The Corporation of the City of London

Group Policy Number: G0033922

Plan: CA - The Corporation of the City of London - CUPE Local 107 - Active Members Under and Over Age 65

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Note: Policy G0033922CA replaces Policy Number 2863 et al, which was effective May 1, 1999.

Group Policy Effective Date: December 1, 2011

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

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

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

You can contact Manulife Financial at 1-800-268-6195 or visit our website at www.manulife.ca/groupbenefits.

This booklet produced: October 14, 2020

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 produced: October 14, 2020

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum

$12.00 per prescription or the Ontario Drug Benefit dispensing fee, whichever is greater

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Physician Services Outside Province of Residence
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Hospital Care

Semi-Private and Private: Unlimited

Chronic Care

Semi-Private: $3 per day up to a maximum of 120 days per 12 consecutive months

Manuscript Generic Drug Plan 2 (previously referred to as Formulary 2 Generic Plan)

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

- Drugs prescribed by a physician or dentist for the treatment of an illness or injury, including any deductible or co-payment the person is required to satisfy under the Ontario Drug Benefit program for a Drug also covered under this policy.
- oral contraceptives
- preventive vaccines and medicines (oral or injected)
- diabetic supplies, including charges for insulin, standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

The following are not Covered Expenses:

- charges made by a practitioner or physician to administer injectable medications
- charges for dietary supplements, health foods, nutritional products, and vitamins (except injectable vitamins)
- charges for Drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- anti-smoking Drugs

- Payment of Covered Expenses

Covered Expenses for any prescribed Drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed Drug, the amount covered is the cost of the prescribed product.

- 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 Financial for payment.

- Payment of Drug Claims

Your Group Benefit Card provides your pharmacist with immediate confirmation of covered Drug expenses. This means that when you present your Group Benefit Card to your pharmacist at the time of purchase, you and your eligible Dependents will not incur out-of-pocket expenses for amounts covered by this benefit plan for prescription Drugs.

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

To fill a prescription for covered Drug expenses:

a) present your Group Benefit Card to the pharmacist at the time of purchase, and

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

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

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Group Benefit Card with you at that time
- the prescription is not payable through the Group Benefit Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please contact Manulife Financial.

Vision Care

- eye exams, 1 exam up to a maximum of $80 in any 24 consecutive months for employees only

- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $350 in any 24 consecutive months. Prescription glasses required due to a prescription change, $350 in any 12 consecutive months. Replacement glasses due to loss or breakage, $350 in any 12 consecutive months.

Note: Non-prescription safety glasses, non-prescription sunglasses and elective laser vision correction procedures are not covered.

Professional Services

- $1,500 per Policy Year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, masseur/massage therapist, naturopath, speech pathologist, physiotherapist and clinical psychologist

- Effective January 1, 2023 - $1,600 per Policy Year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, masseur/massage therapist, naturopath, speech pathologist, physiotherapist and clinical psychologist.

Hearing Aids

$2,000 per 36 consecutive months

Out-of-Province/Out-of-Canada

Charges incurred for medical treatment given outside the Insured Person's province of residence required as a result of a Medical Emergency while temporarily outside the province of residence provided that the Insured Person who receives the treatment is also insured by the Provincial Plan during the absence from the province of residence. Treatment must occur during the first 60 consecutive days while outside the province of residence.

Expenses are payable up to a maximum of $1,000,000 per trip.

Emergency Travel Assistance

Emergency Travel Assistance, a Travel Assist Benefit, is provided when required as a result of a Medical Emergency during the first 60 consecutive days while travelling outside your province of residence for other than health reasons.

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Dental Association Approved Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

100% for Basic Services - Level I (formerly Dental Plan 9)

100% for Supplementary Basic Services - Level II (formerly Dental Plan 9)

50% for Major Restorative Services - Level IV (formerly Dental Rider 4)

50% for Orthodontics - Level V (formerly Dental Rider 3)

Benefit Maximums

Unlimited for Level I and Level II

$1,000 per Policy Year for Level IV

$3,000 per lifetime for Level V

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 Common Insurance 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 The Corporation of the City of London. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy, the terms of the Group Policy will apply.

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

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

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

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

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

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

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

Your Group Benefit Card

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

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

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

Explanation of Common Insurance Terms

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

Benefit Percentage (Co-insurance)

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

Covered Expenses

For Extended Health Care, expenses specified are covered to the extent that they are Reasonable and Customary unless otherwise stipulated, as determined by Manulife Financial, provided they are:

- for the treatment of an illness 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 Policy will not assume coverage of the charges for such treatments, services or supplies.

For Dental Care, expenses are covered if they:

- are incurred for the necessary dental care of an Insured 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 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 Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Deductible

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

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.

- Child

- your or your spouse's natural or adopted Child, foster Child or stepchild, who is:

  - unmarried

  - under age 21, or under age 25 if a full-time student at an accredited school, college or university

  - not employed on a full-time basis, and

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

- a Child who is incapacitated on the date he or she reaches the age when 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 the employee for support, maintenance and care, due to a mental or physical disability.

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

Drug

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

Drug Dispensing Fee

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

Drug Dispensing Fee Maximum

the maximum amount that is covered under this Policy for a Drug Dispensing Fee

Experimental or Investigational

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

Full-time

permanent, Full-time Employee as per The Corporation of the City of London.

- Part-time

permanent, Part-time Employee as per the Corporation of the City of London.

- Temporary

temporary, Full-time or Part-time Employee as per the Corporation of the City of London.

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.

Insured Person

you or your Dependent who is covered for benefits provided under this policy and for whom the current premiums are being paid.

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.

Medical Emergency

with respect to Out-of-Province or Out-of-Canada and Emergency Travel Assistance benefits, a Medical Emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while an Insured Person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the Insured Person is stable enough to return to his province of residence.

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.

Policy Year

for Extended Health Care: December 1st to November 30th

for Dental Care: April 1st to March 31st

Provincial Plan

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

Reasonable and Customary

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.

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.

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

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

Your Group Benefit Program is provided by The Corporation of the City of London, in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

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

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

Your Plan Administrator is _____

Phone Number: _____

Please record the name of your Plan Administrator and the contact number in the space provided.

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your Plan Administrator. Your Plan Administrator 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 Plan Administrator. Such changes could include:

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

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

Naming a Beneficiary

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

How to Submit a Claim

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

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

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, Manulife Financial 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.

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” (ie., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (ie., 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, Part-time or Temporary employee of The Corporation of the City of London,
- are a member of an eligible class, and
- 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.

If you decline to enrol in coverage on the date that you first become eligible for coverage, you will only be eligible to enrol on any subsequent policy anniversary date of this policy, except that if you decline to enrol when first eligible because you are covered for comparable benefits under your Spouse's group plan you will be eligible for coverage under this policy immediately following the termination date of coverage under your Spouse's plan, provided written application is submitted within the 31 day period following such termination date.

Effective Date of Insurance

Your Group Benefits will be effective on the date you are eligible. 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.

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

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- the date you retire
- 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.

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.

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 And Amending Various Legislative Provisions). 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.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible

Nil

Drug Dispensing Fee Maximum

$12.00 per prescription or the Ontario Drug Benefit dispensing fee, whichever is greater

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Physician Services Outside Province of Residence
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Covered Expenses

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

- for the treatment of an illness 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 Policy will not assume coverage of the charges for such treatments, services or supplies.

Advance Supply Limitation

- Drug Expenses

The maximum quantity of Drugs that will be payable for each prescription will be limited to the quantity prescribed by the physician or dentist.

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

- charges, in excess of the hospital's public Ward charge, for semi-private and private accommodation, provided:

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

  - the accommodation was specifically elected in writing by the patient

- semi-private accommodation for confinement in a chronic care facility, to a maximum of $3 per day for up to a maximum of 120 days per 12 consecutive months
- charges for any portion of the cost of Ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Manuscript Generic Drug Plan 2 (previously referred to as Formulary 2 Generic Plan)

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

- Drugs prescribed by a physician or dentist for the treatment of an illness or injury including any deductible or co-payment the Insured Person is required to satisfy under the Ontario Drug Benefit program for a Drug also covered under this policy
- oral contraceptives
- preventive vaccines and medicines (oral or injected)
- diabetic supplies, including charges for insulin, standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

The following are not Covered Expenses:

- charges made by a practitioner or physician to administer injectable medications
- charges for dietary supplements, health foods, nutritional products, and vitamins (except injectable vitamins)

- charges for Drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

- anti-smoking Drugs

- Payment of Covered Expenses

Covered Expenses for any prescribed Drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed Drug, the amount covered is the cost of the prescribed product.

- 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 Financial for payment.

- Payment of Drug Claims

Your Group Benefit Card provides your pharmacist with immediate confirmation of covered Drug expenses. This means that when you present your Group Benefit Card to your pharmacist at the time of purchase, you and your eligible Dependents will not incur out-of-pocket expenses for amounts covered by this benefit plan for prescription Drugs.

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

To fill a prescription for covered Drug expenses:

a) present your Group Benefit Card to the pharmacist at the time of purchase, and

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

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

- you cannot locate a participating Pay Direct Drug pharmacy

- you do not have your Group Benefit Card with you at that time

- the prescription is not payable through the Group Benefit Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please contact Manulife Financial.

Vision Care

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

- eye exams including refractions, 1 exam up to a maximum of $80 in any 24 consecutive months for employees only

- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $350 in any 24 consecutive months. Prescription glasses required due to a prescription change, $350 in any 12 consecutive months. Replacement glasses due to loss or breakage, $350 in any 12 consecutive months.

Note: Non-prescription safety glasses, non-prescription sunglasses and elective laser vision correction procedures are not covered.

Physician Services Outside Province of Residence

Charges incurred for the services of a physician, due to a Medical Emergency, while the Insured Person is travelling or temporarily living outside their province of residence, shall be limited to the difference between the amount stated in the Provincial Medical Association suggested Fee Schedule in effect at the time the services are provided and the Reasonable and Customary charges made for such services.

- Expenses Not Covered

No benefit is payable for any expenses incurred outside the province of residence when the Insured Person could have been returned to the province of residence without risk to the Insured Person's life or health, even if the treatment available in the province of residence is of lesser quality than that available elsewhere.

Professional Services

$1,500 per Policy Year combined for services of a chiropractor (including x-rays), osteopath, podiatrist/chiropodist, masseur/massage therapist, naturopath, speech pathologist, physiotherapist and clinical psychologist

Effective January 1, 2023 - $1,600 per Policy Year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, masseur/massage therapist, naturopath, speech pathologist, physiotherapist and clinical psychologist.

Recommendation by a physician for Professional Services is not required, except for services of a masseur/massage therapist and speech pathologist. Recommendation is required once per 12 consecutive months for masseur/massage therapists.

Medical Services and Supplies

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

Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by a Registered nurse.

Services must be certified in writing as Medically Necessary by the attending Physician.

Covered Expenses are subject to a maximum of ninety 8 hour shifts per calendar year.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

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

Ambulance

- Licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available

Medical Equipment

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

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

  - Durable Medical Equipment: apnea monitor, manual hospital beds, respirator (an apparatus used for the purpose of providing artificial respiration over a prolonged period of time, in cases where the respiratory muscles are paralyzed), respiratory and oxygen equipment, and other durable equipment usually found only in hospitals. Compressor units and nebulizers are not covered.

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses. In the case of myoelectric or sports prostheses, consideration will be limited to the amount that would otherwise be paid for standard type artificial limbs. Repairs to prosthetic appliances are also covered.
- contact lenses or glasses following cataract surgery or when the person lacks an organic lens, limited to 1 per eye per lifetime.
- surgical stockings with a mean compression value of 25 mmHg or higher, to a maximum of 4 pairs per 24 consecutive months for you and 2 pairs per 24 consecutive months for your Dependents provided a treatment plan describing the Insured Person's medical condition and the proposed treatment is submitted to and approved by Manulife Financial prior to consideration of a claim for payment
- surgical brassieres, to a maximum of 6 per calendar year
- braces (other than foot braces and digital toe props), trusses, collars, leg orthosis, casts and splints, these items must be Medically Necessary and/or treating a medical condition. They will attach to or be worn as part of the body to give support to movable parts, or weak muscles or to strained ligaments. Physician recommendation must include diagnosis. Charges for braces for dental defects are not covered.

- modifications and adjustments to stock-item orthopaedic shoes or regular footwear (when a treatment plan describing the Insured Person's medical condition and the proposed treatment is submitted to and approved by Manulife Financial prior to consideration of a claim for payment), when recommended by a physician or podiatrist/chiropodist

- custom-made shoes (when a treatment plan describing the Insured Person's medical condition and the proposed treatment is submitted to and approved by Manulife Financial prior to consideration of a claim for payment) which are required because of a medical condition that, based on evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a Certified orthopaedic footwear specialist)

- casted, custom-made orthotics recommended by a physiatrist, podiatrist/chiropodist, orthopaedic surgeon or rheumatologist, provided a treatment plan describing the Insured Person's medical condition and the proposed treatment is submitted to and approved by Manulife Financial prior to consideration of a claim for payment, to a maximum of

    - 2 pairs per 12 consecutive months up to a maximum of $400 per pair for you

    - 1 pair per 36 consecutive months up to a maximum of $400 per pair for your Spouse and for your covered Dependent Children age 18 and above

    - 1 pair per 12 consecutive months up to a maximum of $400 per pair for your covered Dependent Children under age 18,

- cost, installation, repair and maintenance of hearing aids, (including charges for initial batteries but not for replacement batteries) on the written prescription of a Licensed, Certified or Registered audiologist, otolaryngologist, otologist or physician, to a maximum of $2,000 per 36 consecutive months

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies (where a surgical stoma exists)

- continuous positive airway pressure (CPAP) unit.

- medicated dressings and burn garments

- wigs and hairpieces for patients with temporary hair loss as a result of a medical treatment, up to a maximum of 1 per lifetime

- oxygen

- insulin pump supplies. Glucometers and insulin pumps are not covered.

- one aerochamber, limited to once per 12 consecutive months

- radium and radioactive isotope treatments

- blood products, where permitted by law

- tracheotomy supplies

- stump socks

- charges by a licensed medical laboratory for diagnostic services which are not covered by a Government Plan.

- charges for the treatment of accidental injuries to teeth or jaw due to a force or blow external to the mouth and have occurred while the person was insured for this Benefit. The treatment must be reported within 90 days following the date of the accident and must be completed within one year from the date of the accident. Injuries due to biting or chewing are not covered.

Out-of-Province/Out-of-Canada

- treatment required as a result of a Medical Emergency which occurs during the first 60 consecutive 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 $1,000,000 per trip.

Charges for the following are payable under this expense:

- physician's services in excess of the amount paid by the Provincial Plan

- 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 Insured Person to the nearest medical facility or hospital where adequate treatment is available (refusal to comply with the transfer request will end Manulife Financial's liability)

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

- services which are deemed to be within the practice of nursing and which can only be provided by a Registered Nurse (R.N.) during or immediately following hospitalization

- up to $300 per trip for charges made by a Licensed physiotherapist, chiropractor, podiatrist/chiropodist or osteopath (including x-rays)

- laboratory tests and x-rays ordered by the Insured Person's attending physician

- the cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes

- charges for any Drug which is prescribed by a physician or dentist and dispensed by a Licensed pharmacist. Charges for vitamins, vitamin/mineral preparations, food supplements, general public (G.P.) products and over-the-counter drugs are not covered, whether prescribed or not.

- the cost of splints, casts, crutches, canes, slings, trusses, walkers and/or the temporary rental of a wheelchair

- up to $2,000 for the treatment of accidental injuries to the natural teeth due to a force or blow external to the mouth. The treatment must be begun within the period of coverage for the trip and completed within 183 days of the accident.

- up to $200 for emergency treatment to relieve dental pain, excluding root canals, provided treatment is rendered at least 200 km from the Insured Person's province of residence

- up to $100 during one period of hospitalization, to cover miscellaneous incidental hospital expenses

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

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.

Manulife Financial will not pay benefits for expenses incurred outside the province of residence when the Insured Person could have returned to the province of residence without risk to the Insured Person's life or health, even if the treatment available in the province of residence is of lesser quality than that available elsewhere.

- Expenses Not Covered

No benefit is payable for any expenses incurred outside the province of residence when the Insured Person could have been returned to the province of residence without risk to the Insured Person's life or health, even if the treatment available in the province of residence is of lesser quality than that available elsewhere.

Emergency Travel Assistance

Emergency Travel Assistance is a travel assistance program available for you and your covered Dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a Medical Emergency during the first 60 consecutive days while travelling outside your province of residence for other than health reasons.

Note: the provisions of the Emergency Travel Assistance Benefit are subject to change by Manulife Financial. However, if a change in coverage occurs, it will apply only to trips beginning on or after the effective date of the change.

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.

The Insured Person is encouraged to contact the Emergency Travel Assistance organization to initiate emergency travel claims as soon as possible.

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, 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 Financial shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

If Medically Necessary, arrangements will be made to transfer an Insured Person to and from the nearest medical facility or to a medical facility in the Insured Person's province of residence (refusal to comply with the transfer request will end Manulife Financial's liability). Expenses incurred for the medical transportation will be paid, as described under 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) **Repatriation**

When required by the Insured Person's attending Physician, one-way economy transportation will be arranged to enable the Insured Person to return to the Insured Person's province of residence, including, if necessary, the cost to accommodate a stretcher. This benefit will also apply to one other Insured Person who is travelling with the patient at the time the Medical Emergency occurs. This benefit is only provided when the Insured Person does not have a valid open-return air ticket.

If Medically Necessary for a qualified medical attendant to accompany the Insured Person, expenses incurred for round-trip transportation will be paid.

g) **Return of Dependent Children**

If Dependent Children are left unattended due to the hospitalization of an Insured Person, arrangements will be made for local care of such Children or to return the Children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

h) **Visit of Family Member/Friend**

Expenses incurred for round-trip economy transportation will be paid for an Immediate Family Member or friend to visit an Insured Person who becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by Manulife Financial.

i) **Vehicle Services**

If an Insured Person is unable to operate his owned or rented vehicle due to illness or injury, 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).

If the Insured Person's private vehicle is stolen or rendered inoperable due to an accident, one-way economy transportation will be arranged to enable the Insured Person to return to the Insured Person's province of residence.

j) **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 or friend to travel, if necessary, to identify the deceased prior to release of the body.

k) **Meals and Accommodation**

When return to the province of residence is delayed beyond the planned termination date of the trip due to sickness or injury of an Insured Person or Travelling Companion, expenses incurred for meals and accommodation for the Insured Person and his eligible Dependents will be paid, subject to a combined maximum of $1,500 (Canadian) per Medical Emergency, limited to expenses of not more than $150 per day.

Non-Medical Assistance

a) **Return of Deceased**

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 city of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Alternatively, up to $2,500 will be reimbursed for cremation and/or burial of the Insured Person at the place of death.

Expenses for 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 counsel, 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.

Automatic Extension Of Coverage

If an Insured Person is confined to Hospital on the date the 60 days coverage period ends, coverage will continue until discharge from the Hospital.

In addition, coverage will automatically be extended to the Insured Person and any accompanying covered Dependents for up to 72 hours:

a) following discharge from a period of Hospitalization which extended past the end of the 60 consecutive days coverage period;

b) beyond the end of the 60 consecutive days coverage period when return to the province of residence is delayed, by order of the attending Physician, due to a covered Medical Emergency;

c) beyond the end of the 60 consecutive days coverage period when return to the province of residence is delayed:

    1. due to the delay of a common carrier (airplane, bus, taxi, train) on which the Insured Person is a passenger; or

    2. due to a traffic accident or mechanical failure of a private automobile en route to the departure point.

Exceptions

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

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

How to Access Emergency Travel Assistance - Your Group Benefit Card

Your Group Benefit 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 Group Benefit Card also lists your I.D. number and Group Policy number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have a Group Benefit Card, please contact your Plan Administrator.

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.

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

All claims must be submitted within 365 days from the end of the calendar year in which the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

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

Exclusions

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

- care, services or supplies which are not Medically Necessary, as determined by Manulife Financial
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit, direct or indirectly, a criminal act under legislation in the jurisdiction where the act was committed, including but not limited to:
    - expenses as a result of, in connection with or in any way associated with driving a motorized vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 milligrams of blood (for the purposes of this exclusion, motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to, an automobile, truck, motorcycle, moped, snowmobile or boat)
- an illness or injury for which benefits are payable under any government plan or legally mandated program
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms, transfer of medical files, rest cures
- services and supplies for which you are entitled to obtain benefits or reimbursement under any Government Plan, or which would be provided without charge in the absence of this Policy
- services or supplies when out of the country for a medical condition for which, prior to departure, medical evidence would suggest that treatment or Hospitalization could be required while on the trip
- services or supplies when out of the country, in connection with or in any way associated with travel booked or commenced contrary to medical advice or after receipt of a terminal prognosis
- medical treatment which is not usual or customary, or is Experimental or Investigational in nature
- cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was insured under the Policy
- services or supplies which are performed or provided by the Insured Person, an Immediate Family Member or a person who lives with the Insured Person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a Covered Expense under this benefit
- services or supplies provided while confined in a nursing home or home for the aged
- nebulizers and vaporizers

- additional, duplicate or replacement appliances or devices except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, subject to prior written approval by Manulife Financial

- services provided in a health spa, chronic care or psychiatric hospital or chronic care unit of a general hospital, except as otherwise provided in this Policy

- care, services or supplies utilized as treatment of lifestyle choices, as determined by Manulife Financial

- willful concealment or misrepresentation of any material fact or circumstance concerning this coverage, either before or after the incurrence of an expense. In the event that any claims submitted by the Insured Person are found to be inappropriate after due investigation, then the Insured Person shall indemnify Manulife Financial from all costs related to the investigation. (Waiver by Manulife Financial of its rights to indemnification in any particular instance will not preclude Manulife Financial from exercising its rights in any other situation that may arise.)

- when out of the country, hospitalization or services rendered in connection with or in any way associated with:

  - ongoing maintenance of an existing medical condition

  - rehabilitation or ongoing care in connection with drug, alcohol or other substance abuse

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:

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

- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and

- Drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). 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 RAMQ 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 RAMQ List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage stated under the Benefit, or
- the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

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

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

i) Deductible amounts, and

ii) the portion of covered drug expenses that is paid by the Insured 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 RAMQ formulary.

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 RAMQ formulary 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 RAMQ 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 RAMQ List are covered, and

ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

iii) the percentage payable by Manulife Financial 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 RAMQ List are covered, and

ii) only covered pharmacy services performed for a drug on the RAMQ List are covered, and

iii) the percentage payable by Manulife Financial 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 specified under the Benefit is subject to the following conditions:

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

ii) only covered pharmacy services related to a drug on the RAMQ List are covered,

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

iv) the annual out-of-pocket maximum is as stipulated in the then applicable Legislation, and

v) 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 RAMQ List

Coverage for Drugs that are listed as a Covered Expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care

If you or your Dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

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

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

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Dental Association Approved Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

100% for Basic Services - Level I (formerly Dental Plan 9)

100% for Supplementary Basic Services - Level II (formerly Dental Plan 9)

50% for Major Restorative Services - Level IV (formerly Dental Rider 4)

50% for Orthodontics - Level V (formerly Dental Rider 3)

Benefit Maximums

Unlimited for Level I and Level II

$1,000 per Policy Year for Level IV

$3,000 per lifetime for Level V

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of an Insured 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 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 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, Manulife Financial will pay benefits as if the least expensive course of treatment were used. Manulife Financial will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I – Basic Services (previously referred to as Dental Plan 9)

- complete oral exam, once per 36 months (3 years)
- full-mouth x-rays, once per 36 months (3 years)
- panoramic x-rays, once per 36 months (3 years)
- one unit of light scaling and one unit of polishing, once every 6 months for persons under age 17 and once every 9 months for persons age 17 and above, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months for persons under age 17 and once every 9 months for persons age 17 and above, when the service is performed in Quebec

- recall exams and bitewing x-rays, once every 6 months for persons under age 17 and once every 9 months for persons age 17 and above
- fluoride treatments
- routine diagnostic and laboratory procedures
- oral hygiene instruction or reinstruction, once every 6 months for persons under age 17 and once every 9 months for persons age 17 and above
- fillings (amalgam, silicate, acrylic and composite) and retentive pins
- pit and fissure sealants, limited to 1 replacement per tooth per lifetime
- pre-fabricated full coverage restorations (metal and plastic)
- minor surgical procedures, simple extractions and post-surgical care
- complicated extractions including impacted and residual roots
- consultation limited to 2 units every 12 consecutive months, anaesthesia, and conscious sedation
- denture repairs, relines, rebases and adjustments, 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
- microbiological tests for determination of pathologic agents
- unscheduled office/institutional appointments
- sinus exam
- bacteriological tests for determination of dental caries susceptibility
- biopsy of soft or hard tissue
- cytological tests
- frenectomy
- surgical incision/excision

Level II – Supplementary Basic Services (previously referred to as Dental Plan 9)

- 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

  – provisional splinting

  – occlusal equilibration, up to a maximum of 8 units per 12 months

  - oral mucosal disorders
  - periodontal surgery
  - periodontal appliances (including bruxism appliances)
- endodontic services which include root canals and therapy, root amputation, apexifications, chemical bleaching, periapical services, surgical and emergency services
- fractures

Level IV – Major Restorative Services (previously referred to as Dental Rider 4)

- restorative services, once per 5 years
  - crowns, inlays, onlays, posts
  - replacement of crowns, inlays, onlays
  - gold foil restorations
- fixed prosthodontics services, once per 5 years
  - initial provisions of fixed bridgework
  - replacement of fixed bridgework or the addition of teeth to bridgework

Level V – Orthodontics (previously referred to as Dental Rider 3)

- correction of malocclusion of the teeth
- observation and adjustment
- appliances for tooth guidance or uncomplicated tooth movement
- appliances to control harmful habits
- retention appliances
- fixed or cemented, unilateral and bilateral appliances
- myofunctional therapy
- space maintainers

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, Manulife Financial suggests that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Submitting a Claim

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

All claims must be submitted within 365 days from the end of the calendar year in which the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Exclusions

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

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit, direct or indirectly, a criminal act under legislation in the jurisdiction where the act was committed
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- charges for broken dental appointments, transfer of files, third party examinations, travel to and from appointments, or completion of claim forms
- a charge, or a portion of a charge, which is eligible for reimbursement under any other part of the Policy, or through a government plan or legally mandated program
- services or supplies for which no charge would normally be made in the absence of insurance
- treatment rendered for a correction of temporomandibular joint dysfunction
- laboratory fees which exceed Reasonable and Customary charges
- services or supplies which are performed or provided by the Insured Person, an Immediate Family Member or a person who lives with the Insured Person
- implants, or any services rendered in conjunction with implants
- services or supplies which are not specified as a covered expense under this benefit
- willful concealment or misrepresentation of any material fact or circumstance concerning this coverage, either before or after the incurrence of an expenses. In the event that any claims submitted by the Insured Person are found to be inappropriate after due investigation, then the Insured Person shall indemnify Manulife Financial from all costs related to the investigation. (Waiver by Manulife Financial of its rights to indemnification in any particular instance will not preclude Manulife Financial from exercising its rights in any other situation that may arise).

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.