



The City of Whitehorse

Plan Document Number: G0126237

Group Policy Numbers: G0126236, G0126238

Plan H: Confidential Exclusion

Note: The above are the main numbers you should provide as a reference when contacting Manulife. Be sure to record these numbers 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

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.

Authorized Licensed Producer

organization approved by Health Canada to produce and sell Medical Marijuana.

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 Plan.

- 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.

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

Explanation of Common Insurance Terms

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 formularies, recognized clinical practice guidelines, or an Advisory Body.

Earnings

your regular rate of pay from your employer (prior to deductions), excluding bonuses, overtime pay and commissions. Earnings may include other income as agreed to in writing by your employer and Manulife.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- a) the amount reported on your claim form; or
- b) the amount reported by your employer to Manulife and for which premiums have been paid.

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.

Explanation of Common Insurance Terms

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 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.

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.

Medical Marijuana

also known as medical cannabis, refers to any Drug made from cannabis or its active ingredients that does not have a Drug Identification Number, is authorized for specific medical conditions and authorized by a health care professional whose scope of practice within their province permits them to authorize the use of Medical Marijuana. For the purpose of this Policy, the term "Drug" includes Medical Marijuana.

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 Drugs, supplies or services to determine eligibility based on predefined clinical criteria and a Pharmacoeconomic or cost effectiveness evaluation.

Explanation of Common Insurance Terms

Provincial Plan

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

Qualifying Period

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

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.

Strains

Medical Marijuana Strains are either pure or hybrid varieties of the Cannabis group of plants.

Take Home Pay (Net Earnings)

your Earnings, less deductions normally made for federal and provincial income tax.

Total Disability or Totally Disabled

For Life Insurance and Long Term Disability

a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- a) your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and
- b) any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above.

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

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

Waiting Period

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

Ward

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

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits:

- a) as of the first of the month following 60 calendar days of continuous service for Employee Life Insurance, Employee Optional Life Insurance, Dependent Optional Life Insurance, Accidental Death and Dismemberment, Extended Health Care, Dental Care and Critical Illness Benefits; and
- b) after a Waiting Period of 90 calendar days of continuous service for the Long Term Disability Benefits;

as long as you:

- a) are an active permanent employee of The City of Whitehorse and work at least 15 hours per week; and
- b) are younger than the Termination Age; and
- c) are residing in Canada.

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.

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.com/groupbenefits. Further medical evidence may be requested by Manulife.

Late Application

An application is considered late when you:

- a) apply for insurance on any person after having been eligible for more than 31 days; or
- b) 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:

- 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.

Who Qualifies for 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, 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 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. This does not apply to Dependent Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.

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.com/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.com/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.com/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 and Accidental Death and Dismemberment benefits;
- b) 90 days of the first diagnosis of the Condition, for Critical Illness;
- c) 180 days from the end of the Qualifying Period, for claims for disability benefits, or when applying for waiver of premiums; and
- d) 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 and AD&D claims, complete the Life Claim form.

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

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

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

For Disability claims, complete the LTD Member's statement. A corresponding LTD Physician's statement (for Long Term Disability) or Waiver Physician's statement (for Waiver of Premiums) must be completed by your attending physician.

For Critical Illness Claims, visit the forms section at www.manulife.com/groupbenefits or contact your plan administrator. To submit a Critical Illness Insurance claim, the person must have survived their illness for 30 days or more past the date they were first diagnosed.

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.com/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, Employee Optional Life Insurance and Accidental Death and Dismemberment

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;
- b) the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date;
- c) the date your employer terminates coverage;
- d) the date you enter the armed forces of any country on a full-time basis;
- e) the date the Group Policy terminates or coverage on the class to which you belong terminates;
- f) the date you reach the Termination Age; or
- g) 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.

Health Service Navigator™ Services

The member care centre support is available from 8 AM to 8 PM Monday to Friday your local time.

Your Extended Health Care benefit includes Health Service Navigator, a service designed to provide credible health information and resources to assist you and your eligible dependents 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.

Your Group Benefits

Life Insurance Benefit

(Employee Life, Employee Optional Life, Dependent Optional Life)

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 - 2 times your annual Earnings, to a maximum of \$500,000

Non-Evidence Limit - \$500,000

Benefit Reduction - your benefit amount reduces by 50% at age 70

Termination Age - your benefit amount terminates at retirement

Employee Optional Life

Benefit Amount - increments of \$10,000 to a maximum of \$300,000

Non-Evidence Limit - \$100,000

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

For Employee Life and Employee Optional Life

Qualifying Period for Waiver of Premium - 119 days

Optional Life Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

No amount of Optional Life Insurance will be paid for any Non-Evidence Limit amount when death is directly or indirectly attributable to a pre-existing condition during the first 24 months of insurance.

For Your Dependents:

If one of your dependents dies while insured, the amount of this benefit is paid to you.

Optional Benefit Amount

- **Spouse** - increments of \$10,000 to a maximum of \$300,000

- **Child** - increments of \$5,000 to a maximum of \$25,000

Non-Evidence Limit - \$50,000

Qualifying Period for Waiver of Premium - same as Employee Life

Termination Age

Spouse - employee's or Spouse's age 70 or employee's retirement, whichever is earlier.

Child - employee's or Spouse's age 70 or employee's retirement, whichever is earlier.

Exclusions

If death results from suicide any amount of Dependent Optional Life Insurance that has been in effect for less than one year will not be payable.

No amount of Spousal Dependent Optional Life Insurance will be paid for any Non-Evidence Limit amount when death is directly or indirectly attributable to a pre-existing condition during the first 24 months of insurance.

Naming a Beneficiary (all Benefits)

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

If you have not appointed a beneficiary under this policy, but you had appointed a beneficiary under a prior policy where you were covered prior to becoming covered under this policy, then the most recently appointed beneficiary under that prior policy is considered your beneficiary under this policy.

You should review your beneficiary designation to be sure that it reflects your current intent.

Employee Optional Life and Spousal Optional Life Eligibility

Insurance for any amounts less than or equal to the stated Non-Evidence Limit are subject to the following conditions:

- a) you may apply to add insurance for yourself or any Dependent at any time;
- b) you or your Spouse, as applicable, must be in good health;
- c) you or your Spouse must not have any physical or mental condition that prevents you or your Spouse:
 - i. from regularly attending to your occupation or your spouse's occupation if Actively at Work;
or
 - ii. from choosing to be employed or engaged in any occupation if not Actively at Work;
- d) you or your Spouse, as applicable, have never been declined when you or your Spouse have applied for Life Insurance or Critical Illness insurance with any insurer or other entity; and
- e) where evidence of insurability is required for any amount of insurance, you or your Spouse must provide Manulife Financial with such evidence that is satisfactory in Manulife Financial's opinion.

You may apply for an increase or decrease in the Benefit Amount for yourself or your Spouse at any time. Where, as a result of any increase, the total Benefit Amount on such person does not exceed the Non-Evidence Limit, and where Manulife Financial approves such increase, then the Pre-Existing Conditions exclusion will apply to the increased portion of the Benefit Amount, commencing on the resulting effective date that such increase is approved. The Pre-Existing Conditions exclusion will continue to apply to the original Benefit Amount from the date that such Benefit Amount became effective.

Where you apply to increase the Benefit Amount on yourself or your Spouse, so that the total resulting Benefit Amount on such person exceeds the Non-Evidence Limit, then detailed evidence of insurability will be required by Manulife Financial. If the increase is approved by Manulife Financial, then the Pre-Existing Conditions exclusion will cease to apply to the total resulting Benefit Amount.

Your Group Benefits

Employee Optional Life and Spousal Optional Life Exclusion

No amount of Employee or Spousal Dependent Optional Life Insurance will be paid for any Non-Evidence Limit amount when your death or your Spouse's death is directly or indirectly attributable to a Pre-Existing Condition during the first 24 months of insurance.

A Pre-existing Condition means an illness or injury for which, during the 24 months prior to the date you or your Spouse's insurance under this benefit became effective, or the latest date of reinstatement of your insurance or your Spouse's insurance whichever is applicable, you or your Spouse have exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication; or where treatment would have been sought by a prudent individual during the 24 months prior to the date that your or your Spouse's insurance under this benefit became effective, or the latest date of reinstatement of insurance, whichever is applicable.

Waiver of Premium

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

- Exception

If you are not insured for Optional Life, the Waiver of Premium provision will not apply to your Spouse's Optional Life Insurance.

Entitlement Criteria

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

- a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;
- b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Common Insurance Terms; and
- c) you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife.

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

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- a) the date you cease to be Totally Disabled, as defined under the Explanation of Common Insurance Terms;
- b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Common Insurance Terms;
- c) the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife;
- d) the date you do not attend an examination by an examiner selected by Manulife;

- e) the date of your death; or
- f) the date of your 65th birthday.

Recurrent Disability

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

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

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

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

Conversion Privilege

If your or your Spouse's Group Benefits terminate or reduce, you and your Spouse 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 or your Spouse 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 differences may exist.

Accidental Death and Dismemberment Benefit

Benefit Details

For You:

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

Accidental Death and Dismemberment

Benefit Amount - 2 times your annual Earnings, to a maximum of \$500,000

Benefit Reduction - your benefit amount reduces by 50% at age 70

Termination Age - your benefit amount terminates at retirement

Qualifying Period for Waiver of Premium - 119 days

Your Group Benefits

Schedule of Losses

A loss shown in this schedule is covered provided it:

- a) is a direct result of the accidental injury;
- b) occurs within 365 days from the date of the accidental injury; and
- c) is total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of the Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of Both Arms or Both Legs - 100%
- Loss of or Loss of Use of One Arm and One Leg - 75%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 75%
- Loss of Sight of One Eye - 75%
- Loss of Speech or Hearing in Both Ears - 75%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while the insured person is living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which the insured person was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If the insured person disappears after a conveyance in which he was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if the insured person's body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife will pay incurred expenses, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife; and
- b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of \$10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

If the insured person dies as a direct result of an accidental injury which occurs while travelling 150 kilometres or more from his place of residence, Manulife will pay for expenses incurred for the preparation and transportation of the insured person's body to his place of residence.

The amount payable is subject to a maximum of \$10,000.

Family Transportation Expenses

If, as a direct result of an accidental injury, the insured person suffers a loss specified in the Schedule of Losses and is confined to a hospital located 150 kilometres or more from the insured person's place of residence, Manulife will pay the hotel and travel expenses incurred by an Immediate Family Member, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife;
- b) for hotel accommodations in the vicinity of the hospital; and
- c) for transportation by the most direct route to the hospital, including return fare.

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of \$0.20 per kilometre travelled.

The amount payable is subject to a maximum of \$5,000 per accident.

Your Group Benefits

Dependent Education Expenses

If you die as a direct result of an accidental injury, Manulife will pay the tuition for each Child who is under age 25 and enrolled as a full-time student:

- a) in a school for higher learning above the secondary school level; or
- b) at the secondary school level, but who enrolls as a full-time student in a school for higher learning within 365 days after your death.

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionnel (CEGEP), community college or trade school.

The maximum payable each year for each Child is the lesser of:

- a) 5% of your Accidental Death and Dismemberment benefit amount; or
- b) \$5,000.

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- a) tuition expenses incurred prior to your death; or
- b) room and board expenses, or other living, travelling or clothing expenses.

Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your Spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Manulife will pay for expenses incurred by your Spouse, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife; and
- b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of \$10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Seat Belt Benefit

If the insured person dies as a direct result of an accidental injury sustained while driving or riding in an automobile, Manulife will pay an additional amount equal to 10% of your Accidental Death and Dismemberment benefit, provided the insured person was wearing his seat belt and it was properly fastened at the time of the accidental injury.

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife will pay day-care expenses for each Child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 90 days from the date of your death.

The maximum payable each year for each Child is the lesser of:

- a) 5% of your Accidental Death and Dismemberment benefit amount; or
- b) \$5,000.

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- a) expenses incurred prior to your death; or
- b) room and board expenses, or other living, travelling or clothing expenses.

Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, the insured person:

- a) suffers a loss of, or loss of use of, both feet or both legs; or
- b) becomes a hemiplegic, paraplegic, or quadriplegic;

and requires the use of a wheelchair to be ambulatory, Manulife will pay for incurred expenses, provided the expenses are:

- a) reasonable and necessary, as determined by Manulife;
- b) incurred within 3 years from the date of the accidental injury;
- c) for alterations to the insured person's home for the purpose of making it wheelchair accessible; and
- d) for modifications to one motor vehicle for the purpose of making it wheelchair accessible.

The amount payable is subject to a maximum of \$10,000.

Hospitalization Allowance

If, as a direct result of an accidental injury, the insured person suffers a loss specified in the Schedule of Losses and is confined to a hospital, Manulife will pay a monthly benefit, provided:

- a) the hospital confinement begins while the person is covered under this benefit; and
- b) the insured person has been confined to the hospital for longer than the qualifying period of 7 consecutive days, and continues to be confined at the end of such period.

The amount of benefit payable is equal to 1% of your Accidental Death and Dismemberment benefit amount, up to a maximum of \$2,500 per month.

Benefits are payable while the insured person is hospital confined, up to a maximum benefit period of 12 months.

Your Group Benefits

- Recurrent Hospitalization

If the insured person becomes hospitalized again due to the same accidental injury within 183 days following a period for which benefits were payable under this provision, this subsequent period of confinement will be considered a continuation of the previous period of hospital confinement.

In such case, the qualifying period of 7 days will be waived and the benefit which was payable during the previous period of hospitalization will be re-instated. Benefits for all such recurrences will not be paid for a combined period longer than the maximum benefit period of 12 months.

Permanent and Total Disability

If, as a direct result of an accidental injury, you become permanently and totally disabled while insured for this benefit, Manulife will pay a lump sum benefit, provided:

- a) you become permanently and totally disabled within 365 days after the date of the accidental injury; and
- b) you have been permanently and totally disabled for a continuous period of 12 months and remain so disabled at the end of this period.

The amount of benefit payable is equal to your Accidental Death and Dismemberment benefit amount.

- Definition of Permanent and Total Disability

You are considered permanently and totally disabled if you are wholly and continuously disabled due to an accidental injury which is severe enough, in Manulife's opinion, to permanently prevent you from working for remuneration or profit.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

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.

If you have not appointed a beneficiary under this policy, but you had appointed a beneficiary under a prior policy where you were covered prior to becoming covered under this policy, then the most recently appointed beneficiary under that prior policy is considered your beneficiary under this policy.

You should review your beneficiary designation to be sure that it reflects your current intent.

Waiver of Premium

If, while the Group Policy is in force, your Insurance premium is waived because you are Totally Disabled, the premium for this benefit will also be waived. (See Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the Group Policy terminates.

Exclusions

No Accidental Death and Dismemberment benefits are payable if the loss results from:

- a) suicide or self-inflicted injuries;
- b) war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion;
- c) an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity;
- d) riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew;
- e) riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer;
- f) committing or attempting to commit an assault or criminal offence; or
- g) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol.

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 - \$1,000,000 per lifetime

Deductible - Nil

Benefit Percentage (Co-insurance)

100% for
Hospital Care
Drugs
Vision
Professional Services
Medical Services and Supplies

Note:

The Benefit Percentage for Out-of-Province/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 - last day of the month following retirement

Your Group Benefits

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 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 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, include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife 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'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.

Manulife Vitality

If you're eligible for Extended Health Care coverage with Manulife Financial, you can choose to participate in Manulife *Vitality* – a digital wellness program that rewards you for making positive health choices.

How does it work?

Earn Vitality Points™ by doing the little things in life – getting a flu shot, going to the gym or getting your teeth cleaned. The more you move and do to improve your lifestyle, the more points you earn, and higher Vitality Status™ you'll reach.

a) Know your health

Your Vitality Age™ gives you an idea of your overall health. And depending on your day-to-day choices, it could be higher or lower than your actual age. Complete your Vitality Health Review™ (VHR) to find out your Vitality Age and other insights into your health.

b) Improve your health

Record your exercise and healthy activity. A customized weekly goal-setting process helps you make healthy choices to improve or maintain your lifestyle – and you earn points for doing so.

c) Enjoy the rewards

Reach your weekly goals, collect your points, and earn rewards from companies like Tim Horton's, Cineplex and Indigo.

How do you get started?

You need to sign up before you can start using this program.

- a) Sign in to your Group Benefits site using your plan contract number and member certificate number.
- b) Click "Sign up for Manulife *Vitality*"
- c) Read the information. Then select "Sign up now!"

Don't forget to download the Manulife *Vitality* for Group Benefits app. That's how you'll become eligible to earn rewards.

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.

Your Group Benefits

- 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, intrauterine devices and diaphragms;
- c) injectable medications;
- d) Life-Sustaining Drugs;
- e) preventive vaccines and medicines (oral or injected);
- f) sclerotherapy;
- g) standard syringes, needles and diagnostic aids, required for the treatment of diabetes; and

- h) Medical Marijuana for the treatment of specific medical conditions approved by Manulife, subject to the following:
 - i) Prior Authorization must be approved by Manulife before Medical Marijuana claims are submitted; and
 - ii) the product must be obtained according to the Access to Cannabis for Medical Purposes Regulations (ACMPR); and
 - iii) approval may be valid for a predefined period. Prior Authorization must be re-approved when the predefined period ends; and
 - iv) all approved claims for Medical Marijuana will be required to go through Manulife's Medical Marijuana Program to be eligible for coverage.

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) anti-smoking Drugs;
- f) anti-obesity Drugs;
- g) Drugs used in the treatment of a sexual dysfunction; or
- h) prescription vitamins.

- Drug Maximums

Fertility Drugs - \$2,400 per lifetime

Medical Marijuana - \$1,500 per calendar year

Sclerotherapy - \$40 per day per injection

Diabetic Supplies - lancets, glucose sensors and other miscellaneous supplies, up to a maximum of \$4,000 per 5 calendar years

All other covered Drug expenses - Unlimited

- 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 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.

Your Group Benefits

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 and the Drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife for payment.

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.

- Medical Marijuana Program

To be considered eligible for reimbursement, the insured person must use Manulife Financial's Medical Marijuana program.

Manulife Financial uses the expertise of an approved vendors clinical team of experts and their external Medical Cannabis Advisory Board to establish the medical conditions and criteria for the reimbursement of Medical Marijuana.

On approval for coverage, the insured person is contacted by a Manulife Financial Medical Marijuana approved vendor, who provides case management services and coordination of the dispensing of Medical Marijuana. Case management services include:

- a) program introduction;
- b) Medical Marijuana management and expertise to identify the most suitable Strain for the medical condition Medical Marijuana is approved for;
- c) submission requests for approved Strain to an Authorized Licensed Producer participating in Manulife's Medical Marijuana program;
- d) coordination of the Medical Marijuana delivery to the insured person's home or other location where legislation permits;
- e) medication monitoring for effectiveness of the Strain being used;
- f) support with side effect management; and
- g) access to a hotline for consultation.

- Payment of Drug Claims (excluding Medical Marijuana)

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.

- Payment of Drug Claims for Medical Marijuana

The Pay Direct Drug Card is honoured by the Authorized Licensed Producer participating in the Medical Marijuana Program.

To fill a prescription for a covered Medical Marijuana expenses:

- a) present the Pay Direct Drug Card; and
- b) pay any amounts that are not covered under this Benefit.

Reimbursement of covered Medical Marijuana expenses will be payable directly to the authorized licensed producer. Requests for covered medical marijuana purchased without the Pay Direct Drug Card will be reimbursed directly to the Employee.

Vision Care

eye exams, up to \$75 per 2 calendar years

Professional Services

Services provided by the following licensed practitioners to a combined maximum of \$750 per calendar year:

- a) Acupuncturist
- b) Chiropractor
- c) Massage Therapist
- d) Mental Health Practitioners*
- e) Naturopath
- f) Osteopath
- g) Physiotherapist
- h) Podiatrist/Chiropodist
- i) Speech Therapist

Your Group Benefits

*Mental Health Practitioners include Clinical Counsellors, Marriage and Family Therapists, Psychoanalysts, Psychologists, Psychotherapists and Social Workers only

Recommendation by a physician for Professional Services is not required.

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.

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 \$25,000 per calendar year.

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

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

Charges for a 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

Rental or, when approved by Manulife or your employer, purchase of:

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

Non-Dental Prostheses, Supports and Hearing Aids

- a) external prostheses. Breast prostheses are limited to \$400 per 2 calendar years;
- b) surgical stockings, up to a maximum of 2 pairs per calendar year;
- c) surgical brassieres, up to a maximum of 2 per calendar year;
- d) braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;
- e) 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 \$200 per calendar year per Dependent Child and \$400 per calendar for any other person (must be constructed by a certified orthopaedic footwear specialist);
- f) casted, custom-made orthotics, up to a maximum of \$400 per calendar year (recommendation of either a physician, physiotherapist or podiatrist is required); and
- g) cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of \$400 per 5 calendar years.

Other Supplies and Services

- a) ileostomy, colostomy and incontinence supplies;
- b) medicated dressings and burn garments;
- c) wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$300 per calendar year (recommendation of a Physician is not required);
- d) oxygen;
- e) microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec;
- f) 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;
- g) continuous glucose monitoring machines (including sensors and transmitters) and insulin pumps, up to a maximum of \$4,000 per 5 calendar years;
- h) continuous positive airway pressure machine supplies (recommendation of a Physician is not required); and
- i) stump socks, up to a maximum of 5 pairs per calendar year.

Your Group Benefits

- In-Canada Medical Travel

Charges for the following expenses, when referred by a Physician to a hospital, medical treatment centre or medical specialist because, in the Physician's opinion, adequate medical treatment is not available within 1,000 kilometers round trip of the insured person's province of residence, up to a maximum of \$1,000 every 24 months:

- a) transportation for:
 - i) round trip economy class travel tickets via a commercial airline, rail, bus or ferry for the insured person and companion; or
 - ii) mileage for other land transportation (e.g. automobile or taxi) calculated according to the Canada Automobile allowance rate for the year the expense was incurred. Excludes amenities and rental fare other than fuel.
- b) accommodation in a hotel or other commercial facility combined for the insured person and, if required, the insured person's companion, during the treatment and one day before and after the treatment, up to a maximum of \$75 per day
- c) meals combined for the insured person and, if required, the insured person's companion, during the treatment and one day before and after the treatment, up to a maximum of \$50 per day

Transportation must take place within 2 months of the Physician's referral.

The insured person requires a medical recommendation by a Physician stating that the insured person requires medical assistance from a companion for the companion to be a Covered Expense under this benefit.

Out-of-Province/Out-of-Canada

- a) treatment required as a result of a medical emergency which occurs during the first 60 days 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, up to a maximum of \$5,000,000 per lifetime.

A Medical Emergency is:

- i) a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your Dependent) is travelling outside of his province of residence, or
- ii) a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the insured person (you or your Dependent) has not:

- i) been treated or tested for any new symptoms or conditions
- ii) had an increase or worsening of any existing symptoms
- iii) changed treatments or medications (other than normal adjustments for ongoing care)
- iv) been admitted to the hospital for treatment of the condition

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

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

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

- b) referral outside Canada for treatment which is available in Canada to a maximum of \$3,000 per 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 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 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

Emergency Travel Assistance provides travel assistance for you and your Dependents while you are temporarily outside your province of residence and is offered for the same period as specified under the Out-of-Province/Out-of-Canada benefit. 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.

Your Group Benefits

Medical Emergency Assistance

A Medical Emergency is:

- a) a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your Dependent) is travelling outside of his province of residence; or
- b) a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

Stable means that, in the 90 days before departure, the insured person (you or your Dependent) has not:

- a) been treated or tested for any new symptoms or conditions;
- b) had an increase or worsening of any existing symptoms;
- c) changed treatments or medications (other than normal adjustments for ongoing care); or
- d) been admitted to the hospital for treatment of the condition.

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

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

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his 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 insurance 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 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 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.

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.

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).

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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, 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, 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.

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 plan document 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.

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.

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Exclusions

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

- a) 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;
- b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- c) committing or attempting to commit an assault or criminal offence;
- d) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;
- e) an illness or injury for which benefits are payable under any government plan or workers' compensation;
- f) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;
- g) services or supplies provided by an employer's medical or dental department;
- h) services or supplies for which no charge would normally be made in the absence of insurance;
- i) services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance;
- j) services or supplies which are not permitted by law to be paid;
- k) services or supplies which are required for recreation or sports;
- l) services or supplies which would have been payable by the Provincial Plan if proper application had been made;
- m) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;
- n) medical or surgical care which is cosmetic, except sclerotherapy;
- o) 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;
- p) services or supplies which are provided while confined in a hospital on an in-patient basis; or
- q) services or supplies which are not specified as a covered expense under this benefit.

Continuation of Coverage

If a person is Disabled when insurance under this Benefit terminates, Covered Expenses related to the treatment of the Disability will continue to be payable by Manulife.

Coverage will be continued for up to 90 days after insurance would otherwise have terminated while the person remains Disabled. 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 eligible for disability benefits under any other provision of this Policy.

A Dependent will be considered Disabled if he is receiving medical treatment from a physician and confined to a hospital or to his home.

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%.

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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 - Current Fee Guide for General Practitioners and Specialists for the Province in which the services are rendered

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

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50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I and Level II

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

\$1,500 per lifetime for Level V

Termination Age - last day of the month following retirement

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, one per 24 months;
- b) full-mouth x-rays, once per 24 months combined for full mouth x-rays and panoramic x-rays
- c) panoramic x-rays, once per 24 months combined for full mouth x-rays and panoramic x-rays
- d) one unit of light scaling and one unit of polishing, once every 5 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 5 months, when the service is performed in Quebec;
- e) recall exams and fluoride treatments, once every 5 months;
- f) bitewing x-rays, unlimited films per recall;
- g) routine diagnostic and laboratory procedures;
- h) oral hygiene instruction, once every 5 months;

- i) 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;
- j) pre-fabricated full coverage restorations (metal and plastic);
- k) space maintainers (appliances placed for orthodontic purposes are not covered);
- l) minor surgical procedures and post-surgical care;
- m) extractions (including impacted and residual roots)
- n) consultations, anaesthesia, and conscious sedation;
- o) 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;
- p) injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery;
- q) gold foil restorations;
- r) polishing of removable prosthodontics; and
- s) repairs to crowns, including recementation and removal.

Level II - Supplementary Basic Services

- a) surgical procedures not included in Level I (excluding implant surgery);
- b) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - i) scaling not covered under Level I, and root planing,
 - ii) provisional splinting,
 - iii) occlusal equilibration, 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) re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Level III - Dentures

- a) initial provision of full or partial removable dentures;
- b) replacement of removable dentures, provided the dentures are required because:
 - i) a natural tooth is extracted and the existing appliance cannot be made serviceable,
 - ii) the existing appliance is at least 60 months old and cannot be made serviceable, or

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

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

Level IV - Major Restorative Services

- a) crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;
- b) inlays, covering at least 3 surfaces, provided the tooth cusp is missing;
- c) initial provision of fixed bridgework;
- d) replacement of bridgework, provided the new bridgework is required because:
 - i) a natural tooth is extracted and the existing appliance cannot be made serviceable,
 - ii) the existing appliance is at least 60 months old and cannot be made serviceable, or
 - iii) the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation.

Expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable.

Level V - Orthodontics

Orthodontic services

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. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the plan will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge;
- 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.

Health Care Spending Account

Your benefit program includes a health care spending account, which provides you and your dependents with financial assistance for medical and dental expenses. Please refer to your **Health Care Spending Account - Plan Member Guide** for complete details on this benefit.

Your Group Benefits

Long Term Disability

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

The Benefit

Benefit Amount - 60% of monthly Earnings, to a maximum of \$4,000

Non-Evidence Limit - \$4,000

Qualifying Period - 119 days

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

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Entitlement Criteria

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

- a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;
- b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Common Insurance Terms; and
- c) you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife.

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

Periods for Which You are Not Entitled to Benefits

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

- a) not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife;
- b) receiving Employment Insurance maternity or parental benefits;
- c) on lay-off during which you become Totally Disabled;
- d) on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;
- e) receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan;

- f) working in any occupation, except as provided for under the Rehabilitation Assistance provision; or
- g) incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

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

- a) Workers' Compensation or similar coverage;
- b) Canada or Quebec Pension Plans, excluding dependent benefits but including CPP/QPP Retirement benefits; and
- c) any government motor vehicle automobile insurance plan or policy, unless prohibited by law.

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross Earnings (net Earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

- a) any group, association or franchise plan;
- b) any retirement or pension plan;
- c) earnings or payments from any employer, including vacation pay;
- d) self-employment; and
- e) any government plan, excluding Employment Insurance Benefits.

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Benefit Calculation Rules

Manulife will apply the following rules in determining your disability benefit:

- a) benefits payable from other sources which began before the commencement of your current disability will not be taken into account;
- b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife;
- c) subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;
- d) benefits payable under individual disability income insurance will not be taken into account;
- e) for benefits payable, other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife; and
- f) if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife and assumed to be paid.

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Subrogation

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

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

Tax Status of Benefits

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

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

Payment of Disability Benefits

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

Rehabilitation Assistance

Once Manulife determines that you are Totally Disabled, if appropriate, and at Manulife's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife will take into account:

- a) the nature, extent and expected duration of your disability;
- b) your level of education, training or experience; and
- c) the nature, scope, objectives and cost of a Vocational Plan.

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife will provide a structured Vocational Plan that will prepare you for a return to work, either:

- a) with your employer;
- b) with an alternate employer; or
- c) in a self-employed capacity.

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross Earnings; net Earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- a) the date you cease to be Totally Disabled, as defined under the Explanation of Common Insurance Terms;
- b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Common Insurance Terms;
- c) the date you do not attend an examination by an examiner selected by Manulife;
- d) the date on which benefits have been paid up to the Maximum Benefit Period for this benefit; or
- e) the date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, Manulife will treat the disability as a continuation of your previous disability.

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

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

Waiver of Premium

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

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Exclusions

No benefits are payable for any disability related to:

- a) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- c) medical or surgical care which is not medically necessary;
- d) the committing of or the attempt to commit an assault or criminal offence;
- e) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol; or
- f) abuse of addictive substances, including Drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife.

Critical Illness Benefit

(Optional Employee Critical Illness, Optional Spousal Critical Illness, Optional Child Critical Illness)

Your Group Policy number for Critical Illness benefits is **G0126238**.

Please refer to your **Critical Illness Employee Brochures** for more details on this benefit.

The Critical Illness Insurance Plan helps guard against the financial consequences of a serious, life-threatening or life-altering illness. The purpose of the benefit is to help you deal with any loss of income, medical costs, home modifications, or career changes stemming from your illness.

It will provide a one-time, lump-sum benefit in the event that you (or your covered dependents) are diagnosed with one of a specified list of critical conditions, as detailed at the end of this benefit.

The claimant must have survived his or her illness for 30 days or more past the date he or she was first diagnosed. We will evaluate your claim using the Entitlement Criteria.

For You:

Optional Benefit Amount - increments of \$5,000, to a maximum of \$150,000 (minimum benefit of \$10,000)

Non-Evidence Limit - Evidence of Insurability is required for all amounts of Optional Critical Illness Insurance.

Termination Age - your benefit terminates at the earlier of age 70, your retirement or your Critical Illness benefit is paid out

For Your Dependents:

Optional Spousal Benefit Amount - increments of \$5,000, to a maximum of \$150,000 (minimum benefit of \$10,000)

Optional Child Benefit Amount - \$10,000 each Child

Non-Evidence Limit - Evidence of Insurability is required for all amounts of Optional Spousal Critical Illness Insurance.

Termination Age

Spouse - your benefit terminates at the earlier of your Spouse's age 70, your retirement or your Optional Spousal Critical Illness benefit is paid out

Child - your benefit terminates at the earlier of your age 70, your retirement, your Child's limiting age as specified under Definitions or your Optional Child Critical Illness benefit is paid out

Explanations of Terms Associated with Critical Illness Benefits

Child

you or your spouse's natural or legally adopted Child, or stepchild who:

- a) is insured under the provincial plan;
- b) is unmarried;
- c) is not employed on a full-time basis;
- d) is not eligible for insurance as an employee under this or any other group policy; and
- e) relies on you for financial support; and
- f) under age 21, or under age 25 if a full-time student

Employee

the person having the primary relationship with the policyholder and:

- a) is at least 18 years old but less than the Termination Age as indicated under this benefit;
- b) is directly employed by the policyholder on a permanent and full-time basis;
- c) is compensated for services by the policyholder; and
- d) is residing in Canada.

Immediate Family Member

an Immediate Family Member is a person who is:

- a) the Employee; or
- b) the Employee's Spouse or Child.

Physician

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

Your Group Benefits

Spouse

a Spouse is your legal Spouse, or the person continuously living with you in a role like that of a marriage partner, who is insured under the Provincial Plan. The Spouse you indicate on your application for Spousal Critical Illness Insurance will be the only one spouse eligible for Spousal Critical Illness Insurance under this policy. For this coverage, we will not consider a person you have divorced, a person cohabiting with you who is not in the role of a marriage partner, or a person you are separated from, (regardless of whether or not there is a court order or formal separation agreement).

Entitlement Criteria

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

- a) Manulife receives medical evidence documenting your diagnosis of a covered Critical Illness condition; and
- b) the diagnosis of any Critical Illness is made by a Physician, practicing medicine in Canada in a specialty relating to the applicable Critical Illness.

At any time, Manulife may require you to submit to a medical examination or evaluation by an examiner selected by Manulife.

Your Group Benefits

Critical Illness Covered Conditions

Group Critical Illness Covered Conditions	You and your Spouse	Your Child
Alzheimer's Disease	X	X
Aortic Surgery	X	X
Benign Brain Tumour	X	X
Blindness	X	X
Cancer (Life-Threatening)	X	X
Coma	X	X
Coronary Artery Bypass Surgery	X	X
Deafness	X	X
Heart Attack (Myocardial Infarction)	X	X
Heart Valve Replacement	X	X
Kidney Failure (End Stage Renal Disease)	X	X
Loss of Limbs	X	X
Loss of Speech	X	X
Major Organ Failure on Waiting List for Transplant	X	X
Major Organ Transplant	X	X
Motor Neuron Disease	X	X
Multiple Sclerosis	X	X
Occupational HIV Infection	X	X
Paralysis	X	X
Parkinson's Disease	X	X
Severe Burns	X	X
Stroke (Cerebrovascular Accident)	X	X
Autism		X
Cerebral Palsy		X
Congenital Heart Disease (for which corrective surgery has been performed)		X
Cystic Fibrosis		X
Down Syndrome		X
Muscular Dystrophy		X
Type 1 Diabetes Mellitus		X

Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are Totally Disabled, the premium for your Critical Illness benefit and that of your Dependents will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates, or the date the covered person's Critical Illness Benefit is paid out. However, if the benefit is paid out for one insured person, the Waiver of Premium shall remain in force for the remaining insured persons for whom benefits have not yet been paid out.

Conversion Privilege

If you are under age 65 and your Group Benefits terminate, you may be eligible to convert the Critical Illness Insurance on you and/or your Dependents to a Personal Critical Illness policy, without medical evidence. You must apply for the coverage within 31 days of the termination of your Critical Illness Insurance. If you are diagnosed with a covered Critical Illness condition during this 31-day period, the amount of Critical Illness Insurance available for conversion will be payable, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your plan administrator.

Your Group Benefits

Exclusions

No benefits are payable for any Critical Illness related to:

- a) any specific exclusions associated with a given condition set out in the Covered Critical Illness Conditions Appendix;
- b) self-inflicted injuries or illnesses;
- c) abuse of addictive substances, including drugs and alcohol;
- d) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- e) the committing of or the attempt to commit an assault or criminal offence;
- f) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury;
- g) taking a poisonous substance or inhaling toxic gases or fumes;
- h) a situation where your Child is born and diagnosed with a condition within the first ten months of the effective date of Child coverage;
- i) a Pre-Existing Condition incurred or diagnosed during the first 24 months of coverage or latest reinstatement of coverage. This limitation applies whether or not the insured person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement.

A Pre-Existing Condition is an illness or injury for which the insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication - or where treatment would have been received by a prudent individual - during the 24 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness Benefit; or

- j) cancer or benign brain tumour if within the **first 90 days** of your coverage effective date you have any of the following:
 - i) signs or symptoms that lead to a diagnosis of cancer or benign brain tumour, regardless of the date when the diagnosis is made
 - ii) medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or benign brain tumour, regardless of when the diagnosis is made
 - iii) a diagnosis of cancer or benign brain tumour

