee's plan benefits.

Increases in Plan Benefits

An increase in plan benefits on an Employee or Dependent will take effect as follows, if the Employee is then Actively at Work:

a) if evidence of good health is not required, on the Effective Date for Increases in Plan Benefits shown in the Benefit Schedule; and

b) if evidence of good health is required, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when an increase in plan benefits would otherwise take effect, this increase in plan benefits will take effect on the next day on which he is again Actively at Work.

Decreases in Plan Benefits

A decrease in the amount for which any person is covered takes effect when the person is first eligible for the decreased amount.

This Section applies only if this Plan replaces a Prior Plan.

Concessions Granted

Manulife Financial grants a Transfer of Coverage for Employees not Actively at Work to persons who were covered under the Prior Plan when it terminated.

This concession is as described below.

Transfer of Coverage

Eligibility

An Employee who is not Actively at Work on the Effective Date is still eligible under this Plan if he:

a) was covered under the Prior Plan when that Plan terminated; and

b) would be eligible for plan benefits under this Plan if Actively at Work on its Effective Date.

Amount Transferred

An Employee eligible to transfer benefits will be eligible under this Plan for the lesser of:

a) the amount for which he was covered under the Prior Plan when it terminated; and

b) the amount of plan benefits for which he would be eligible under the Plan if Actively at Work on its Effective Date.

Effective Date of Transfer

Plan benefits under a transferred benefit will become effective on the later of:

a) the date plan benefits provided under the Prior Plan would terminate in the absence of this provision; and

b) the Effective Date of this Plan.

16 Termination of Insurance

Termination of Employee Plan Benefits

An Employee's plan benefit coverage terminates on the earliest of:

a) the date the Employee no longer satisfies the definition of Employee;

b) the date the Employee ceases to be Actively at Work;

c) the date the Employer terminates the Employee's coverage;

d) the date the Employee enters the armed forces of any country on a full-time basis;

e) the date this Plan terminates or coverage on the classification to which the Employee belongs terminates;

f) the date the Employee reaches the Termination Age, as shown under each Benefit in the Benefit Schedule; or

g) the date the Employee dies.

Termination of Employment Exceptions

If an Employee ceases to be Actively at Work, his coverage will normally terminate as specified under the Termination of Employee Plan Benefits provision. However, the Employer will waive this rule and continue plan benefit coverage under the conditions set out below. An Employee's plan benefit coverage can only be continued on a basis that does not discriminate against another Employee.

Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all plan benefit coverage will continue until the Employer terminates the coverage until age 65 (or for up to 12 months, if such Employee is age 64 or older and eligible for insurance).

Due to Maternity or Parental Leave of Absence

If an Employee ceases to be Actively at Work due to Maternity or Parental leave of absence, all plan benefit coverage may continue for the period of leave to which the Employee is entitled by legislation governing the Employer until age 65 (or for up to 12 months, if such Employee is age 64 or older and eligible for insurance).

In jurisdictions where the continuation of plan benefit coverage is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required contribution must also accompany the request for termination.

Due to Other Leave of Absence or Temporary Lay-Off

If an Employee ceases to be Actively at Work due to a leave of absence other than Maternity or Parental leave, or due to Temporary Lay-off, all plan benefit coverage may continue until the Employer terminates it, but in no event beyond 12 months from the date such absence began for Leave of Absence, or 24 months from the date such absence began or the date the Employee is removed from the recall list, whichever is earlier for Temporary Lay-Off.

Disability Coverage During Leave of Absence and Temporary Lay-Off

If, while covered for disability benefits under this Plan Document, an Employee becomes disabled on or after the date Leave of Absence or Temporary Lay-Off commences, the Qualifying Period for disability benefits will start as of the date of disability. Benefits will become payable on the later of:

a) the date the Qualifying Period is satisfied; or

b) the date the Employee is scheduled to return to work.

Legislated Benefit Extensions

If legislation mandates that employee benefits continue for a limited period after an Employee's employment terminates, the Employer will extend each plan benefit for the minimum period required by law.

Termination of Dependent Plan Benefits

Plan benefit coverage on an Employee's Dependent terminates on the earliest of:

a) the date the Employees plan benefit coverage terminates;

b) the date the Dependent is no longer eligible for plan benefit coverage under the provisions of this Plan;

c) the date written notification is received from the Employee to cease his Dependent coverage because his Dependents are covered under another plan for benefits similar to the ones in this Plan; or

d) the date a required contribution is due but not paid.

18 Extended Health Care

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the care of a covered person once he has satisfied the Deductible.

Payment is subject to an overall Maximum Benefit and to any maximum amount shown in the Benefit Schedule and in the Covered Expenses section below. Lifetime maximums apply to all periods combined in which a covered person is covered by the Employer.

Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Satisfying the Deductible

The Deductible is satisfied:

a) when Covered Expenses incurred for the care of a covered person exceed the Individual Deductible; or

b) when expenses applied to Individual Deductibles for a covered person's family exceed the Family Deductible.

Deductible Carry-Forward

Covered Expenses used to satisfy a Deductible in the last 3 months of a calendar year may also be used to satisfy the Deductible in the following calendar year.

Covered Expenses

Expenses shown below are covered if they:

a) are Medically Necessary for the treatment of an illness or injury of a covered person and are recommended by a Physician; and

b) are incurred for the care of a person while he is covered under this Benefit; and

c) are reasonable taking all factors into account.

These Expenses are covered to the extent that:

a) they are Reasonable and Customary, as determined by the Administrator or the Employer; and

b) they are not covered under the Provincial Plan or any other government-sponsored program; and

c) they can legally be covered.

All Extended Health Care Benefits are paid as if the person were covered under the Provincial Plan.

In the event that a Provincial Plan or government-sponsored program or plan or legally mandated program discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this Plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

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 that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by the Physician or Dentist; or

b) a 3 month supply.

Hospital Services in Canada

- Hospital Care

Hospital charges in excess of the charges for standard Ward accommodation, up to the Hospital maximum shown in the Benefit Schedule, provided:

a) the covered person was confined to Hospital on an in-patient basis; and

b) the accommodation was specifically elected in writing by the covered person.

- Chronic Care

Confinement in a Chronic Care Facility which starts within 14 days of discharge from a Hospital confinement of at least 5 days, up to the Chronic Care Maximum shown in the Benefit Schedule.

- Expenses Not Covered

Charges for any portion of the cost of Ward accommodation, utilization or copayment fees (or similar charges).

20 Extended Health Care

Provincial Drug Plan 1

Charges incurred for the following when prescribed in writing by a Physician or Dentist and dispensed by a licensed Pharmacist, up to the maximum for this Covered Expense shown in the Benefit Schedule.

- Drugs

Charges for any Drug which is included as a benefit in the current British Columbia Drug Benefit Formulary or in the current British Columbia Drug Benefit List of Non-Formulary Benefits.

The following expenses are not covered:

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

b) charges for 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; and

c) anti-smoking Drugs.

- Diabetic Supplies

Charges for standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

Vision Care

Charges for the following Vision Care expenses when prescribed by an ophthalmologist, optometrist, or oculist:

a) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, up to the Prescription Glasses maximum shown in the Benefit Schedule; and

b) contact lenses if prescribed as medically necessary or required to improve vision to at least a 20/40 level in the better eye, provided this level cannot be attained with glasses, up to the Contact Lenses maximum shown in the Benefit Schedule.

Professional Services

Services of a licensed Chiropractor, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Osteopath, Speech Therapist, Physiotherapist, Psychologist, Acupuncturist and Dietician, up to the Professional Services maximum shown in the Benefit Schedule.

The recommendation of a Physician is not required for Professional Services.

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit are payable only after the Provincial Plan’s maximum for the benefit year has been paid.

Medical Services and Supplies

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

- Private Duty Nursing

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

a) a registered nurse; or

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

Covered Expenses are subject to the Private Duty Nursing maximum shown in the Benefit Schedule.

In addition, coverage for custodial care of a terminally ill eligible family member by:

a) a registered nurse;

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

c) a registered care aide (or equivalent designation)

are also eligible subject to the overall Private Duty Nursing maximum shown in the Benefit Schedule.

Charges for the following services are not covered:

a) service provided primarily for custodial care, homemaking duties, or supervision, except as provided under the terminally ill provision as described above;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient, except as provided under the terminally ill provision as described above;

c) service performed while the patient is confined in a hospital, a nursing home, or any similar institution; and

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

The Employer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing services begin. The Administrator will then advise the Employee of any benefit that will be provided.

- Rental of Major Medical Equipment

The rental or, when approved by the Administrator or the Employer, purchase of:

a) Mobility Equipment: crutches, canes, walkers, and wheelchairs*; and

b) Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals.

*Electric wheelchairs are also eligible, when a member is incapable of using a manual wheelchair

- Non- Dental Prostheses, Supports and Hearing Aids

Charges for external prostheses including, artificial eyes, limbs, larynxes and mastectomy forms. Charges for myoelectrical limbs are not covered.

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

Charges for the following expenses, when recommended by a Physician, podiatrist or chiropractor:

a) stock-item orthopaedic shoes;

b) modifications or adjustments to stock-item orthopaedic shoes or regular footwear; and

c) custom-made shoes which are:

1. constructed by a Certified Orthopaedic Footwear Specialist; and

2. 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.

Charges will be subject to the Orthopaedic Shoes maximum shown in the Benefit Schedule.

Charges for casted, custom-made orthotics which are recommended by a Physician, podiatrist, chiropractor or physiotherapist, up to the Custom-Made Orthotics maximum shown in the Benefit Schedule.

Charges for cost, installation, repair, and maintenance of a hearing aid or aids (including charges for batteries), up to the Hearing Aids maximum shown in the Benefit Schedule.

Charges for surgical stockings up to the Surgical Stockings maximum shown in the Benefit Schedule.

Charges for surgical brassieres up to the Surgical Brassieres maximum shown in the Benefit Schedule.

- Other Supplies

The cost of ileostomy, colostomy and incontinence supplies.

The cost of oxygen.

The cost of medicated dressings and burn garments.

The cost of wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to the Wigs and Hairpieces maximum shown in the Benefit Schedule.

- Diagnostic Procedures

Charges for microscopic and other similar diagnostic tests and services, rendered in a licensed laboratory in the province of Quebec.

- Ambulance

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

- Dental Treatment

Charges for the treatment of accidental injuries to the natural teeth or jaw. Expenses are subject to an annual maximum of $2,500. The accident must be due to a force or blow external to the mouth and have occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 12 months of the accident.

Injuries due to biting or chewing are not covered.

- Out-of-Province or Out-of-Canada

Charges incurred for the following medical treatment given outside the insured person's province of residence:

a) treatment required as a result of a Medical Emergency arising while temporarily outside the province of residence provided that the insured person who receives the treatment is also insured by the Provincial Plan during the absence from the province of residence.

   A Medical Emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while an insured person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the insured person is stable enough to return to his province of residence.

These charges are subject to the Out-of-Province or Out-of-Canada Maximum shown in the Benefit Schedule.

For all treatment given out of Province, other than emergency medical treatment, Manulife Financial:

a) requires that it be recommended as necessary by a Physician practicing in the Province, and

b) suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

Manulife Financial will then advise the Employee of any benefit that will be provided.

Charges for the following are payable under this Covered Expense:

a) Physician's services;

b) Hospital room and board at standard Ward rates. Charges in excess of Ward rates are payable if this Benefit covers Hospital Services in the Province. In such case, the amount payable under this expense is subject to the Hospital maximum shown in the Benefit Schedule;

c) the cost of special Hospital services;

d) Hospital charges for out-patient treatment;

e) licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or Hospital where adequate treatment is available; and

f) medical evacuation for admission to a Hospital or medical facility in the province where the patient normally resides.

Covered Expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

All other charges incurred while outside the province of residence are payable under the appropriate Covered Expense on the same basis as if they were incurred in the province of residence.

24 Dental Care Benefit

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the dental care of a covered person.

Payment is subject to any maximum amounts shown in the Benefit Schedule and to any limit on benefits shown in the Covered Expenses section below. Lifetime Maximums apply to all periods combined in which a person is covered by the Employer.

In determining if an expense is covered, the Employer may require the following information:

a) x-rays and a complete dental chart showing any extractions, fillings, or other work performed prior to the date of the incurred expenses for which claim is being made;

b) itemized bills from the dentist or other sources, of services or treatments; and

c) laboratory or hospital reports, casts, molds or study models, or other similar evidence of the condition or treatment of the teeth or mouth.

- Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Covered Expenses

Expenses shown below are covered if they:

a) are incurred for the necessary dental care of a covered person;

b) are incurred for the care of a person while he is covered under this Benefit;

c) are incurred for services provided by a Dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license;

d) are reasonable as determined by the Employer or the Administrator, taking all factors into account; and

e) do not exceed:

   i) the fees recommended in the Dental Fee Guide shown in the Benefit Schedule, or

   ii) reasonable and customary charges, as determined by the Employer or the Administrator, if such expenses are not included in the Dental Fee Guide shown in the Benefit Schedule.

Alternate Benefits

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

Level I – Basic Services

a) complete oral examinations, twice per calendar year

b) complete mouth x-rays, once per 3 year period and panoramic x-rays, once per 3 year period

c) recall examinations, twice per calendar year

d) bitewing x-rays, twice per calendar year

e) routine diagnostic and laboratory procedures

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

g) fluoride treatment, twice per calendar year

h) space maintainers (excluding appliances placed for orthodontic purposes)

i) fillings, (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants. Replacement fillings are covered only if:

   i) the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay; or

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

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

k) minor surgical procedures, simple extractions, and post surgical care

l) complicated extractions including impacted and residual roots

m) consultation, anaesthesia, and conscious sedation

n) denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

o) injection of antibiotic Drugs when administered by a Dentist in conjunction with dental surgery

Level II – Supplementary Basic Services

a) surgical procedures not included in Level I (excluding implant surgery)

b) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

   i) scaling not covered under Level I, and root planing

   ii) provisional splinting

   iii) occlusal equilibration

c) 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.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and endodontic treatment had begun exposing a tooth, the Employer will pay for expenses related to such treatment provided the expense is incurred within 31 days after the plan benefits terminate.

Level III - Dentures

a) initial provision of full or partial removable dentures

b) replacement of removable dentures, provided the new dentures are necessary due to one of the following:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable

   ii) the existing appliance is at least 60 months old and cannot be made serviceable

   iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a denture had been taken prior to the termination, the Employer will pay for expenses related to the installation of the denture provided the expense is incurred within 31 days after the plan benefits terminate.

Level IV – Major Restorative Services

a) crowns and onlays (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay). Services are limited to once per tooth per 5 year period.

b) inlays (covering at least 3 surfaces, provided the tooth cusp is missing)

c) initial provision of fixed bridgework

d) replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable

   ii) the existing appliance is at least 60 months old and cannot be made serviceable

   iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent bridge. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a crown, onlay or bridgework had been taken prior to the termination, the Employer will pay for expenses related to the installation of the crown, onlay or bridgework provided the expense is incurred within 31 days after the plan benefits terminate.

Level V - Orthodontics

a) correction of malocclusion of the teeth

b) observation and adjustment

c) appliances for tooth guidance or uncomplicated tooth movement

d) appliances to control harmful habits

e) retention appliances

f) fixed or cemented, unilateral and bilateral appliances

Pre-Determination of Benefits

When a proposed course of treatment is expected to cost more than $500, a treatment plan should be filed with the Administrator before treatment begins.

The Administrator will then advise the Employee of the amount, if any, that is payable.

Expenses not Covered

No benefit is payable for any expense which is directly or indirectly related to:

a) a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program;

b) self-inflicted injuries or illnesses, whether the person is sane or insane;

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

d) the committing of or the attempt to commit an assault or criminal offence;

e) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the covered person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;

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

g) charges for services or supplies:

   i) when there would have been no charge at all in the absence of plan benefit coverage;

   ii) which are received from a medical or dental department maintained by an employer, association or trade union; or

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

iv) which are not specified as a Covered Expense under this Benefit;

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

i) cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan;

j) implants, or any services rendered in conjunction with implants. However, if an implant is the treatment of choice and the implant is part of a bridge, crown or denture, then only the cost of the bridge, crown or denture will be considered eligible.

k) anti-snoring or sleep apnea devices;

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

m) the replacement of removable appliances which are lost, mislaid or stolen;

n) laboratory fees which exceed Reasonable and Customary charges, as determined by the Employer or the Administrator; or

o) oral hygiene instruction.

The Benefit

If an Employee dies while covered for this Benefit and while his Dependents are covered under this Plan, the Employer will continue the Dependent coverage for a period of up to 3 months. The Benefit Schedule shows which Dependent coverage will be continued under this Benefit.

Plan Benefit Coverage Continued

The coverage continued on a Dependent will be the same as that which was in effect on the date of the Employee's death. This coverage will be subject to any age reduction or termination shown in the Plan at that time.

Termination of Plan Benefit Coverage

The maximum period for extended coverage is 3 months. Coverage on any Dependent ceases prior to this:

a) if the Dependent would cease to qualify as a Dependent, even if the Employee were still alive; or

b) if this Plan terminates.

30 Payment of Claims

Payees

All benefits for an Employee and such Employee's Dependents are payable to the Employee, unless the Employee has previously authorized payment to be made to the person and/or corporation which has rendered services, treatment or supplies. If the Employee is not alive, these benefits are payable to such Employee's estate.

- Payment of Small Amounts

If any amount up to $2,000 is payable to a person who is not alive or who cannot give a valid discharge for such payment, the Employer may pay the amount to:

a) any relative of that person; or

b) any person or institution incurring expenses for the care or maintenance of that person.

Requirement of Proof

No claim for benefits will be paid until the Employer receives satisfactory proof in writing that such benefits are payable under the terms of this Plan.

The Employer or Administrator reserves the right to request any additional information necessary, as determined by the Employer or Administrator, to validate the eligibility of a claim for benefits under this Plan. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

Claims for drug benefits which were not handled on a credit-card basis must be submitted on forms provided by the administering company and forwarded to the address shown on the form. Proof that benefits are payable must be submitted by or on behalf of the Employee and received by the Employer or the Administrator at their respective Head Offices or at one of their local offices by December 31 of the following calendar year in which the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while plan benefits under this Plan are in force. Upon termination of a person's plan benefits under this Plan, proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

a) December 31 of the following calendar year in which the expense was incurred; or

b) 90 days from the date of termination of plan benefit coverage.

Date Costs are Incurred

The expense for a service or supply is deemed to have been incurred on the date the service was performed or the supply furnished. If a procedure involves multiple appointments, the expense is deemed to be incurred on the date the procedure is completed. For supplies that have to be ordered, the expense will be deemed to be incurred on the date the supplies were paid for. Proof of receipt of the supplies is required.

Continuing Proof

If benefits are being paid or coverage continued on a covered person because of disability, the Employer may require written proof that this person remains Disabled under the terms of this Plan. This proof will be required as often as may reasonably be necessary.

Examination by the Employer

The Employer reserves the right to have any person in respect of whom a claim is being made under this Plan submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the Administrator, as often as may reasonably be required. No benefits will be payable if, without reasonable cause, the covered person fails to undergo such examination.

Subrogation

If a covered person suffers personal injury or loss for which he has a right to bring action for damages against a third party, the Employer shall be subrogated to the covered person's rights to recover damages to the extent that it may be obligated to pay benefits to the covered person. In such case, the Employer will require the covered person to complete a subrogation reimbursement agreement. The Employer has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the covered person shall reimburse the Employer for benefits paid or payable. Unless notified to the contrary, the covered person's solicitor shall also represent the Employer's interests in such a recovery.

Time Limit on Legal Action

No legal action against the Employer or the Administrator may be commenced less than 60 days after proof has been filed in accordance with the above requirements. No such action may be brought more than two years after the last day on which proof of claim would be accepted under the terms of this Plan.

Co-ordination of Benefits

The Employer will co-ordinate its Extended Health Care and Dental Care Benefits payable under this Plan with other Plans which also cover a covered person for similar Benefits.

Plans co-ordinated with this Plan

For the purposes of the Co-ordination of Benefits, Plan means:

a) other group insurance programs;

b) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan; and

c) individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

How Claims are Co-ordinated

Benefits payable under this Plan will be reduced, when necessary, so that no more than 100% of eligible expenses incurred during a calendar year are jointly paid by this Plan and all Plans which come before it in the Order of Benefit Payment.

For the purposes of this provision, eligible expenses are as defined in each Policy or Plan document, before any applicable payment limitations, such as deductible, benefit percentage and maximums, are applied. An expense is eligible only to the extent that it is Reasonable and Customary.

32 Payment of Claims

Order of Benefit Payment

The Order of Benefit Payment is established by applying the following rules to the various Plans which cover eligible expenses. The rules are applied from first to last until an order is established.

a) The Plan with no Co-ordination of Benefits provision in the Policy or Plan document is deemed to pay its benefits first (primary carrier).

b) If all Plans have a Co-ordination of Benefits provision, the following rules are applied to determine the Order of Benefit Payment. The rules depend on the basis on which the person is covered in the Plan.

i) Employee/Member

The Plan which covers the person as an employee/member is deemed to pay its benefits before a Plan which covers that person as a dependent.

If the person is an employee/member under more than one Plan, the following order applies:

1) the Plan where the person is an active full-time employee, then

2) the Plan where the person is an active part-time employee, then

3) the Plan where the person is a retiree.

ii) Dependent - Spouse

If a dependent spouse is also covered as an employee/member under another Plan, the Plan which covers the spouse as an employee/member is deemed to pay its benefits before the Plan which covers the spouse as a dependent.

If the spouse is an employee/member under more than one Plan, the order of benefit payment is as outlined under “Employee/Member” above.

iii) Dependent - Child

If a dependent child is covered under more than one Plan, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

However, in situations where the parents of the dependent child are separated or divorced, the following order applies:

1) the Plan of the parent with custody of the child, then

2) the Plan of the spouse of the parent with custody of the child, then

3) the Plan of the parent not having custody of the child, then

4) the Plan of the spouse of the parent not having custody of the child.

Where divorced or separated parents share joint custody of the dependent child, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

c) For dental accidents, Extended Health Care Plans with accidental dental coverage determine benefits before Dental Plans.

d) If the Order of Benefit Payment cannot be established by the preceding rules, benefits will be pro-rated between or among the Plans in proportion to the amounts that would have been paid under each Plan had there been coverage by only that Plan.

Special Rules Applied

The Employer will apply the following rules in co-ordinating benefits under this Plan:

a) if a person does not apply for a benefit for which he is eligible under another Plan, the amount of such benefit will be estimated by the Employer and assumed to be paid;

b) if only part of a Plan provides for the co-ordination of benefits, this part will be considered a separate Plan from the part which does not provide for co-ordination;

c) this Plan is considered to be a Plan in applying the rules which establish an Order of Benefit Payment;

d) when a Plan provides benefits in the form of service rather than cash payments, the Reasonable and Customary value of the service rendered is deemed to be both an Allowable Expense and a benefit paid; and

e) if a 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.

Administration of the Provision

The Employer has the right to release to or obtain from any other insurer, person or institution, information needed to administer the Co-ordination of Benefits provision in this Plan. The Employer has the right to recover any payments in excess of the amount determined to be payable in accordance with this provision.

34 Administration of the Policy

Method of Administration

This Plan must be administered in accordance with the Employer's instructions.

Notice of New Employees

The Employer must supply enrolment material to eligible Employees and inform the Administrator of the addition of new Employees as they become eligible for plan benefit coverage.

Notice of Terminated Employees

The Employer must inform the Administrator of the termination of plan benefit coverage on Employees on or before the date on which this coverage terminates. The Employer is also responsible for the retrieval of every prescription drug credit-card issued under this Plan. Payments made or the cost of drugs dispensed with respect to ineligible persons because of the late receipt of termination notice or the Employer's failure to retrieve drug credit-cards will be recovered from the Employer if they can not be recovered from the Employee on whose behalf they were paid.

Uniform Practices

Options available to the Employer must be chosen and administered by the Employer on a uniform basis without prejudice to any Employee.

Clerical Error and Misstatement

A clerical error is a mistake in writing or copying data. A clerical error made by the Employer or the Administrator will not invalidate plan benefit coverage otherwise in force, or continue plan benefit coverage otherwise terminated under the terms of this Plan.

If a covered person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of plan benefit coverage;

b) the amount of plan benefits; and

c) any other rights or benefits under this Plan.

The Employer will adjust the plan benefits in force where these are affected by a clerical error or a misstatement of age.

Employee Contributions

The Administrator is not responsible for the collection of any employee contributions required for plan benefits under this Plan.

Termination of the Plan

The Employer may refer to the Discontinuance of Agreement provision of the Administrative Agreement between the Employer and the Administrator for further information on terminating the Plan.

Gender

In this Plan Document, unless the context requires otherwise, reference to the masculine gender will also include the feminine gender.

Currency of Payment

All amounts payable under this Plan, to or by the Employer, are payable in Canadian currency.

Conformity with the Law

If a provision of this Plan Document is contrary to any law to which it is subject, this provision will be deemed to conform to the minimum requirements of such law.

36 PLAN DOCUMENT ADDENDUM

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under the Plan Document to covered persons who reside in Quebec will be administered as outlined in this Addendum.

If a provision of the Plan Document or this Addendum is, in full or in part, contrary to the Legislation or any other law or regulation replacing it, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the then applicable laws and regulations.

Covered Drug Expenses

The following expenses are covered:

a) drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and

b) drugs that are listed as a covered expense in the Plan Document but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List)

The following provisions apply only to the coverage of drugs that are on the RAMQ List. For all other covered drug expenses, the provisions stated in the Plan Document will apply.

a) **Percentage Payable By the Administrator**

Prior to the Annual Out-of-Pocket Maximum being reached, the percentage of covered expenses payable under the Plan Document will be:

i) For any drugs on the RAMQ List which are not otherwise covered under the terms of the Plan Document, the percentage payable is as set out by the then applicable Legislation.

ii) For any drug on the RAMQ List which is covered under the terms of the Plan Document, the percentage payable is the greater of:

- the benefit percentage stated in the Plan Document, or

- the percentage as set out by the then applicable Legislation.

After the Annual Out-of-Pocket Maximum has been reached, the percentage of covered expenses payable under the Plan Document will be 100%.

b) **Annual Out-of-Pocket Maximum**

The Annual Out-of-Pocket Maximum is the portion of covered drug expenses which must be paid by a covered person in a calendar year, before the percentage payable under the Plan Document will be 100%. Amounts that will be applied to the Annual Out-of-Pocket Maximum are:

i) the deductible amounts, and

ii) the portion of covered drug expenses that is payable by the covered person, when the benefit percentage under the Plan Document is less than 100%.

The Annual Out-of-Pocket Maximum for the Employee and his Spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for dependent children.

For the purposes of calculating the Out-of-Pocket Maximum for the Employee and His Spouse, those portions of covered drug expenses paid for dependent children will be applied to the person who is closest to reaching the Annual Out-of-Pocket Maximum.

c) **Deductible**

Deductible amounts, if any, stated in the Plan Document will apply, up to the Annual Out-of-Pocket Maximum. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums, if any, stated in the Plan Document will not apply to drugs on the RAMQ List. Drug coverage provided after the lifetime maximum amount stated in the Plan Document is reached is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Eligible Dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of attainment of:

i) the age specified in the Plan Document, and

ii) age 26.

Drug coverage provided for Dependent Children after the age stated in the Plan Document is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and
ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for covered Drug Expenses**

Provided the person is otherwise eligible for the drug benefit under the Plan Document, the Termination Age, if any, specified in the Plan Document will not apply. Drug coverage provided after the Termination Age specified in the Plan Document is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered,

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation,

iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

iv) the premium required for the drug coverage is the premium for the Extended Health Care Benefit.

g) **Continuation of Coverage - Concerted Work Stoppages**

In the event of a strike, lock-out or other concerted work stoppages, coverage will continue until the later of:

i) the length of time, if any, specified in the Plan Document, and

ii) 30 days

Coverage for drugs that are listed as a covered expense in the Plan Document, but are not on the RAMQ List

With respect to drugs that are covered under the Plan Document but are not on the RAMQ List, all the provisions stated in the Plan Document will apply.