# GROUP HEALTH CENTRE

**Plan Document Number:** G0050867

**Group Policy Number:** G0010867

**Plan AA:** CUPE Full Time and Part Time greater than 0.67 FTE – Former Class 5

**Employee Name:** _____

**Certificate Number:** _____

## Welcome to Your Group Benefit Program

**Plan Document Effective Date:** December 1, 2012

**Group Policy Effective Date:** December 1, 2012

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

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

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

This booklet redrafted: May 6, 2014

# Table of Contents

This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

**This version of the Benefit Summary redrafted:** May 6, 2014

# Employee Life Insurance

**The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0010867.**

**Benefit Amount** - *2* times your annual earnings, to a maximum of $350,000

**Termination Age** - your benefit amount terminates at age *65* or retirement, whichever is earlier.

# Accidental Death and Dismemberment

**The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0010867.**

**Benefit Amount** - *2* times your annual earnings, to a maximum of $350,000

**Termination Age** - your benefit amount terminates at age *65* or retirement, whichever is earlier.

# Extended Health Care

***The Benefit***

**Overall Benefit Maximum** - Unlimited

**Deductible** - Nil

**Drug Dispensing Fee Maximum**

The dispensing fee will be fully covered electronically at the Group Health Centre pharmacy. For all other pharmacies, the dispensing fee will be covered, but the claim must be manually submitted to Manulife Financial for reimbursement.

**Benefit Percentage (Co-insurance)**

100% for
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

**Note:**
*The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.*
*The Benefit Percentage for Emergency Travel Assistance is 100%.*

**Termination Age** - end of the month following attainment of age 65

# Benefit Summary

***Direct Drugs - Plan 3***

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

- drugs for the treatment of an illness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- diabetic supplies (excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment)

*Charges for the following are not covered:*

- the administration of injectable medications
- drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction
- intrauterine devices and diaphragms
- prescription vitamins

**- Drug Maximums**

Fertility drugs - $*5,000* per lifetime

Anti-smoking drugs - $*200* per calendar year

All other covered drug expenses - Unlimited

**- Payment of Drug Claims**

Drug Claims will be processed electronically at the Group Health Centre pharmacy. Drug claims incurred at all other pharmacies will require manual submission to Manulife for reimbursement.

***Vision Care***

- purchase and fitting of frames for prescription glasses, to a maximum of $30 per 24 months
- purchase and fitting of lenses for prescription glasses, to a maximum of once per 24 months without a prescription change. If a change in prescription is obtained, new lenses can be purchased prior to the end of the 24 month period
- prescription contact lenses, $150 per 24 months

**Note:** You may elect either the prescription glasses (lenses) provision or the prescription contact lenses provision.

***Professional Services***

Services provided by the following licensed practitioners:

- Chiropractor - $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist
- Podiatrist/Chiropodist - $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist
- Massage Therapist - $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist

# Dental Care

***The Benefit***

**Deductible** - Nil

**Dental Fee Guide** - *Ontario* Fee Guide for General Practitioners and Specialists which was in effect *2* years prior to the current Fee Guide

**Benefit Percentage (Co-insurance)**

*100*% for Level I - Basic Services

*100*% for Level II - Supplementary Basic Services

*50*% for Level III - Dentures

*50*% for Level IV - Major Restorative Services

*50*% for Level V - Orthodontics

**Benefit Maximums**

unlimited for Level I and Level II

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

$*2,000* per lifetime for Level V

**Termination Age** - employee's age *65*

# Long Term Disability

**The Long Term Disability Benefit is insured under Manulife Financial's Policy *G0010867*.**

**Benefit Amount** - *60*% of monthly earnings, to a maximum of $*3,000*

**Qualifying Period** - *120 days*

**Maximum Benefit Period** - to age *65*

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

***Designed with Your Needs in Mind***

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

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits,
- information you need, and simple instructions, on how to submit a claim.

***Important Note***

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of GROUP HEALTH CENTRE. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance, Accidental Death and Dismemberment and Long Term Disability Benefits, and the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from your employer), the terms of the Policy or Plan Document will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

You or any of your covered dependents have the right to request a copy of any or all of the following items:

- the Group Policy and/ or Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

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

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

***Your Group Benefit Card***

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

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

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

# Explanation of Commonly Used Terms

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

***Benefit Percentage (Co-insurance)***

the percentage of Covered Expenses which is payable by your employer.

***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 your employer.

***Dependent***

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

**- Spouse**

your legal spouse, or a person continuously living with you in a role like that of a marriage partner.

**- Child**

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

  - unmarried

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

  - not employed on a full-time basis, and

  - not eligible for coverage as an employee under this or any other Group Benefit Program

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

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

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

- a stepchild must be living with you to be eligible

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

***Drug***

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

***Earnings***

your regular rate of pay from your employer (prior to deductions), excluding regular bonuses, regular overtime pay and regular commissions.

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

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

***Experimental or Investigational***

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

***Immediate Family Membe***r

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

***Licensed, Certified, Registered***

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

***Life-Sustaining Drugs***

drugs which are necessary for the survival of the patient.

***Medically Necessary***

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

***Non-Evidence Limit***

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

***Provincial Plan***

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

# Explanation of Commonly Used Terms

***Reasonable and Customary***

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

***Take Home Pay (Net Earnings)***

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

***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.

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

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

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

## *Your Employer's Representative*

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

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

Your Employer's representative is _____

Phone Number: _____

## *Applying for Group Benefits*

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your employer. Your employer then forwards the application to Manulife Financial.

## *Making Changes*

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

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

# The Claims Process

## *Naming a Beneficiary*

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance and Accidental Death and Dismemberment.

**This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.**

## *How to Submit a Claim*

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number, Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

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

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

### *Payment of Extended Health Care and Dental Claims*

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

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

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

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

## *Co-ordination of Extended Health Care and Dental Care Benefits*

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

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

Plan means:

- other Group Benefit Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

**Order of Benefit Payment**

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

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

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

  - For Claims incurred by you or your Dependent Spouse:

    The Plan covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

    In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

    - The Plan where the person is covered as an active full-time employee, then
    - The Plan where the person is covered as an active part-time employee, then
    - The Plan where the person is covered as a retiree.

  - For Claims incurred by your Dependent Child:

    The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

    However, if you and your Spouse are separated or divorced, the following order applies:

    - The Plan of the parent with custody of the child, then
    - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child), then
    - The Plan of the parent not having custody of the child, then
    - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child).
    - Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

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

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

**Submitting a Claim for Co-ordination of Benefits**

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

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

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

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

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

## *Eligibility*

You are eligible for Group Benefits if you:

- are a full-time or part-time employee of GROUP HEALTH CENTRE and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

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

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

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

***Required Number of Hours***

Full-time employee

For Long Term Disability – 1,975.5 hours of continuous service

For All Other Benefits – first of the month coincident with or next following 490 hours of continuous service

Part-time employee - *25* hours per week

## *Medical Evidence*

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

# Who Qualifies for Coverage?

## *Late Application*

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days, or
- re-apply for coverage on any person whose coverage had earlier been cancelled.

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

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan, or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your employer. Further medical evidence may be requested by Manulife Financial.

## *Late Dental Application*

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

## *Effective Date of Coverage*

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

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

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

## *Termination of Coverage*

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee for reasons other than retirement
- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

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

# Employee Life Insurance

**The Employee Life Insurance Benefit is insured under Manulife Financial's Policy *G0010867*.**

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

***The Benefit***

**Benefit Amount** - *2* times your annual earnings, to a maximum of $350,000

**Non-Evidence Limit** - $*350,000*

**Qualifying Period for Waiver of Premium** - *120 days*

**Termination Age** - your benefit amount terminates at age *65* or retirement, whichever is earlier.

**Waiting Period**

490 hours of continuous service for employees hired on or prior to the Group Policy Effective Date
490 hours of continuous service for all other employees

***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.

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

***Submitting a Claim***

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

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

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

***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.

***Definition of Totally Disabled***

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

- your own occupation, during the Qualifying Period and the *2 years* immediately following the Qualifying Period

- 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 Financial in assessing your disability.

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

***Entitlement Criteria***

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

- 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

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

  - your own occupation, during the Qualifying Period and the following *2 years*, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the *2 years* specified above

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

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

***Termination of Waiver of Premium***

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit

- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following *2 years*, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the *2 years* specified above

- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial
- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date of your death
- the date of your *65*th 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 Financial will waive the Qualifying Period.

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

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

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

***Conversion Privilege***

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee 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 Financial within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

# Accidental Death and Dismemberment

**The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy *G0010867*.**

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.

***The Benefit***

**Benefit Amount** - *2* times your annual earnings, to a maximum of $*350,000*

**Non-Evidence Limit** - $*350,000*

**Qualifying Period for Waiver of Premium** - *120 days*

**Termination Age -** your benefit amount terminates at age *65* or retirement, whichever is earlier.

**Waiting Period**

*none* for employees hired on or prior to the Group Policy Effective Date
490 hours of continuous service for all other employees

***Schedule of Losses***

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- 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 your 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 or Loss of Use of Both Arms or Both Legs - 200%
- 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 One Arm and One Leg - 100%
- 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 - 50%
- Loss of Sight of One Eye - 50%
- Loss of Speech or Hearing in Both Ears - 50%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 25%
- Loss of All Toes of One Foot - 12.5%
- 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 you are living).

***Repatriation Expenses***

If you die as a direct result of an accidental injury which occurs while travelling 150 kilometres or more from your place of residence, Manulife Financial will pay for expenses incurred for the preparation and transportation of your body to your place of residence.

The amount payable is subject to a maximum of $*2,500*.

***Family Transportation Expenses***

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and are confined to a hospital located 150 kilometres or more from your place of residence, Manulife Financial will pay the hotel and travel expenses incurred by an immediate family member, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- for hotel accommodations in the vicinity of the hospital
- 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 $2,000 per accident.

***Dependent Education Expenses***

If you die as a direct result of an accidental injury, Manulife Financial will pay the tuition for each child who is enrolled as a full-time student:

- in a school for higher learning above the secondary school level, or
- at the secondary school level, but who enrols 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 professionel (CEGEP), community college or trade school.

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

- *5*% of your Accidental Death and Dismemberment benefit amount, or
- $*5,000*

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

No payment will be made for:

- tuition expenses incurred prior to your death
- 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 Financial will pay for expenses incurred by your spouse, provided the expenses are:

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

The amount payable is subject to the lesser of $10,000 or 10% of the Benefit Amount.

No amount will be paid for 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, you:

- suffer a loss of, or loss of use of, both feet or both legs, or
- become a hemiplegic, paraplegic, or quadriplegic

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

- reasonable and necessary, as determined by Manulife Financial
- incurred within 3 years from the date of the accidental injury
- for alterations to your home for the purpose of making it wheelchair accessible
- 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*.

***Educational Benefit***

If expenses are payable under this benefit for an injury that requires an you to change your occupation, Manulife Financial will pay the tuition fee for enrolling you as a student at a post secondary institution for training in a new occupation. To qualify for an educational benefit, you must enroll at a post secondary institution within 365 days after the date of your accident.

No payment will be made for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room and board or other ordinary living, travelling, or clothing expenses.

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

***Surgical Reattachment***

If a person suffers a specified loss and the dismembered part is surgically reattached, 50% of the benefit for such specified loss will be paid, regardless of the use regained in the reattached part. If the reattachment fails and the reattached part is removed within 1 year after the reattachment is performed, the balance of the benefit will be payable.

***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***

See Employee Life Insurance... Naming a Beneficiary.

***Submitting a Claim***

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form.

Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

***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 this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

***Exclusions***

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

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- 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
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

# Extended Health Care

**Your Extended Health Care Benefit (other than Emergency Travel Assistance and Out-of-Province/Canada Emergency Medical Treatment) is provided directly by GROUP HEALTH CENTRE. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.**

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

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

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

***The Benefit***

**Overall Benefit Maximum** - Unlimited

**Deductible** - Nil

**Drug Dispensing Fee Maximum**

The dispensing fee will be fully covered electronically at the Group Health Centre pharmacy. For all other pharmacies, the dispensing fee will be covered, but the claim must be manually submitted to Manulife Financial for reimbursement.

**Benefit Percentage (Co-insurance)**

*100*% for
Drugs
Vision
Professional Services
Medical Services and Supplies

***Note:***
*The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.*
*The Benefit Percentage for Emergency Travel Assistance is 100%.*

**Termination Age -** end of the month following attainment of age 65

**Waiting Period**

490 hours of continuous service for employees hired on or prior to the Plan Document Effective Date
490 hours of continuous service for all other employees

***Covered Expenses***

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial or your employer, provided they are:

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account

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

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

***Advance Supply Limitation***

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

**- 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.

***Direct Drugs - Plan 3***

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

- drugs for the treatment of an illness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- diabetic supplies (excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment)

*Charges for the following are not covered:*

- the administration of injectable medications
- drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction

- intrauterine devices and diaphragms
- prescription vitamins

**- Drug Maximums**

Fertility drugs - $*5,000* per lifetime

Anti-smoking drugs - $*200* per calendar year

All other covered drug expenses - Unlimited

**- Payment of Drug Claims**

Drug Claims will be processed electronically at the Group Health Centre pharmacy. Drug claims incurred at all other pharmacies will require manual submission to Manulife for reimbursement.

***Vision Care***

- purchase and fitting of frames for prescription glasses, to a maximum of $30 per 24 months
- purchase and fitting of lenses for prescription glasses, to a maximum of once per 24 months without a prescription change. If a change in prescription is obtained, new lenses can be purchased prior to the end of the 24 month period
- prescription contact lenses, $150 per 24 months

**Note:** You may elect either the prescription glasses (lenses) provision or the prescription contact lenses provision.

***Professional Services***

Services provided by the following licensed practitioners:

- Chiropractor – $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist
- Podiatrist/Chiropodist - $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist
- Massage Therapist - $500 per calendar year combined for services of a chiropractor, podiatrist/chiropodist and massage therapist

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

***Medical Services and Supplies***

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.

**Non-Dental Prostheses and Supports**

- casted, custom-made orthotics, up to a maximum of $*250* per calendar year (recommendation of either a physician or a podiatrist is required)

**Other Supplies and Services**

- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

***Out-of-Province/Out-of-Canada***

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

  A Medical Emergency is:

  - a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or

  - 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 covered person (you or your dependent) has not:

  - been treated or tested for any new symptoms or conditions

  - had an increase or worsening of any existing symptoms

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

  - been admitted to the hospital for treatment of the condition

  Coverage is not available if you (or your 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.

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

*Charges for the following are payable under this expense:*

- physician's services

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

- the cost of special hospital services

- hospital charges for out-patient treatment

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

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

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

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

***Emergency Travel Assistance***

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

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

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

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

**Medical Emergency Assistance**

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or

- 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 covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions

- had an increase or worsening of any existing symptoms

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

- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your 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 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 covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered 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 covered person is entitled, the administrator 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 covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered 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 covered 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 a covered 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 a covered person, one-way economy transportation will be arranged to enable each covered 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 covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered 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 a covered 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 a covered 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 a covered 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 the administrator.

j) **Vehicle Return**

If a covered 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 covered person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If a covered 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 a covered 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 a covered 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 covered 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 covered person plans to travel.

***Health Advice and Assistance***

The following services are available for a covered 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 covered person.

c) **Link to 911**

If necessary, a covered 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 covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

**Exceptions**

The administrator, and the company contracted by the administrator 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 a covered 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 employer.

***Submitting a Claim***

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

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

All claims must be submitted within 12 months after the date the expense was incurred.

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

***Subrogation (Third Party Liability)***

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

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

***Exclusions***

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence

- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

# Dental Care

**Your Dental Care Benefit is provided directly by GROUP HEALTH CENTRE. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.**

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** - *Ontario* Fee Guide for General Practitioners and Specialists which was in effect *2* years prior to the current Fee Guide

**Benefit Percentage (Co-insurance)**

*100*% for Level I - Basic Services

*100*% for Level II - Supplementary Basic Services

*50*% for Level III - Dentures

*50*% for Level IV - Major Restorative Services

*50*% for Level V - Orthodontics

**Benefit Maximums**

unlimited for Level I and Level II

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

$*2,000* per lifetime for Level V

**Termination Age -** employee's age *65*

**Waiting Period**

490 hours of continuous service for employees hired on or prior to the Plan Document Effective Date
490 hours of continuous service for all other employees

***Covered Expenses***

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by your employer or Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your employer or Manulife Financial, 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, your employer will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

***Level I - Basic Services***

- complete oral exam, one per 2 calendar years
- full-mouth x-rays, one per 2 calendar years
- panoramic x-rays, one per 36 months
- light scaling, twelve units per 12 months
- one unit of polishing, once every *9* months
- recall exams, once every 9 months
- bitewing x-rays, once every 24 months
- fluoride treatments, once every *12* months
- oral hygiene instruction, once every 6 months
- routine diagnostic and laboratory procedures
- diagnostic casts
- initial oral hygiene instruction, plus one recall
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultations, anaesthesia, and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

***Level II - Supplementary Basic Services***

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
  - scaling not covered under Level I, and root planing, up to a combined maximum of 6 units per calendar year
  - provisional splinting
  - occlusal equilibration, up to a maximum of 4 units per calendar year
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
  - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
  - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

***Level III - Dentures***

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation
- 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***

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

- 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

**Note:** Orthodontic Services for Dependent children are a Covered Expense only if the Dependent child is 6 years of age or over when treatment commences.

***Late Entrant Limitation***

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

***Pre-Determination of Benefits***

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested 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 Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

***Submitting a Claim***

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within 12 months after the date the expense was incurred.

***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, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

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

***Exclusions***

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

# Long Term Disability

**The Long Term Disability Benefit is insured under Manulife Financial's Policy G0010867.**

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

***Definition of Totally Disabled***

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

- your own occupation, during the Qualifying Period and the *2 years* immediately following the Qualifying Period
- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the *2 years* specified above
- any combination of duties that regularly took a minimum of 60% of your time to complete.

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

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

# Your Group Benefits

***The Benefit***

**Benefit Amount** - *60*% of monthly earnings, to a maximum of $*3,000*

**Non-Evidence Limit** - $*3,000*

**Qualifying Period** - *120 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

**Waiting Period**

1,975.5 hours of continuous service for employees hired on or prior to the Group Policy Effective Date
1,975.5 hours of continuous service for all other employees

***Entitlement Criteria***

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

- 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.

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

  - your own occupation, during the Qualifying Period and the following *2 years*,

  - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the *2 years* specified above and

  - any combination of duties that regularly took a minimum of 60% of your time to complete;

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

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

***Periods for Which You are Not Entitled to Benefits***

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

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

- receiving Employment Insurance maternity or parental benefits

- on lay-off during which you become Totally Disabled
- on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan
- working in any occupation, except as provided for under the Rehabilitation Assistance provision
- 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:

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans, excluding dependent benefits

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:

- any group, association or franchise plan
- any retirement or pension plan
- earnings or payments from any employer, including severance payments and vacation pay
- self-employment
- any government plan, excluding Employment Insurance Benefits
- Canada or Quebec Pension Plans' dependent 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 Financial will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account
- 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 Financial
- 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

- benefits payable under individual disability income insurance will not be taken into account
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial, and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid

***Subrogation***

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial 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 Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

***Tax Status***

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 Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial'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 Financial will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- 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 Financial will provide a structured Vocational Plan that will prepare you for a return to work, either:

- with your employer
- with an alternate employer
- 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 Financial 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:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:
  - your own occupation, during the Qualifying Period and the following *2 years*,
  - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the *2 years* specified above and
  - any combination of duties that regularly took a minimum of 60% of your time to complete
- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit
- 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 Financial 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.

***Submitting a Claim***

To submit a claim, you must complete the Long Term Disability claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

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

***Exclusions***

*No benefits are payable for any disability related to:*

- self-inflicted injuries or illnesses
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- medical or surgical care which is not medically necessary
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- 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 Financial
- a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which drugs were prescribed, within 90 days prior to the effective date of your coverage.

# Notes

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