The Corporation of the City of Vaughan

Group Policy Number: G0155212

Plan M2: City of Vaughan Retired Firefighters Age 65 and Over

Note: The above is the main number you should provide as a reference when contacting Manulife. Be sure to record this number and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

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Important information about your benefits:

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. Every effort has been made to describe the program accurately. However, should there be a question of interpretation, the terms outlined in the official plan documents will prevail.

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

a) the Group Policy;

b) your application for group benefits; and

c) 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 Group Policy.

Manulife 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.

Explanation of Common Insurance Terms

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

Adherence

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

Advisory Body

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

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by Manulife.

Birth

the complete live delivery of a child from its mother.

Covered Expenses

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

Deductible

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

Dependent

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

- Spouse

your legal Spouse, or a person continuously living with you in a role like that of a marriage partner for at least 24 months.

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

- Child

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

a) unmarried;

b) under age 22, or under age 25 if a full-time student attending an accredited educational institute, college or university;

c) not employed on a full-time basis; and

d) not eligible for insurance as an employee under this or any other Group Benefit Program.

A newborn Child shall become eligible from the moment of birth.

A stepchild must be living with you to be eligible.

A Child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible Dependent. However, the Child must have been 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 you for support, maintenance and care, due to a mental or physical handicap.

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

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

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

Due Diligence

a process employed by Manulife to assess new Drugs, existing Drugs with new indications, services or supplies to determine eligibility under the Group Policy. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial/Territorial formularies, recognized clinical practice guidelines, or an Advisory Body.

Exclusive Distribution

Manulife-approved vendors.

Experimental or Investigational

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

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 Drug

includes but is not limited to:

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

b) a Drug that contains the same active ingredient that has not been deemed interchangeable in the province/territory where the Drug is dispensed; but has been identified as interchangeable by Manulife.

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.

Explanation of Common Insurance Terms

Life-Sustaining Drugs

non-prescription Drugs which are necessary to sustain life.

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

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

Non-Evidence Limit

you must submit satisfactory medical evidence to Manulife for Benefit Amounts greater than this amount.

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

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

Prior Authorization

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

Provincial/Territorial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province/territory where the insured 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;

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

c) the maximum price established by law.

Ward

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

Eligibility

You are eligible for Group Benefits, as long as you:

a) are a retired employee of The Corporation of the City of Vaughan and retired in accordance with the OMERS Act and had permanently worked for at least 5 continuous years up to the date of retirement; and

b) are younger than the Termination Age; and

c) are residing in Canada and eligible for your Provincial/Territorial Benefit Plan.

Your Dependents are eligible for coverage 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.

Note: Where used in this Benefit Booklet, the term employee shall mean retiree.

Evidence of Insurability

Medical evidence is required when you apply for insurance in excess of the Non-Evidence Limit.

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

In all cases, medical evidence can be submitted by completing the Evidence of Insurability form, available from your plan administrator, or at www.manulife.ca/groupbenefits. Further medical evidence may be requested by Manulife*.*

Late Application

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

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

b) apply for benefits, and benefits under your spouse's plan have not terminated.

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, whichever is later.

Your Dependent's insurance becomes effective on the date the Dependent becomes eligible, or the date any required medical evidence on the Dependent is approved by Manulife, whichever is later.

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

For any changes in coverage (Dependent coverage, beneficiary information, name, applying for coverage that was previously waived), complete the Application for Change form, available at www.manulife.ca/groupbenefits, or from your plan administrator.

The Claims Process

Submitting a Claim

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

Submit Online (if applicable)

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

If your health care service provider cannot send Manulife 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. Mailing instructions are included on the claim form.

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

Submission Requirements

Claims must be submitted within the following timeframes:

a) 90 days from the date of the loss, for claims for Life benefits; and

b) 12 months from the date the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while insurance under the plan is in force. Upon termination of a person's insurance under this plan, proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

   i) 12 months from the date the expense was incurred; or

   ii) 90 days from the date of termination of coverage.

For Life claims, complete the Life Claim form.

For Extended Health Care, complete the Extended Health Care form. Visit the forms section at www.manulife.ca/groupbenefits to determine which claimed expenses can be submitted via the website.

For Out-of-Province/Territory or Out-of-Canada expenses, complete the Out of Province/Territory claim form. Expenses must first be submitted to the Provincial/Territorial Plan for payment. Any outstanding balance should be submitted to Manulife, along with the explanation of payment from the Provincial/Territorial Plan.

For Dental Care, claims can be submitted either electronically by your dentist, or you can complete a standard dental claim form.

Co-ordination of Extended Health Care and Dental Care Benefits

Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and (briefly) here's how it works:

If you have a claim for yourself: then submit to Manulife first. For any unpaid balances, send a copy of your Manulife claim statement and the other insurance carrier's claim form to the other insurance company for processing.

If you have a claim for your Spouse: then submit the claim to your Spouse's insurance company. For any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing.

If you have a claim for a dependent Child: then send the claim to the insurance carrier of the parent whose birthdate falls earliest in the calendar year first. Submit any unpaid balance to the other insurance company.

For complete details, please go to www.manulife.ca/groupbenefits.

Naming a Beneficiary

This Plan 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.

Manulife does not accept beneficiary designations for any benefits other than Employee Life Insurance.

Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against Manulife less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitation of Actions Act (NB)
Civil Code of Quebec (QC)

Termination of Insurance

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

a) the date you cease to be an eligible employee, for reasons other than retirement;

b) the date your employer terminates coverage;

c) the date you enter the armed forces of any country on a full-time basis;

d) the date the Group Policy terminates or coverage on the class to which you belong terminates;

e) the date you reach the Termination Age; or

f) 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.

Employee and Family Assistance Program

Your benefits offer an Employee and Family Assistance Program. It can help with challenges you face at work, at home, and in life.

It's delivered by a leading supplier of employee and family assistance programs. It's a full-service program offered across Canada.

This booklet is only a summary of the services. Your plan sponsor has an agreement with Manulife which provides details about Employee and Family Assistance Program. It explains the services in full. If this booklet differs at all from that Agreement, the Agreement will apply.

If you have any questions about these services, ask your plan administrator or Manulife.

Employee and Family Assistance Program services are for:

- you
- your spouse
- your dependents

What this program offers

Here are the services offered by this program.

Short-term counselling
You may call a counsellor and ask for short-term counselling.

The first time you call, you can ask for emergency help, or set up a first meeting. You may call toll-free, 24 hours a day, seven days a week. The service can be in English or French. Simply call 1-844-505-6240 to get help with issues such as anxiety, stress, divorce, family, mental health, weight management, smoking, general health concerns, and more.

Your plan covers short-term counselling. How much counselling you get will depend on your needs, at your counsellor's discretion.

Short-term counselling may help with stress and anxiety from:

- your job
- marital and family problems
- alcohol and drug use
- anger management
- pre-retirement planning
- grief
- physical or sexual abuse
- general health issues.

You can ask for short-term counselling for any number of these issues.

As part of short-term counselling, a counsellor will:

- assess the issue
- give support
- teach skills to help manage the issue
- help create a response plan.

Your Group Benefits

Referrals
If short-term counselling isn't right for your issue, your counsellor may refer you. They may refer you to another service agency or organization.

Your counsellor does not provide the service they refer you to, or help pay for it.

Work-Life services

Your plan offers coaching for lifestyle and other specialty issues. It's offered by phone or online. It may help you with issues like these.

Life balance solutions

- Childcare and parenting caregiver support – help to deal with parenting issues.
- Eldercare or family care – one-on-one support that offers custom information for your situation.

Financial counselling

Your plan covers up to 50 min of financial counselling. There is 1 session per year, per presenting issue.

You can ask for help with things like:

- budgeting and managing debt
- bankruptcy
- insurance
- the financial side of divorce or separation
- early retirement
- real estate transactions.

Legal counselling

This benefit covers up to 30 minutes of legal counselling. There is 1 session per year, per presenting issue. You'll meet with a lawyer who specializes in the area of law you need.

If you need other legal services, you must arrange it and pay any fees or expenses. You can hire the lawyer at a discount.

Grief and loss coaching

Your plan can help if you're dealing with grief or loss. It offers coaching support, plus other resources.

It can help with:

- the loss of a loved one
- job loss
- divorce or the end of a relationship.

Relationship solutions

This is a coaching service for couples. It helps couples take a proactive approach to enhancing their relationship.

Career Services

Your plan offers help with career development. It helps you to identify and list your skills and aptitudes. It can also help assess your personality traits, values, and interests that relate to your choice of a career.

It may also offer coaching for:

- Career Planning
- change and transition management
- time management.
- Pre-Retirement Planning

Smoking cessation

Need help to quit smoking? This resource can help. It offers personal support to help you deal with the physical dependence on nicotine. It also helps you deal with the psychological dependence on smoking habits and the desire to smoke.

Nutritional counselling

Looking for nutritional guidance? This benefit can help with the counselling you want. It's designed to teach you healthy eating habits, how to improve weight and energy, and avoid disease.

It includes:

- advice on topics ranging from general healthy eating to weight gain/loss
- personalized food plans
- one-on-one coaching sessions with a Canadian-registered dietitian.

Online courses

Your plan offers online resources. You may access any available material on the website as often as you wish.

Helpful topics include:

- stress management
- parenting foundations
- anger management.

Childcare and eldercare support

This service can help you find a new daycare for your child, or a long-term care facility for an elderly parent.

The database is only an information resource. It doesn't help pay for any services.

Cognitive Behavioural Therapy (iCBT)

Self-directed online therapy offers participants access to a wide range of resources designed to help with various topics related to the body, the mind, relationships, work and personal finances. You can use the program as much as you want.

While accessing a wide range of resources at your own convenience, asynchronous counselling support is also available as needed via messaging.

Exclusions

The Employee and Family Assistance Program services won't cover:

- costs for any physical health issues
- costs for travelling to or from an appointment
- fees for cancelling an appointment
- expenses you should submit to your health benefits
- costs outside of counselling, such as books or other items
- services or items this booklet doesn't list under Employee and Family Assistance Program services. For the complete list, ask your plan sponsor about their Employee and Family Assistance Services Agreement.

Life Insurance Benefit

Benefit Details

Employee Life

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

Benefit Amount - $15,000

Non-Evidence Limit - $15,000

Termination Age - your benefit amount terminates upon your death

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your plan administrator.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife within 31 days of the termination or reduction of your Life Insurance. If you die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your plan administrator. Provincial/Territorial differences may exist.

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

Overall Benefit Maximum - Unlimited

Deductible - $100 Individual, $100 Family, per calendar year

Not applicable to:
- Hospital Care
- Drugs
- Out-of-Province/Territory or Out-of-Canada Emergency Medical Treatment
- Out-of-Canada – Referrals

Note: The deductible is not applicable to Emergency Travel Assistance.

Benefit Percentage (Co-insurance)

100% up to the Reasonable and Customary limitations for
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies

90% for
- Drugs

Note:
The Benefit Percentage for Out-of-Province/Territory or 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%.

Termination Age – none

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary, as determined by Manulife, provided they are:

a) Medically Necessary for the treatment of an illness or injury and recommended by a physician;

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

d) not covered under the Provincial/Territorial Plan or any other government-sponsored program;

e) legally insurable;

f) used as prescribed or recommended by a physician; and

g) 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 and shared with your employer as required.

In the event that a provincial/territorial 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 using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include as a covered expense, exclude or apply maximum limits.

At Manulife'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 has the right to ensure you or your Dependents access Manulife's Exclusive Distribution channels where applicable when purchasing a drug, service or supply. Manulife 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 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 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.

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.

- 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

a) charges, in excess of the hospital's public Ward charge, for private accommodation, provided:

   i) the person was confined to hospital on an in-patient basis, and

   ii) the accommodation was specifically elected in writing by the patient

b) private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days

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

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your Drug benefit.

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:

a) Drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist;

b) oral contraceptives;

c) injectable vitamins and medications;

d) Life-Sustaining Drugs;

e) Drugs used in the treatment of a sexual dysfunction; and

f) standard syringes, needles and diagnostic aids, required for the treatment of diabetes.

Charges for the following expenses are **not** covered:

a) charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment;

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

c) Drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis;

d) Drugs determined to be ineligible as a result of Due Diligence;

e) fertility Drugs;

f) prescription vitamins;

g) non-prescription injectable vitamins;

h) anti-smoking Drugs;

i) intrauterine devices and diaphragms; or

j) over-the-counter drugs.

- Payment of Covered Expenses

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

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/Territorial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

Manulife 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

If your prescription contains a written direction from your physician or dentist that the prescribed Drug is not to be substituted with another product, the maximum amount covered is the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial/Territorial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

Reimbursement at the cost of a prescribed Drug, where a Lower Cost Alternative Drug is available, will only be considered if medical evidence is provided by the treating physician to support why the Lower Cost Alternative Drug cannot be tolerated or is ineffective.

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

- 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:

a) you cannot locate a participating Pay Direct Drug pharmacy;

b) you do not have your Pay Direct Drug Card with you at that time; or

c) 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

a) eye exams, to a maximum of $450 per 2 calendar years combined for eye exams and prescription glasses

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $450 per 2 calendar years combined for eye exams and prescription glasses ;

c) 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 per lifetime;

d) visual training, to a maximum of $10 per half hour; and

e) elective laser vision correction procedures and prescription safety glasses are not covered.

Professional Services

Services provided by the following licensed practitioners:

a) Acupuncturist - $50 per visit

b) Chiropractor - $50 per visit. In addition, $50 per calendar year for x-rays.

c) Massage Therapist - $50 per visit

d) Mental Health Practitioners* - 10 visits per calendar year to a maximum of $2,500 per calendar year

e) Naturopath - $50 per visit

f) Osteopath - $50 per visit. Charges for x-rays are not eligible.

g) Physiotherapist - $50 per visit

h) Podiatrist/Chiropodist - $50 per visit. In addition, surgery up to a maximum of $200 per calendar year. Charges for x-rays are not eligible.

i) Speech Therapist - $50 per visit

*Mental Health Practitioners include Psychoanalysts, Psychologists, Psychotherapists and Social Workers only

Recommendation by a physician for Professional Services is not required.

Expenses for some of these Professional Services. other than podiatrist/chiropodist, may be payable in part by Provincial/Territorial Plans. Coverage for the balance of such expenses prior to reaching the Provincial/Territorial Plan maximum may be prohibited by provincial/territorial legislation. In those provinces/territories, expenses under this Benefit Program are payable after the Provincial/Territorial Plan's maximum for the benefit year has been paid.

Expenses for podiatrist/chiropodist may be payable in part by Provincial/Territorial Plans. In those provinces/territories, expenses under this Benefit Program are payable after the Provincial/Territorial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

Note: *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 a maximum of $10,000 per calendar year, up to a maximum of $25,000 per lifetime.

Charges for the following services are **not** covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

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

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

Ambulance

Charges for a licensed ambulance service provided in the patient's province/territory of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available, from one hospital to another, or from hospital to insured person’s residence.

Medical Equipment

Rental or, when approved by Manulife, 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.

Non-Dental Prostheses and Supports

a) external prostheses;

b) breast prosthesis, initial following a mastectomy and a replacement every 2 calendar years;

c) surgical stockings, up to a maximum of 2 pairs per calendar year;

d) surgical brassieres, up to a maximum of 2 per calendar year;

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

f) custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of 1 pair per calendar year (must be constructed by a certified orthopaedic footwear specialist).

Other Supplies and Services

a) ileostomy, colostomy and incontinence supplies;

b) medicated dressings and burn garments;

c) wigs and hairpieces, up to a maximum of $100 per lifetime for patients with temporary hair loss as a result of chemotherapy, and up to a maximum of $250 per lifetime for patients with Alopecia Totalis;

d) oxygen;

e) continuous glucose monitoring machines, $4,000 per calendar year including sensors and transmitters;

f) viscosupplementation;

g) microscopic and other similar diagnostic tests and services, including Radium treatments, non-dental x-rays, prostate specific antigen (PSA), cancer antigen 125 (CA125), anti-cardiolpi antibodies and human papillomavirus (HPV) tests, rendered in a licensed laboratory in any province/territory; and

h) 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/Territory or Out-of-Canada and Emergency Travel Assistance

IMPORTANT NOTICE

Your Group Policy includes travel coverage – what's next? We want you to understand (and it is in your best interests to know) what your Policy includes, what it excludes, and what is limited (payable but with limits). Please take time to read through this benefits booklet before you travel.

- This benefit covers claims arising from sudden and unforeseen situations (example: accidents and emergencies) and typically not follow-up or recurrent care.
- To qualify for this benefit, you and your dependents must meet all of the eligibility requirements (example: covered by your provincial/territorial health insurance plan for the duration of your trip).
- This benefit contains limitations and exclusions. Examples may include: Medical Conditions that are not Stable, Medical Emergencies related to pregnancy or delivery within 4 weeks of the expected date of delivery.
- This benefit may not cover claims related to pre-existing Medical Conditions, whether diagnosed or not at the time of departure.
- In the event of a claim your prior medical history may be reviewed.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. IF YOU HAVE QUESTIONS, PLEASE CONTACT THE MANULIFE CUSTOMER SERVICE CENTRE AT 1-800-268-6195 OR ONLINE AT MANULIFE.CA

Special definitions

The following terms apply for the purposes of medical Treatment provided outside of the Employee or Dependent's province/territory of residence.

Hospital

a Hospital is an institution that is licensed as an accredited hospital that is staffed and operated for the care and Treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment.

a Hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the older adults or health spa.

Medical Condition

any disease, illness or injury (including symptoms of undiagnosed conditions).

Medical Emergency

a sudden and unforeseen Medical Condition that requires immediate Treatment. A Medical Emergency no longer exists when the evidence reviewed by Manulife indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment.

Physician

a Physician is a person licensed in the jurisdiction where the services are provided, to prescribe and administer medical Treatment.

Reasonable and Customary Charges

charges incurred for drugs, services and supplies that are comparable to what other providers charge for similar drugs, services and supplies in the same geographical area.

the lowest of:

a) The prevailing amount charged in the absence of insurance for the same or comparable drug, services or supply in the same geographical area in which the charge is incurred, as determined by Manulife; or

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

c) the maximum price established by law; or

d) the amount as determined by Manulife as reasonable to be charged for the drug, service, or supply.

Stable

a Medical Condition is considered Stable when in the 90 days prior to departure **all** of the following statements are true:

a) there has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment, and

b) there has not been any change to any existing prescribed drug, or any recommendation or starting of a new prescription drug, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, and

c) the Medical Condition has not become worse, and

d) there have not been any new, more frequent or more severe symptoms, and

e) there has been no hospitalization or referral to a specialist, and

f) there have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

g) there is no planned or pending treatment.

All of the above conditions must be met for a Medical Condition to be considered Stable.

Treatment, Treat

a procedure prescribed, performed or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing and surgery.

Out-of-Province/Territory or Out-of-Canada

Coverage Information

a) Treatment required as a result of a Medical Emergency which occurs during the first 2 weeks while temporarily outside the province/territory of residence, provided the insured person who receives the Treatment is also covered by the Provincial/Territorial Plan during the absence from the province/territory of residence, up to a maximum of $1,000,000 per lifetime.

b) referral outside of Canada for medical Treatment which is available in Canada at 50% coverage to a maximum of $3,000 per 3 calendar year

   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 included in the above maximum.

   For all non-emergency medical Treatment out of Canada:

   i) the Treatment must be recommended by a Physician practicing in Canada, and

   ii) it is advisable that you submit a detailed Treatment plan with cost estimates before Treatment begins. You will then be notified of any benefit that will be provided.

Charges for the following are payable under this expense:

a) Physician's services;

b) 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;

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/territory 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/Territorial Plan.

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

Emergency Travel Assistance

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

Please call the travel assistance organization before obtaining Treatment, so we may:

a) confirm coverage

b) provide referrals

c) provide assistance

d) authorize Treatment

If it is medically impossible for you to call prior to obtaining Treatment, we ask you to call or have someone call on your behalf as soon as possible.

Your Emergency Travel Assistance card lists the toll-free numbers to call in case of an emergency, while travelling outside your province/territory. 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 an Emergency Travel Assistance Card, please contact your plan administrator.

Emergency Travel Assistance is a travel assistance program available for you and your covered Dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a Medical Emergency while travelling outside your province/territory of residence, for the same period as specified under the Out-of-Province/Territory or Out-of-Canada benefit.

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

Medical Emergency Assistance

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**

Payment and co-ordination of expenses will take into account the insurance that the insured person is eligible for under a Provincial/Territorial 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 shall have the right to recover the excess amount by assignment of Provincial/Territorial 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 or territory of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province/Territory or 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.

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.

j) **Vehicle Return**

If an insured person is unable to operate their 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/Territory 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 their province/territory 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.

Exceptions

Manulife, and the company contracted by Manulife 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.

No Out-of-Province/Territory or Out-of-Canada Medical Emergency or Emergency Travel Assistance benefits are payable for expenses directly or indirectly related to:

a) any Medical Condition which is not Stable in the 90 days before the scheduled date of departure from the province/territory of residence;

b) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

c) further related medical Treatment if Manulife determines that you should transfer to another facility or return to your home province/territory of residence for treatment;

d) tests, Treatment or surgery for which you could have returned home, after your Medical Emergency Treatment has started. This includes but is not limited to invasive or investigative testing, MRI, CT, surgery, cardiac catheterization, other cardiac procedures, transplant, and follow up appointments;

e) non-Emergency or elective Treatment (e.g. cosmetic surgery, chronic care, rehabilitation, or any Treatment not immediately medically required, including any expenses for directly or indirectly related complications);

f) any claim, if you or your Dependent are not covered under the Government Health Insurance Plan (GHIP) of your province or territory of residence for the entire duration of the trip. It is your responsibility to check that you do have this coverage;

g) any charges incurred relating to a trip made for the purpose of obtaining a diagnosis, Treatment, surgery, investigation, palliative care, or any alternative therapy, as well as any related complication;

h) any Medical Condition or symptoms for which it is reasonable to believe or expect that Treatment will be required during your trip;

i) the continued Treatment, recurrence or complication of a Medical Condition or related condition, following Emergency Treatment during your trip, if Manulife determines that your Emergency has ended and you are able to return to your province/territory of residence for further Treatment;

j) a Medical Condition that is the result of you or your covered Dependent not following Treatment as prescribed, including prescribed prescription or over-the-counter medication;

k) any Medical Emergency related to a to pregnancy, delivery, or complications of either, for insured persons who are pregnant and travelling within 4 weeks of the expected date of delivery;

l) a Medical Condition arising during your trip from, or in any way related to, the operation of a motor vehicle or watercraft of any kind by you or your covered Dependent while impaired by a drug or any intoxicant or having a blood alcohol level of more than 80 mg of alcohol per 100 ml of blood.

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

Exclusions

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

a) war, whether declared or undeclared, insurrection, the hostile actions of any armed forces, willing participation in a riot or civil commotion or any service in the armed forces of any country;

b) your involvement in the commission or attempted commission of an assault, criminal offence, or illegal act;

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

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

e) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

f) services or supplies provided by an employer's medical or dental department;

g) services or supplies for which no charge would normally be made in the absence of insurance;

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

i) services or supplies which are not permitted by law to be paid;

j) services or supplies which are required for recreation or sports;

k) services or supplies which would have been payable by the Provincial/Territorial Plan if proper application had been made;

l) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

m) medical or surgical care which is cosmetic;

n) 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;

o) services or supplies which are provided while confined in a hospital on an in-patient basis; or

p) services or supplies which are not specified as a covered expense under this benefit.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

If you and your Dependents reside in Quebec, the following provisions apply to your Drug benefit coverage.

Covered Expenses

The following expenses are covered:

a) Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List, provided such Drugs are on the list at the time the expense is incurred; and

b) covered pharmacy services that are to be paid when the drug is on the Quebec Basic Prescription Drug Insurance Plan List; and

c) Drugs that are listed as a Covered Expense in this Benefit Booklet, but are not on the Quebec Basic Prescription Drug Insurance Plan List.

Coverage for Drugs on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services published for private plans

The following provisions apply to the coverage of Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act. Coverage for all other Drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered Drug expenses payable will be:

i) for any Drugs on the Quebec Basic Prescription Drug Insurance Plan List which are not otherwise covered under the terms of the plan, the percentage as set out by the then applicable Legislation.

ii) for any Legislated pharmacy services, which are not otherwise covered under the terms of the plan, the percentage payable is as set out by the then applicable Legislation.

iii) for any Drug on the Quebec Basic Prescription Drug Insurance Plan List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage stated under The Benefit, 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 Drug expenses payable under this benefit will be 100%.

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

The annual out-of-pocket maximum is a portion of covered Drug expenses or covered pharmacy services which must be paid by you and your Spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are

i) Deductible amounts, and

ii) the portion of covered Drug expenses that is paid by a covered person, when the percentage of Covered Expenses payable under this benefit is less than 100%, and

iii) covered pharmacy services that are performed by pharmacists for Drugs on the Quebec Basic Prescription Drug Insurance Plan List.

The annual out-of-pocket maximum for you and your Spouse is as stipulated in the Legislation and includes those portions of covered Drug expenses and covered pharmacy services relating to a drug on the Quebec Basic Prescription Drug Insurance Plan List paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your Spouse, those portions of covered Drug expenses and covered pharmacy services paid for your 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) for the Drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the Deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to Drugs on the Quebec Basic Prescription Drug Insurance Plan List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services that are performed for Drugs on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by Manulife for Covered Expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

i) the age specified in this Benefit Booklet (please refer to definition of Child in the Explanation of Common Insurance Terms), and

ii) age 26.

Drug coverage and covered pharmacy services provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services performed for a Drug on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by Manulife for Covered Expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the Drug benefit will not apply. Drug coverage provided after the Termination Age as specified under the benefit is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered,

ii) only covered pharmacy services related to a drug on the Quebec Basic Prescription Drug Insurance Plan List are covered,

iii) the percentage payable Manulife stipulated in the then applicable Legislation, and

iv) the premium required for the Drug coverage is the premium for the Extended Health Care benefit.

Coverage for Drugs that are listed as a covered expense in this Benefit Booklet but are not on the Quebec Basic Prescription Drug Insurance Plan List

Coverage for Drugs that are listed as a covered expense under this Benefit but not on the Quebec Basic Prescription Drug Insurance Plan List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care Benefit

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

Deductible - Nil

Dental Fee Guide - Fee Guide for General Practitioners which was in effect 3 years prior to the current Fee Guide for your Province/Territory of Residence

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

Benefit Maximums

unlimited for Level I and Level II

Termination Age – none

Covered Expenses

The following expenses are covered if they:

a) are incurred for the necessary dental care of a covered person while covered under this benefit;

b) 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;

c) are reasonable as determined by Manulife, taking all factors into account; and

d) do not exceed the fees recommended in the Dental Fee Guide, or Reasonable and Customary charges as determined by Manulife, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

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

Level I - Basic Services

a) complete oral exam, once per 2 calendar years;

b) full-mouth or panoramic x-rays, once per 2 calendar years;

c) one unit of light scaling and one unit of polishing, once every 9 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 9 months, when the service is performed in Quebec;

d) recall exams, bitewing x-rays and fluoride treatment, once every 9 months (no limit on number of films for bitewing x-rays);

e) routine diagnostic and laboratory procedures;

f) oral hygiene instruction, once every 6 months;

g) fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:

   i) 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

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

h) pre-fabricated full coverage restorations (metal and plastic);

i) space maintainers (appliances placed for orthodontic purposes are not covered);

j) minor surgical procedures and post-surgical care;

k) extractions (including impacted and residual roots)

l) consultations, anaesthesia, and conscious sedation;

m) 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; and

n) 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, up to a combined maximum of 14 units per calendar year,

   ii) provisional splinting,

   iii) occlusal equilibration, up to a maximum of 8 units per calendar year;

c) endodontic services which include root canals and therapy, root amputation, apexifications and periapical services:

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

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

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 $250 for each insured person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, Manulife 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

Covered Expenses related to dental treatment 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.

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

Exclusions

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

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

b) committing or attempting to commit an assault or criminal offence;

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

d) dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit;

e) anti-snoring or sleep apnea devices;

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

g) services which are payable by any government plan;

h) services or supplies provided by an employer's medical or dental department;

i) services or supplies for which no charge would normally be made in the absence of insurance;

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

k) replacement of removable dental appliances which have been lost, mislaid or stolen;

l) laboratory fees which exceed Reasonable and Customary charges;

m) 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;

n) implants, or any services rendered in conjunction with implants;

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

p) services or supplies which are not specified as a covered expense under this benefit.

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, Manulife will continue the Employee and Family Assistance Program, Extended Health Care and Dental Care benefits without payment of premium. The coverage continued on a Dependent will be the same as that which was in effect on the date of your death and is subject to any age reduction or termination shown in the Group Policy at that time.

Coverage will continue until the earliest of:

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

b) the date similar coverage is obtained elsewhere;

c) the date which is 24 months from your death; or

d) 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.