School Div #4 - Cupe 3766

Group Policy Number: G0026815

Class: CUPE 3766 - Permanent Employees

Employee Name: _____

Certificate Number: _____

Manulife Customer Service Centre: 1-800-268-6195

Welcome to Your Group Benefit Program

Group Policy Effective Date: January 01, 2002

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 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.

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How to Use Your Benefit Booklet

Designed with Your Needs in Mind

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

Your Benefit Booklet includes...

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

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

a clear, concise explanation of your Group Benefits,

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

Important Note

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of School Div #4 - Cupe 3766. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (available from your Plan Administrator), the terms of the Group Policy will apply.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are insured. The Group Policy must be in effect and you must satisfy all the requirements of the Policy.

Where required by law, you or any claimant under the Policy have the right to request a copy of any or all of the following items:

the Policy,

your application for group benefits, and

any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the policy.

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

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

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card

Your Group Benefit Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Group Policy Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Group Policy Number and your Certificate Number are also necessary for ALL correspondence with Manulife Financial. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Common Insurance Terms

The following is an explanation of the Insurance terms used in this Benefit Booklet.

Adherence

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

Adherence

Advisory Body

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

Advisory Body

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by Manulife Financial.

Benefit Percentage (Co-insurance)

Covered Expenses

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

Covered Expenses

Deductible

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

Deductible

Dependent

your Spouse or Child who is insured under the Provincial Plan.

Dependent

- 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.

- Child

your natural or adopted child, or stepchild, who is:

- unmarried;

- under age 21, or under age 25 if a full-time student;

- 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 insurance would normally terminate will continue to be an eligible dependent. However, the child must have been insured 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.

Disease Management Programs

Disease Management Programs — an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

Drug — a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Drug Dispensing Fee

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

Drug Dispensing Fee Maximum — the maximum amount that is covered by Manulife Financial for a drug dispensing fee.

Due Diligence

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

Exclusive Distribution

Exclusive Distribution — Manulife Financial approved vendors.

Experimental or Investigational

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

Explanation of Common Insurance Terms

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.

Interchangeable Drugs

Interchangeable Drugs

includes but is not limited to:

a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;

a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

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

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

Lower Cost Alternative

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

Medically Necessary

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Group Policy.

Patient Assistance Program

Patient Assistance Program

a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Explanation of Common Insurance Terms

Prior Authorization

Prior Authorization

a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Provincial Plan

Provincial Plan

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

Reasonable and Customary

Reasonable and Customary

the lowest of:

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; or

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

the maximum price established by law.

Waiting Period

Waiting Period

none

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 The Board of Education of the Regina School Division #4 of Saskatchewan, 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
- applying for coverage previously waived
- change in name

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

The Claims Process

Naming a Beneficiary

Naming a Beneficiary

Manulife Financial does not accept beneficiary appointments for any benefits under this Plan.

This Policy contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

How to Submit a Claim

How to Submit a Claim

To submit a claim, you can do one of the following:

Submit Online (if applicable)

Sign up to use Manulife Financial's Plan Member Secure Site at www.manulife.com/groupbenefits.

If your health care service provider cannot send Manulife Financial electronic claim transmissions, you can still submit your claim electronically to us online, right from the Plan Member Secure Site.

For fast, easy and secure claim payments, we encourage you to sign up for direct deposit and electronic claim statements when you set up your access on the Plan Member secure site. Even if you mail us your claims, by providing your banking and email information, your claim payments can be deposited quickly to your bank account and you will receive an email notification, including a link to manulife.ca, where you can sign in to view your electronic claim statement.

By Mail

You must complete an applicable claim form and mail it to Manulife Financial. Mailing instructions are included on the claim form.

Claim forms are available at www.manulife.com/groupbenefits, or from your plan administrator.

Payment of Extended Health Care and Dental Claims

Claim Payment

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.

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

Co-ordination of Extended Health Care and Dental Care Benefits

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are insured 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 insured 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.

The Claims Process

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).

Where you and your spouse share joint custody of the 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.

A claim for accidental injury to natural teeth will be determined under Extended 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 insured 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.

Submitting a Claim for Co-ordination of Benefits when both spouses are covered by Manulife Financial

Submitting a Claim for Co-ordination of Benefits when both spouses are covered by Manulife Financial

If both the primary and secondary carrier is Manulife Financial, the insured may not have to resubmit the claim for payment under the second policy.

At time of claim, ensure that the COB information is completed on each claim form every time a claim is submitted; indicate the name of your spouse's insurance company as well as the policy and certificate numbers. Following COB guidelines, the claim will then be processed under both policies.

It should be noted that, since the claim is being considered under two separate policies, payment will be issued on two different cheques.

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you are an employee of the Board of Education of Regina School Division #4 of Saskatchewan who is employed on a regular, permanent basis by the plan sponsor and who is not eligible for coverage under the Teachers Group Extended Health Care Contract.

are a member of an eligible class,

are younger than the Termination Age, and

are residing in Canada.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in 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.

Evidence of Insurability

Evidence of Insurability

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

Late Application

Late Application

An application is considered late when you:

apply for insurance on any person after having been eligible for more than 31 days; or

re-apply for insurance on any person whose insurance had earlier been cancelled.

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 that have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your Plan Administrator.

Further medical evidence may be requested by Manulife Financial.

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 insured person for the first 12 months of coverage.

Who Qualifies for Coverage?

Effective Date of Coverage

Effective Date of Coverage

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

If Evidence of Insurability 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.

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 insurability on the dependent is approved by Manulife Financial, whichever is later.

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 cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date,

the date your employer terminates coverage,

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

the date the Group Policy terminates or insurance on the class to which you belong terminates,

the date you reach the Termination Age, or

the date of your death.

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

Your Group Benefits

Basic Group Life Insurance

Basic Group Life Insurance

The wording for this benefit has been provided by The Co-operators, insurer for this benefit, who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them, effective January 1, 2010.

The amount of insurance below will be payable to your beneficiary upon your death.

Option I - 2 times your salary to a maximum benefit of $300,000 rounded to the next highest $1,000 if not already a multiple thereof.

Option II - 2.5 times your salary to a maximum benefit of $300,000 rounded to the next highest $1,000 if not already a multiple thereof.

Option III - 3 times your salary to a maximum benefit of $300,000 rounded to the next highest $1,000 if not already a multiple thereof.

Excluding Early Retirees

Each Employee 65 Years or older - 50% of the amount in effect on the EmployeeÆs 65th birthday.

Early Retirees between 50 and 65 years of age - 2 times the EmployeeÆs Annual Salary as it was on September 30 prior to your early retirement date, rounded to the next highest $1,000.00 if not already a multiple thereof.

When salary and/or classification entitles you to an increase in excess life insurance, The Co-operators reserves the right to require you to submit evidence of good health prior to granting an increase in the amount of insurance. Your salary is your regular annual earnings paid by your Employer, exclusive of bonuses and overtime earnings.

Living Assistance Benefit

The living assistance benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill employees under age 65.

Application for this benefit must be approved by your employer and The Co-operators will confirm that medical evidence meets the program's requirements before approving payment.

The amount of money available as a living benefit payment is 50% of your Basic Life Insurance benefit, to a maximum of $50,000.

Retirement Benefit

If you retire and are eligible to receive a pension, you will receive a paid-up certificate in the amount of:

Less than 10 consecutive years of service: $1,000
10 consecutive years of service or more: $1,500

Dependents Insurance

Dependents Insurance

The wording for this benefit has been provided by The Co-operators, insurer for this benefit, who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them.

This benefit provides life insurance coverage for your spouse and dependent children.

The amount of the benefit is:

Option I - Spouse: Nil, Child: Nil

Option II - Spouse: Nil, Child: $ 1,000

Option III - Spouse: $ 5,000, Child: $ 1,000

Option IV - Spouse: $ 10,000, Child: $ 2,500

Total Disability Waiver of Premium

If you are totally disabled and the premiums for your basic life insurance coverage are being waived, then premiums for the dependent insurance will also be waived, but only so long as the policy remains in force.

Accidental Death, Disease and Dismemberment

Accidental Death, Disease and Dismemberment

The wording for this benefit has been provided by The Co-operators, insurer for this benefit, who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them.

"Covered Loss" means a Critical Disease Benefit, Accidental Death Benefit or an Accidental/Disease Dismemberment Benefit. The covered loss must occur while you are insured under this benefit. In the case of an accident, the covered loss must occur within 365 days after the date of the accident.

Critical Disease Benefit

The insurance company will pay you an amount equal to 10% of your basic life insurance amount provided you have been diagnosed with a critical disease while insured under this benefit and have been totally disabled from that disease and have not been able to work at any occupation for at least nine (9) months. Benefits are limited to the first covered critical disease in your lifetime.

"Critical Disease" shall mean any one of the following diseases diagnosed after the effective date of your coverage; Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimers Disease, Type I Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease, and Necrotizing Fascitis.

Accidental Death Benefit

If the insurance company is furnished with proof that your death occurs as a direct result of accidental bodily injuries occasioned solely through external, violent and accidental means without negligence on your part, the insurance company will pay an amount equal to 100% of the basic life insurance amount to your beneficiary.

Accidental/Disease Dismemberment Benefit

If the insurance company is furnished with proof that you sustained one of the following losses, as a direct result of a critical disease or resulting directly and independently of all other causes from bodily injuries occasioned solely through external, violent and accidental means, without negligence on your part, the insurance company will pay:

Loss of:

Total paraplegia (total paralysis of both lower limbs), or hemiplegia (total paralysis of one side of the body), or quadriplegia (total paralysis of all four limbs) - 200% of your basic group life insurance benefit

Loss of:

Both hands or both feet, or sight of both eyes, or one hand and one foot, or use of both hands, or use of both arms, or use of both legs, or use of one hand or arm and one leg, or sight of one eye and one hand or one foot - 100% of your basic group life insurance benefit

One hand, or one foot, or one arm, or one leg, or sight of one eye, or use of one hand, or use of one arm, or use of one leg - 50% of your basic group life insurance benefit

The thumb and index finger of the same hand, or loss of speech, or loss of hearing in both ears - 33 1/3% of your basic group life insurance benefit

Rehabilitation Benefit

In the event that you sustain a covered loss and the loss requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such covered loss, the insurance company will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider, within two (2) years from the date of the covered loss.

Payment by the insurance company for the total of all expenses incurred will not exceed ten thousand dollars ($10,000) as the result of any one (1) covered loss. Payment does not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

Family Transportation Benefit

If you sustain a covered loss and are confined as an inpatient in a hospital located at least one hundred and fifty (150) kilometers from your residence and are under the regular care and attendance of a physician or surgeon, the insurance company will pay the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to your location.

This benefit will not exceed the aggregate amount of three thousand dollars ($3,000) for all accommodation and transportation expenses. Payment will not be made for incidental expenses including without limitation charges for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of twenty cents ($0.20) per kilometers travelled.

Home Alteration and Vehicle Modification Benefit

If you sustain a covered loss and subsequently require the use of a wheelchair to be ambulatory, the insurance company will pay the reasonable and necessary expenses incurred for the purpose of making your home and vehicle wheelchair accessible.

Benefits are payable for the cost of alterations to your principal residence and the cost of modifications to one (1) motor vehicle utilized by you, when such modifications are approved by licensing authorities where required.

The expenses must be incurred within two (2) years from the date of the covered loss and are subject to a maximum of $10,000.00 in your lifetime.

Continuation of Education Benefit

In the event that your death occurs as a direct result of a covered loss under this benefit, the insurance company will pay to your beneficiary the education benefit stated below for each of your dependent children who are, at the time of your death enrolled as full-time students:

a) in an institution for higher learning above the secondary school level as defined in the province, territory or country of residence; or

b) at the secondary school level but who will enroll as full-time students in an institution for higher learning within three hundred and sixty-five (365) days after your date of death.

The education benefit is equal to the reasonable and necessary expenses actually incurred for tuition and books, subject to the lesser of a maximum of five percent (5%) of your basic life insurance amount or five thousand dollars ($5,000), for each year the dependent child continues the education, but not to exceed four (4) years, which must run consecutively, with respect to any one (1) dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in an institution for higher learning, but payment will not be made for expenses incurred prior to your death, or for incidental expenses including without limitation room, board or other ordinary living, travelling or clothing expenses.

If none of your dependent children satisfy the above requirements, the insurance company will pay an amount of two thousand five hundred dollars ($2,500) to your beneficiary.

Spousal Occupational Training Benefit

In the event that your death occurs as a direct result of a covered loss under this benefit, the insurance company will pay the reasonable and necessary expenses actually incurred for tuition and books for your spouse to participate in a formal occupational training program to become qualified for active employment in an occupation for which your spouse would not otherwise have sufficient qualification.

Expenses must be incurred within two (2) years from the date of your death and are subject to a maximum lifetime payment of ten thousand dollars ($10,000). Payment will not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

Repatriation Benefit

In the event that your death occurs outside your normal province of residence (due to any cause), the insurance company will pay, to your beneficiary, the reasonable and customary expenses incurred for the preparation of your body and its transportation to the funeral home or the place of interment in proximity to your normal place of residence. Benefits will not exceed ten thousand dollars ($10,000) for all eligible expenses.

Maximum Benefit

In no case shall an amount greater than the basic life insurance amount be paid for all covered losses sustained by you resulting directly or indirectly from the same accident or critical disease with the exception of paraplegia, hemiplegia and quadriplegia where the benefit payable is 200% of the amount of basic life insurance.

Definitions

Loss of hand shall mean severance at or above the wrist.

Loss of foot shall mean severance at or above the ankle.

Loss of thumb shall mean complete loss of one entire phalanx of the thumb.

Loss of index finger shall mean the complete loss of two entire phalanges of the index finger.

Loss of sight, loss of hearing or loss of speech shall mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it shall be deemed that there was no loss for the purposes of this provision.

Loss of use must be caused by tendon, nerve or bone damage. Such loss of use must be total and irrecoverable and must be continuous for a period of 12 months after which any benefit is payable, provided such disability is determined to be permanent.

Paralysis shall mean complete and irreversible paralysis caused by brain, spine, muscle or nerve damage as a result of an accident or covered critical disease which has continued for a period of 12 months from the date of the accident or diagnosis of critical disease, after which any benefit is payable under this benefit.

Institution for higher learning for the education benefit, includes any university, college or trade school.

Hospital, for the family transportation benefit, means an institution licensed as a hospital, open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with twenty-four (24) hour nursing services. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

Regular care and attendance, for the family transportation benefit, means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Immediate family, for the family transportation benefit, means a person who is your spouse, son, daughter, father, mother, brother or sister. Other relatives may be considered in the event that no “immediate family” are living.

Total Disability Waiver of Premium

If premiums for the basic life insurance coverage under this benefit are being waived, then premiums for the accidental death, disease and dismemberment benefit will also be waived, but only so long as the policy remains in force.

Exclusions

No benefits will be paid if your covered loss is caused by or results directly or indirectly from one or more of the following:

suicide or attempted suicide or self-inflicted Injury, while sane or insane, or

insurrection or war (whether war be declared or not) or participation in any riot, or

active service in the armed forces of any country, or

travel or flight in any aircraft, or descent from such aircraft, if you are a pilot or a member of the crew of the aircraft, or if such flight is made for purposes of instruction, training or testing, or

committing, attempting or provoking an assault or criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A “vehicle” means, a vehicle that is drawn, propelled or driven by any means other than muscular power, or

medical care or treatment of any kind including surgery.

Extended Health Care

Extended Health Care

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

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

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - $11.85 per prescription

Benefit Percentage (Co-insurance) -
100% for - Hospital Care - Medical Services & Supplies - Professional Services - Vision

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.
The Benefit Percentage for Drugs is shown below under ManuScript Generic Drug Plan 2 - Prescription Drugs, Payment of Covered Expenses.

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Covered Expenses

Extended Health Care - 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 an illness or injury and recommended by a physician

incurred for the care of a person while insured under this Group Benefit Program

reasonable taking all factors into account

not covered under the Provincial Plan or any other government-sponsored program

legally insurable

used as prescribed or recommended by a physician

associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by Manulife Financial and shared with your employer as required

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

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

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

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

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife Financial.

Advance Supply Limitation

Extended Health Care - 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

- Drug Expenses

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

a) the quantity prescribed by your physician or dentist, or

b) a 34 day supply.

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

Hospital Care

Extended Health Care - 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

confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of $20 per day for 90 days per disability

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist (charges for fertility drugs and anti-obesity drugs are not covered)

oral contraceptives

injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

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)

Charges for drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis are not covered.

Charges for drugs determined to be ineligible as a result of due diligence are not covered.

Charges for drugs used in the treatment of a sexual dysfunction are not covered.

- Drug Maximums

- Drug Maximums

Anti-smoking drugs - $100 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

- Payment of Drug Claims

- Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

you cannot locate a participating Pay Direct Drug pharmacy

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

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.

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

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Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

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

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

you cannot locate a participating Pay Direct Drug pharmacy

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

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.

Vision Care

Extended Health Care - Vision Care

eye exams, once per 12 months for persons under age 18 and once per 24 months for persons age 18 and over

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $250 per 24 months

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 during any 24 months, in addition to the amount allowed under the purchase and fitting of prescription glasses or elective contact lenses

visual training, to a maximum of $200 per lifetime

Your Group Benefits

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $500 per calendar year(s)

Osteopath - $400 per calendar year(s)

Podiatrist/Chiropodist - $400 per calendar year(s)

Massage Therapist - $500 per calendar year(s)

Naturopath - $400 per calendar year(s)

Speech Therapist - $400 per calendar year(s)

Physiotherapist - $400 per calendar year(s)

Psychologist/Social Worker/Clinical Counsellor/Marriage and Family Therapist/Psychoanalyst/Psychotherapist - $500 per calendar year(s)

Acupuncturist - $400 per calendar year(s)

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 Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

Extended Health Care - 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

- 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

Covered Expenses are subject to a maximum of $7,500 per calendar year(s).

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

- 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

- Medical Equipment

rental or, when approved by Manulife Financial, purchase of:

- Mobility Equipment: crutches, canes, walkers, and wheelchairs

- Mozes Detectors

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

- Non-Dental Prostheses, Supports and Hearing Aids

Non-Dental Prostheses, Supports and Hearing Aids

external prostheses

surgical stockings, up to a maximum of 4 pairs per calendar year

surgical brassieres, up to a maximum of 4 per calendar year

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

stock-item orthopaedic shoes, modifications or adjustments to stock-item orthopaedic shoes, custom-made shoes which are required because of a medical abnormality, or special foot appliances which are specially designed and molded for the insured person, up to a combined maximum of $300 per calendar year, provided they are medically necessary and are prescribed by a physician, podiatrist or chiropodist.

cost, installation, repair and maintenance of hearing aids (including charges for batteries), to a maximum of $2,000 every 5 calendar year(s)

- Other Supplies and Services

Other Supplies and Services

ileostomy, colostomy and incontinence 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 $250 per lifetime

supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment), up to a maximum of $1,000 per person per calendar year

oxygen

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

charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, unless a longer period is required by legislation, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided the insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

A medical emergency condition:

a) Coverage is for immediate medical treatment required for:
- a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

b) Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

c) Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.

Stable means in the 90 days before departure, the insured person has not:

been treated or tested for any new symptoms or conditions;

had an increase or worsening of any existing symptoms;

changed treatments or medications (other than normal adjustments for ongoing care);

been admitted to the hospital for treatment of the condition.

Coverage is not available if you (or your dependent) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory.

expenses are payable up to a maximum of $5,000,000 per lifetime

referral outside Canada for treatment which is available in Canada, to a maximum of $3,000 every 3 calendar year(s).

If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar year(s).

For all non-emergency medical treatment out of Canada, Manulife Financial:

requires that it be recommended by a physician practicing in Canada, and

suggests that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be advised of any benefit that will be provided.

Charges for the following are payable under this expense:

physician's services

hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.

special hospital services

hospital charges for out-patient treatment

licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available

medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Extended Health Care - Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

A medical emergency condition:

i) Coverage is for immediate medical treatment required for:
- a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

ii) Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

iii) Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.

Stable means in the 90 days before departure, the insured person has not:

been treated or tested for any new symptoms or conditions;

had an increase or worsening of any existing symptoms;

changed treatments or medications (other than normal adjustments for ongoing care);

been admitted to the hospital for treatment of the condition.

Coverage is not available if you (or your dependent) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of insurance coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the insured person.

Payment and co-ordination of expenses will take into account the coverage that the insured person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the insured person is entitled, Manulife Financial shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

Medical care and services rendered to the insured person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the insured person, the attending physician, the insured person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer an insured person to and from the nearest medical facility or to a medical facility in the insured person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province/Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the insured person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of an insured person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of an insured person, one-way economy transportation will be arranged to enable each insured person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the insured person, and whose fare for transportation and accommodation was pre-paid at the same time as the insured person's fare.

If the insured person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If an insured person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If an insured person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit an insured person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by Manulife Financial.

j) **Vehicle Return**

If an insured person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If an insured person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of an insured person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help an insured person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the insured person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the insured person plans to travel.

Health Advice and Assistance

The following services are available for an insured person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed drug or medicine; and

iii) other health related services that may be requested or required by the insured person.

c) **Link to 911**

If necessary, an insured person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the insured person, the registered nurse will follow-up with the insured person within 24 hours after the medical advice is provided.

Exceptions

Manulife Financial, and the company contracted by Manulife Financial to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of an insured person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

How to Access Emergency Travel Assistance - Your Emergency Travel Assistance Card

Your Emergency Travel Assistance card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your I.D. number and group policy number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have a Emergency Travel Assistance Card, please contact your Plan Administrator.

Health Service Navigator™

Health Service Navigator™

Your Extended Health Care benefit includes Health Service Navigator, a service designed to provide credible health information and resources to assist you in better understanding your health concerns and health services available within Canada and your local community. It includes provincial guides that summarize the coverage available to you through your provincial health plan coverage, a national physician search database and tips on how to navigate and leverage the myriad of health resources available to you within the Canadian health care system. Health Service Navigator also provides access to a second opinion service delivered through a premiere second opinion service coordinator with a consortium of highly ranked U.S. based hospitals that support the service. Second opinions are available for a broad range of specific medical conditions.

Limitations

Any medical conditions that are a direct result of either of the following events are excluded from coverage for Health Service Navigator:

Radioactive Contamination that is not associated with one's occupation; or

War or warlike operations (whether war is declared or not), invasion, act of foreign enemy, hostilities, mutiny, riot, civil commotion, civil war, rebellion, revolution, insurrections, conspiracy, military or usurped power, martial law or state of siege, or any events or causes which determine the proclamation or maintenance of martial law or state of siege.

Furthermore, Manulife Financial shall not be liable for any expense incurred by you or your eligible dependent which is not specifically described and covered under this Health Service Navigator benefit or your Group Benefits Policy, including but not limited to the cost of treatment, travel costs, fees, medical expenses, appointment cancellation charges and other expenses.

Right of Refusal

In some cases, the medical information submitted by the patient may be determined by the physicians of the consortium hospitals to be insufficient, or not of an adequate quality to render a second opinion. In such cases, the second opinion service coordinator will inform the patient within 24 hours, of the reasons for the inability to deliver a report. The patient will then have the opportunity to deliver additional or alternative material to the second opinion service coordinator, for consideration by the physicians of the consortium hospital rendering the opinion. If such information is still insufficient, then the physicians of such consortium hospital have the right to refuse to render a second opinion, and neither they nor the second opinion service coordinator nor Manulife shall have any further obligation in relation to such second opinion request.

Summary Only

Please note that the provisions in this section of the booklet are only intended as a brief summary of the services available under Health Service Navigator. Your plan member brochure has additional information concerning the services. Your Plan Administrator or Manulife Financial can answer any questions you may have about this benefit.

Submitting a Claim

Extended Health Care - Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your Plan Administrator.

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

All claims must be submitted within 12 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.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

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, Manulife Financial 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 Manulife Financial those amounts you recover which, when added to the payments you received from Manulife Financial, exceed 100% of your incurred expenses.

Exclusions

Extended Health Care - Exclusions

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

(not applicable to Health Service Navigator™)

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

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 alcohol

an illness or injury for which benefits are payable under any government plan or workers' compensation

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 insurance

services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance

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 insured person, an immediate family member or a person who lives with the insured 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

Continuation of Coverage

Extended Health Care - Continuation of Coverage

If a person is disabled when insurance under this Extended Health Care benefit terminates, covered expenses related to the treatment of the disability will continue to be payable by Manulife Financial, for up to 90 days. Any claims will be subject to the time limitations as outlined under Submitting a Claim, unless a longer period is required by legislation. However, coverage will terminate if the disabled person becomes eligible for insurance under another group plan.

You will be considered disabled if you are unable to work at any occupation for which you are qualified or may reasonably become qualified by reason of training, education, or experience.

Your dependent will be considered disabled 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.

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

Dental Care - The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for your Province of Residence

Benefit Percentage (Co-insurance) -

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

Unlimited for Level I

Unlimited for Level II

$1,500 per calendar year combined for Level III and Level IV

$1,500 per lifetime for Level V

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of an insured person while insured under this benefit

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

are reasonable as determined by Manulife Financial, taking all factors into account, and

do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide.

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.

Level I - Basic Services

Dental Care - Level I - Basic Services

complete oral exam, one per 2 calendar years

full-mouth x-rays, one per 2 calendar years

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

recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year (for persons age 21 and older, fluoride applications are covered only when the person has been treated for gum disease)

routine diagnostic and laboratory procedures

initial oral hygiene instruction, plus one recall

fillings, retentive pins and pit and fissure sealants. 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)

space maintainers (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

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

appliances to control oral habits

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 8 units per calendar year(s) ;

- provisional splinting; and

- occlusal equilibration, up to a maximum of 8 units per calendar year(s)

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

Level III - Dentures

Dental Care - Level III - Dentures

initial provision of full or partial removable dentures

replacement of removable dentures, provided the dentures are required because:

- a natural tooth is extracted and the existing appliance cannot be made serviceable;

- the existing appliance is at least 60 months old and cannot be made serviceable; or

- the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

dentures required solely to replace a natural tooth which was missing prior to becoming insured for this covered expense are not covered

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay

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

veneers

initial provision of fixed bridgework

replacement of bridgework, provided the new bridgework is required because:

- a natural tooth is extracted and the existing appliance cannot be made serviceable;

- the existing appliance is at least 60 months old and cannot be made serviceable; or

- the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

bridgework required solely to replace a natural tooth which was missing prior to becoming insured for this covered expense is not covered

Level V - Orthodontics

Dental Care - Level V - Orthodontics

orthodontic services

appliances to control oral habits are covered under Level I - Basic Services

Late Entrant Limitation

Dental Care - Late Entrant Limitation

If you or your dependents become insured 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 insured 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, other than treatment covered under Level V - Orthodontics, that was in progress at the time your dental benefits terminate (for reasons other than termination of the Group Policy or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Covered expenses related to dental treatment covered under Level V - Orthodontics, that was in progress at the time your dental benefits terminate (for reasons other than termination of the Group Policy or the Dental Care Benefit) are payable provided a pre-determination for these orthodontics expenses had been issued by Manulife Financial prior to the termination and provided the these expenses are incurred within 90 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.

All claims must be submitted within 12 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.

Many dental offices are equipped to submit claims electronically to Manulife Financial. In this situation, completion of a paper claim form is not required. Ask your dental office about EDI.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, Manulife Financial 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 Manulife Financial those amounts you recover which, when added to the payments you received from Manulife Financial, exceed 100% of your incurred expenses.

Exclusions

Dental Care - Exclusions

No Dental Care benefits will be payable for expenses resulting from:

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

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

injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured 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 insurance

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 insured person, an immediate family member or a person who lives with the insured 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 insured under this Group Benefit Program, Manulife Financial will continue the Extended Health Care and Dental Care benefits without payment of premium, until the earliest of:

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

the date similar coverage is obtained elsewhere,

the date which is 2 years from your death, or

the date the Group Policy terminates.

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.