Saskatchewan School Boards Association

Employer: Sun West S.D. #207

Plan Document Number: G0083400

Group Policy Number: G0035505

Plan: Sun West S.D. #207 - Trustees

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: May 1, 2005

Group Policy Effective Date: May 1, 2005

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 produced: July 17, 2023

Table of Contents

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

Health Service Navigator™

Available as part of your Critical Illness benefit, Health Service Navigator provides health resources and information to assist you and your eligible dependants in learning more about your health concerns and health services available within Canada and your local community. It features access to:

- A national physician search database
- Provincial health plan information Tips and tools to best navigate and leverage the Canadian health resources available
- Credible health, medical condition, treatment plan and medication information
- A second opinion service, where applicable delivered through a second opinion provider and a consortium of provider hospitals.

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

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount - $15,000

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

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount - increments of $10,000 to a maximum of $1,000,000

Termination Age - age 70 or retirement, whichever is earlier

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $1,000,000

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

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount - $15,000

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

Employee Optional Accidental Death and Dismemberment

The Employee Optional Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount - increments of $10,000 to a maximum of $350,000

Termination Age - age 70 or retirement, whichever is earlier

Dependent Optional Accidental Death and Dismemberment

The Dependent Optional Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

Benefit Amount

- Spouse - 0.5 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $175,000 if there are no children; 0.4 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $140,000 if there are children.

- Child - 0.15 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $52,500 if there is no spouse; 0.1 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $35,000 if there is a spouse.

For loss other than loss of life, the amount of Child Benefit, shown above will be calculated using 2 times the percentage for the loss indicated in the SPECIFIED LOSS table, up to a maximum of $75,000

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

Extended Health Care

The Benefit

An Employee may select one of the following Options:

Option 1 - Extended Health Care including Vision Care

Option 2 - Extended Health Care excluding Vision Care

Option 3 - Vision Care Only

Overall Benefit Maximum - Unlimited

Options 1, 2 and 3

Deductible - Nil

Drug Dispensing Fee - the Employee will pay 100% of any Drug Dispensing Fee

Benefit Percentage (Co-insurance)

Option 1

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

80% for
Prescription Drugs

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 2

100% for
Hospital Care
Professional Services
Medical Supplies and Services

80% for
Prescription Drugs

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 3

100% for
Vision Care

Termination Age - employee's retirement

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- vitamin B6 and B12 for weight loss
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs

- preventive vaccines and medicines (oral or injected)

- standard syringes, needles, automatic jet injectors, manual or automatic insulin gun and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol and similar equipment are not covered)

- medical marijuana for the treatment of specific medical conditions approved by Manulife Financial, subject to the following:

    - prior authorization must be approved by Manulife Financial before medical marijuana claims are submitted; and

    - the product must be obtained according to the Access to Cannabis for Medical Purposes Regulations (ACMPR); and

    - approval may be valid for a predefined period. Prior authorization must be re-approved when the predefined period ends; and

    - all approved claims for medical marijuana will be required to go through Manulife Financial's medical marijuana program to be eligible for coverage.

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis

- drugs determined to be ineligible as a result of due diligence

- flu shots

- Drug Maximums

Fertility drugs - $2,500 per lifetime

Anti-smoking drugs - $600 per lifetime

Sexual Dysfunction drugs: $2,500 per lifetime

Medical Marijuana - $2,500 per calendar year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, the Benefit Percentage for drugs and any maximum.

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

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

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

- Medical Marijuana Program

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

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

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

- program introduction
- medical marijuana management and expertise to identify the most suitable strain for the medical condition medical marijuana is approved for
- submission requests for approved strain to an authorized licensed producer participating in Manulife's Medical Marijuana Program
- coordination of the medical marijuana delivery to the covered person's home or other location where legislation permits
- medication monitoring for effectiveness of the strain being used
- support with side effect management, and
- access to a hotline for consultation.

- No Substitution Prescriptions

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

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

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

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

- Payment of Drug Claims (excluding Medical Marijuana)

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

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

Benefit Summary

To fill a prescription for covered drug expenses:

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

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

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

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

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

- Payment of Drug Claims for Medical Marijuana

The Pay Direct Drug Card is honoured by the authorized licensed producer participating in the Medical Marijuana Program.

To fill a prescription for a covered Medical Marijuana expenses:

a) present the Pay Direct Drug Card; and

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

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

Vision Care

For employees choosing Option 1 or 3

- eye exams, $100 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $225 per 24 consecutive months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 24 consecutive months
- elective laser vision correction procedures, to a maximum of $1,000 per lifetime

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $300 per calendar year, including one x-ray per calendar year
- Osteopath - $300 per calendar year, including one x-ray per calendar year
- Podiatrist/Chiropodist - $300 per calendar year, including one x-ray per calendar year
- Massage Therapist - $300 per calendar year

- Naturopath - $300 per calendar year, including supplements
- Speech Therapist - $300 per calendar year
- Physiotherapist - $300 per calendar year
- Psychologist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Clinical Counsellor - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Elder Healer - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Homeopath - $300 per calendar year, including supplements
- Indigenous Healer - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Marriage and Family Therapist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Psychotherapist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Social Worker - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker

Dental Care

The Benefit

Deductible - Nil

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

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% 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

$2,000 per calendar year combined for Level I, Level II, Level III and Level IV

$1,500 per lifetime for Level V

Termination Age - employee's retirement

Employee Optional Critical Illness Insurance

Benefit Amount - increments of $5,000, to a maximum of $250,000 (minimum benefit of $10,000)

Termination Age - your benefit amount reduces to $10,000 at age 65 and terminates at the earlier of age 70, your retirement, or as described under the Termination of Insurance Section of the Policy.

Optional Spousal Critical Illness Insurance

Benefit Amount - increments of $5,000, to a maximum of $250,000 (minimum benefit of $10,000)

Termination Age - your spouse's benefit amount reduces to $10,000 at your spouse's age 65 and terminates at the earlier of your age 70, your retirement, or as described under the Termination of Insurance Section of the Policy.

Optional Child Critical Illness Insurance

Benefit Amount - $5,000 each child

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

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, and
- 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 Sun West S.D. #207. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance, Employee Optional Life Insurance, Dependent Optional Life Insurance, Accidental Death and Dismemberment, Employee Optional Accidental Death and Dismemberment, Dependent Optional Accidental Death and Dismemberment and Critical Illness Benefits and the Plan Document for the Resilience™ Services, Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document, the terms of the Policy or Plan Document 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 and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

Where required by law, you or any claimant under the Group Policy and/or Plan Document has 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.

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 and/or Plan Document.

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

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

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card 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.

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

Adherence

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

Advisory Body

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

Authorized Licensed Producer

organization approved by Health Canada to produce and sell medical marijuana.

Benefit Percentage (Co-insurance)

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

Birth

the complete live delivery of a child from its mother.

Common Accident

the same accidental injury or separate accidental injuries occurring within a 24 hour period.

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 the plan.

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, stepchild or child for whom you are legal guardian, who is:

  - unmarried;

  - under age 21, or under age 26 if a full-time student; and

  - not employed on a full-time basis.

- 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.

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

- a stepchild, unless a full-time student, must be living with you to be eligible.
- a newborn child shall become eligible from the moment of birth.

Disease Management Programs

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

Drug

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

Due Diligence

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

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

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

Immediate Family Member

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

Interchangeable Drug

includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed, or
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

Licensed, Certified, Registered

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

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

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

Medical Marijuana

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

Medically Necessary

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

Non-Evidence Limit

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

Patient Assistance Program

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

Pharmacoeconomics

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

Prior Authorization

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

Provincial Plan

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.

Strains

Medical marijuana strains are either pure or hybrid varieties of the cannabis group of plants.

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: _____

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

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Employee Benefit Plan Enrollment Form, available from your employer. Your employer then forwards the application to the Administrator.

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

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

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 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, 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 or please call Manulife Financial Customer Service at 1-800-268-6195.

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 or part-time employee of Sun West S.D. #207,
- 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.

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 for Employee Optional Life or Dependent Optional Life.

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 or another co-ordinating benefit 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.

Who Qualifies for 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,

- 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, or

- 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. Some examples of such extensions are as follows:

    - if you are absent due to illness or injury, your coverage may be continued as determined by your employer.

    - If you are on a leave of absence (other than maternity or parental) or temporary lay-off, you may elect to continue your benefits coverage at your own expense until the earlier of:

        - 12 months after the date you were last actively at work; or

        - the date you return to work.

    - If you are on a maternity or parental leave of absence, your coverage shall continue for the period of leave to which you are entitled by governing legislation.

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

Health Service Navigator Services

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

Limitations

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

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

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

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

Right of Refusal

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

Summary Only

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

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

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 - $15,000

Non-Evidence Limit - $15,000

Qualifying Period for Waiver of Premium - 105 days

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

Waiting Period - first of the month following 1 month of employment

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 employer.

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 65th birthday.

Recurrent Disability

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

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

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

The Benefit

Benefit Amount - increments of $10,000 to a maximum of $1,000,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, for new employees, evidence of insurability will be waived for an amount of Optional Life Insurance which is $20,000 or less if applied for within 31 days of the date eligible.

Qualifying Period for Waiver of Premium - 105 days

Termination Age - age 70 or retirement, whichever is earlier

Waiting Period - first of the month following 1 month of employment

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your employer.

For details on **Naming a Beneficiary**, **Submitting a Claim** and **Conversion Privilege**, please refer to Employee Life Insurance.

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 65th birthday.

Recurrent Disability

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

Exclusions

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

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0035505.

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

The Benefit

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $1,000,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, for new employees, evidence of insurability will be waived for an amount of Dependent Optional Life Insurance which is $20,000 or less if applied for within 31 days of the date eligible.

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

Waiting Period - first of the month following 1 month of employment

To apply for Dependent Optional Life Insurance you must complete the Application for Optional Life form which is available from your employer.

Submitting a Claim

To submit a Dependent Optional Life Insurance claim, you must complete the Life Claim form, which is available from your employer.

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 loss.

Waiver of Premium

Please refer to Employee Life Insurance for details on the Waiver of Premium provision.

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Optional Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

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

Exclusions

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

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

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

Aggregate Limit - $1,000,000

Benefit Amount - $15,000

Non-Evidence Limit - $15,000

Qualifying Period for Waiver of Premium - 105 days

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

Waiting Period - first of the month following 1 month of employment

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 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 or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

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

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

Exposure and Disappearance

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

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife Financial will pay incurred expenses, 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 a maximum of $10,000.

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

Repatriation Expenses

If 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 $10,000.

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 $10,000 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 a maximum of $10,000.

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

Seat Belt Benefit

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

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay day-care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 365 days from the date of your death.

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:

- expenses incurred prior to your death
- 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.

Critical Disease Benefit

If you have been:

- diagnosed with a critical disease prior to age 65 and after September 1, 1999, and
- totally disabled from that disease and has not been able to work at any occupation for at least 9 months, you will be eligible for the Critical Disease Benefit.

"Critical Disease" shall mean any one of the following diseases diagnosed after the later of September 1, 1999 and the effective date of your coverage: Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type 1 Diabetes (insulin dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

The amount payable will be subject to 10% of the Benefit Amount, to a maximum of $50,000 and limited to the first covered critical disease in your lifetime.

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 employer, 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

Employee Optional Accidental Death and Dismemberment

The Employee Optional Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

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

Aggregate Limit - $1,000,000

Benefit Amount - increments of $10,000 to a maximum of $350,000

Non-Evidence Limit - $350,000

Qualifying Period for Waiver of Premium - 105 days

Termination Age - age 70 or retirement, whichever is earlier

Waiting Period - first of the month following 1 month of employment

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 Employee Optional Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

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

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

Exposure and Disappearance

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

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife Financial will pay incurred expenses, 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 a maximum of $10,000.

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

Repatriation Expenses

If 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 $10,000.

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 $10,000 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 Employee Optional 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 a maximum of $10,000.

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

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay day-care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 365 days from the date of your death.

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

- 5% of your Employee Optional 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:

- expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Common Accident

$1,000,000

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.

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.

Comatose Benefit

If a covered person, while insured under this benefit sustains a covered accidental injury, which independently of all other causes, results in the covered person being in a coma, a Comatose Benefit will be paid. This benefit will be the difference between the amount of the Principal Sum and any other benefits received on account of such Accidental Injury.

The benefit amount for the covered person will be paid to the Employee at the end of the Qualifying Period, at the rate of 1% each month for:

a) 100 months;

b) Until death occurs; or

c) Until the covered person is deemed no longer to be in a Coma or Comatose state, whichever occurs first.

Any remaining benefits at the time of the covered person's death will be paid to the estate of the Employee.

"Coma" shall mean during the elimination period, starting within 31 days of the date of the accident, being in a profound stupor or state of complete and total unconsciousness. Qualifying Period is a 31 day period from the date the insured employee, insured spouse and/or dependent child(ren) becomes comatose for which no benefits are payable.

Naming a Beneficiary

See Employee Life Insurance... Naming a Beneficiary.

Submitting a Claim

To submit an Employee Optional Accidental Death Claim, your beneficiary must complete a Life Claim form. To submit an Employee Optional Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your employer 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 Employee Optional 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

Dependent Optional Accidental Death and Dismemberment

The Dependent Optional Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0035505.

If one of your dependents sustains an accidental injury while insured and suffers a loss specified in the Schedule of Losses below, this benefit provides financial assistance.

The Benefit

Aggregate Limit - $1,000,000

Benefit Amount

- Spouse - 0.5 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $175,000 if there are no children; 0.4 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $140,000 if there are children.

- Child - 0.15 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $52,500 if there is no spouse; 0.1 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $35,000 if there is a spouse.

For loss other than loss of life, the amount of Child Benefit, shown above will be calculated using 2 times the percentage for the loss indicated in the Schedule of Loss table, up to a maximum of $75,000

Qualifying Period for Waiver of Premium - 105 days

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

Waiting Period - first of the month following 1 month of employment

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 Dependent Optional Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

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

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

Exposure and Disappearance

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

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

Repatriation Expenses

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

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

Family Transportation Expenses

If, as a direct result of an accidental injury, the insured person suffers a loss specified in the Schedule of Losses and is confined to a hospital located 150 kilometres or more from the insured person's place of residence, Manulife 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 $10,000 per accident.

Common Accident

$1,000,000

Home Alteration and Vehicle Modification Expenses

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

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

and requires 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 the insured person's 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.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which the insured person is 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.

Comatose Benefit

If a covered person, while insured under this benefit sustains a covered accidental injury, which independently of all other causes, results in the covered person being in a coma, a Comatose Benefit will be paid. This benefit will be the difference between the amount of the Principal Sum and any other benefits received on account of such Accidental Injury.

The benefit amount for the covered person will be paid to the Employee at the end of the Qualifying Period, at the rate of 1% each month for:

a) 100 months;

b) Until death occurs; or

c) Until the covered person is deemed no longer to be in a Coma or Comatose state, whichever occurs first.

Any remaining benefits at the time of the covered person's death will be paid to the estate of the Employee.

"Coma" shall mean during the elimination period, starting within 31 days of the date of the accident, being in a profound stupor or state of complete and total unconsciousness. Qualifying Period is a 31 day period from the date the insured employee, insured spouse and/or dependent child(ren) becomes comatose for which no benefits are payable.

Submitting a Claim

To submit a Dependent Optional Accidental Death Claim, a Life Claim form must be submitted. To submit a Dependent Optional Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your employer 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 Group Policy terminates.

Exclusions

No Dependent Optional 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

The Extended Health Care Benefit is administered through Manulife Financial Contract G0083400. 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.

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

An Employee may select one of the following Options:

Option 1 - Extended Health Care including Vision Care

Option 2 - Extended Health Care excluding Vision Care

Option 3 - Vision Care Only

Overall Benefit Maximum - Unlimited

Options 1, 2 and 3

Deductible - Nil

Drug Dispensing Fee - the Employee will pay 100% of any Drug Dispensing Fee

Benefit Percentage (Co-insurance)

Option 1

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

80% for
- Prescription Drugs

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 2

100% for
- Hospital Care
- Professional Services
- Medical Supplies and Services

80% for
- Prescription Drugs

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 3

100% for Vision Care

Termination Age - employee's retirement

Waiting Period - first of the month following 1 month of employment

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 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
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this 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.

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

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

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

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Advance Supply Limitation

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

- Drug Expenses

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

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

b) a 34 day supply.

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

Hospital Care

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

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

  - the accommodation was specifically elected in writing by the patient

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

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist

- oral contraceptives, intrauterine devices and diaphragms

- vitamin B6 and B12 for weight loss

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

- life-sustaining drugs

- preventive vaccines and medicines (oral or injected)

- standard syringes, needles, automatic jet injectors, manual or automatic insulin gun and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol and similar equipment are not covered)

- medical marijuana for the treatment of specific medical conditions approved by Manulife Financial, subject to the following:

    - prior authorization must be approved by Manulife Financial before medical marijuana claims are submitted; and

    - the product must be obtained according to the Access to Cannabis for Medical Purposes Regulations (ACMPR); and

    - approval may be valid for a predefined period. Prior authorization must be re-approved when the predefined period ends; and

    - all approved claims for medical marijuana will be required to go through Manulife Financial's medical marijuana program to be eligible for coverage.

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis

- drugs determined to be ineligible as a result of due diligence

- flu shots

- Drug Maximums

Fertility drugs - $2,500 per lifetime

Anti-smoking drugs - $600 per lifetime

Sexual Dysfunction drugs - $2,500 per lifetime

Medical Marijuana - $2,500 per calendar year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, the Benefit Percentage for drugs and any maximum.

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

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

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

- Medical Marijuana Program

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

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

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

- program introduction
- medical marijuana management and expertise to identify the most suitable strain for the medical condition medical marijuana is approved for
- submission requests for approved strain to an authorized licensed producer participating in Manulife's Medical Marijuana Program
- coordination of the medical marijuana delivery to the covered person's home or other location where legislation permits
- medication monitoring for effectiveness of the strain being used
- support with side effect management, and
- access to a hotline for consultation.

- No Substitution Prescriptions

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

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

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

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

- Payment of Drug Claims (excluding Medical Marijuana)

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

- Payment of Drug Claims for Medical Marijuana

The Pay Direct Drug Card is honoured by the authorized licensed producer participating in the Medical Marijuana Program.

To fill a prescription for a covered Medical Marijuana expenses:

a) present the Pay Direct Drug Card; and

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

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

Vision Care

For employees choosing Option 1 or 3

- eye exams, $100 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $225 per 24 consecutive months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 24 consecutive months
- elective laser vision correction procedures, to a maximum of $1,000 per lifetime

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $300 per calendar year, including one x-ray per calendar year
- Osteopath - $300 per calendar year, including one x-ray per calendar year
- Podiatrist/Chiropodist - $300 per calendar year, including one x-ray per calendar year
- Massage Therapist - $300 per calendar year

- Naturopath - $300 per calendar year, including supplements
- Speech Therapist - $300 per calendar year
- Physiotherapist - $300 per calendar year
- Psychologist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Clinical Counsellor - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Elder Healer - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Homeopath - $300 per calendar year, including supplements
- Indigenous Healer - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Marriage and Family Therapist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Psychotherapist - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker
- Social Worker - $300 per calendar year combined for services of a psychologist, clinical counsellor, elder healer, indigenous healer, marriage and family therapist, psychotherapist and social worker

In response to the Call to Action 22 of the Truth and Reconciliation Commission, the Saskatchewan School Boards Association Employee Benefits Plan recognizes Indigenous healing practices, Indigenous healers and Elders within our coverage policies.

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

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

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, or
- a registered nursing assistant (or equivalent designation) who has completed an approved medications training program.

Covered Expenses are subject to a maximum of $5,000 per calendar year(s)

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

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

Medical Equipment

- rental or, when approved by Manulife Financial, purchase of:
  - Mobility Equipment: crutches, canes, walkers, and wheelchairs
  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings, up to a maximum of 2 pairs per calendar year
- surgical brassieres, up to a maximum of 2 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of $100 per calendar year(s) combined with custom-made orthotics (recommendation of either a physician or a podiatrist is required)

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

- casted, custom-made orthotics, up to a maximum of $100 per calendar year(s) combined with stock-item orthopaedic shoes (recommendation of either a physician or a podiatrist is required)

- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $500 per 3 consecutive year(s)

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies

- medicated dressings and burn garments

- wigs and hairpieces for patients with hair loss, up to a maximum of 1 per lifetime

- blood pressure monitors, up to a maximum of $200 per 5 years

- oxygen

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

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

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs during the first 60 days while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, subject to the overall maximum.

  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.

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

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

  For all non-emergency medical treatment out of Canada:

  - the treatment must be recommended by a physician practicing in Canada, and

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

Charges for the following are payable under this expense:

- 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 during the first 60 days 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 - Ambulance.

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 the 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 15 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, the Plan 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 the Plan 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:

- for Out-of-Province/Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of 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

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 under this benefit will be as follows:

i) for any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is 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 this Benefit, 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 this Benefit, the percentage payable is the greater of:

- the benefit percentage stated under The Benefit; and
- the percentage as set out by the then applicable Legislation.

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

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

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

i) deductible amounts, and

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

iii) covered pharmacy services that are performed by pharmacists for drugs on the 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 the Administrator 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:

- only drugs that are on the RAMQ List are covered, and
- only covered pharmacy services performed for a drug in the RAMQ List are covered, and
- the percentage payable by the Administrator 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 the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,

iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

v) the cost required for the drug coverage is the cost of 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

The Dental Care benefit is administered through Manulife Financial Contract G0083400. 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 - Current Fee Guide for General Practitioners for your Province of Residence

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% 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

$2,000 per calendar year combined for Level I, Level II, Level III and Level IV

$1,500 per lifetime for Level V

Termination Age - employee's retirement

Waiting Period - first of the month following 1 month of employment

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

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the Plan 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

- complete oral exam, one per 2 calendar years
- full-mouth x-rays, one per 2 calendar years
- one unit of light scaling and one unit of polishing once every 6 months, when the service is performed outside Quebec, or prophylaxis (polishing) one every 6 months, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, one every 6 months
- routine diagnostic and laboratory procedures

- initial oral hygiene instruction, plus one recall
- pit and fissure sealants
- space maintainers (appliances placed for orthodontic purposes are not covered) for dependent children under age 22

Level II – Supplementary Services

- fillings (amalgam, silicate, acrylic and composite) and retentive pins. 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)
- 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
- 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 16 units per calendar year;
  - provisional splinting; and
  - occlusal equilibration, up to a maximum of 8 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 for dependent children only, provided treatment commences prior to reaching age 19

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 15 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, the Plan 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 the Plan 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:

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- 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. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the plan will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge.

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

- services or supplies which are not specified as a covered expense under this benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Extended Health Care and Dental Care benefits without requiring any contribution from you, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms),

- the date similar coverage is obtained elsewhere,

- the date which is 12 months from your death, or

- the date the Plan Document terminates.

Critical Illness Benefits

Your Plan Contract number for Critical Illness benefits is G0031008.

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

Employee Optional Critical Illness Insurance

If, while you are insured for this benefit, you are diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Employee Optional Critical Illness benefit. You must have survived your illness for 14 days or more past the date you were first diagnosed. Some Critical Illness conditions have a specific qualifying period. For those conditions, the survival period will be described in the covered conditions below.

The Benefit

Benefit Amount - increments of $5,000, to a maximum of $250,000 (minimum benefit of $10,000)

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Optional Critical Illness Insurance which is $50,000 or less if applied for within 31 days of the date eligible.

Termination Age - your benefit amount reduces to $10,000 at age 65 and terminates at the earlier of age 70, your retirement, or as described under the Termination of Insurance Section of the Policy.

Waiting Period - none

Optional Spousal Critical Illness Insurance

If, while you are insured for this benefit, your spouse is diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Optional Spousal Critical Illness benefit. Your spouse must have survived their illness for 14 days or more past the date they were first diagnosed. Some Critical Illness conditions have a specific qualifying period. For those conditions, the survival period will be described in the covered conditions below.

The Benefit

Benefit Amount - increments of $5,000, to a maximum of $250,000 (minimum benefit of $10,000)

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Spousal Optional Critical Illness Insurance which is $50,000 or less if applied for within 31 days of the date eligible.

Termination Age - your spouse's benefit amount reduces to $10,000 at your spouse's age 65 and terminates at the earlier of your age 70, your retirement, or as described under the Termination of Insurance Section of the Policy.

Waiting Period - none

Optional Child Critical Illness Insurance

If, while you are insured for this benefit, your child is diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Optional Child Critical Illness benefit. Your child must have survived their illness for 14 days or more past the date they were first diagnosed. Some Critical Illness conditions have a specific qualifying period. For those conditions, the survival period will be described in the covered conditions below.

The Benefit

Benefit Amount- $5,000 each child

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

Waiting Period - none

Explanations of Terms Associated with Critical Illness Benefits

Child

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

- is insured under the provincial plan;
- is unmarried;
- is not employed on a full-time basis;
- is not eligible for insurance as an employee under this or any other group policy;
- relies on you for financial support; and
- under age 21, or under age 26 if a full-time student.

Employee

the person having the primary relationship with the policyholder and:

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

Immediate Family Member

an Immediate Family Member is a person who is:

- the Employee; or
- the Employee's Spouse or Child.

Physician

a doctor of medicine, licensed to practice medicine in the place in Canada where the services are provided. For the purposes of this benefit, unless stated otherwise, reference to a Physician also includes Nurse Practitioner within their scope of practice.

Specialist

a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered Critical Illness condition for which the benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, and as approved by Manulife, a condition may be diagnosed by a qualified medical practitioner practicing in Canada.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The specialist must not be the policyholder, the insured person, a relative of or business associate of the policyholder or of the insured person.

Spouse

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

Survival Period

the period starting on the date of diagnosis of the Critical Illness condition and ending 14 days later, except where a covered Critical Illness described below modifies this definition. The survival period does not include the number of days on life support. The insured person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.

Entitlement Criteria

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

- Manulife receives medical evidence documenting your diagnosis of a covered Critical Illness condition;
- the diagnosis of any Critical Illness is made by a physician or a specialist, practicing medicine in Canada in a specialty relating to the applicable Critical Illness;
- the diagnosis is not a recurrence of a previous condition, except as described under the Second Event Cancer benefit;
- any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not you, your policyholder, a relative of or business associate of yours or of your policyholder.

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

No benefit will be payable when a critical illness condition is diagnosed while the insured person is not covered under this policy.

Once a benefit has become payable, the insured person for whom a claim has been paid out will not be covered for another claim that is the result of the same critical illness condition, except as specified under the Second Event Cancer benefit.

Multiple Event Coverage

Means, you or your spouse could receive additional, separate paid Critical Illness claims. A claim may be eligible from each covered condition category for up to three (3) claims in total, and an additional claim as described in the “Second Event Cancer benefit”.

Once a claim is paid within a category, the covered condition category will be subject to restrictions that prevent the insured person from receiving another payment from the same category, except in the second cancer event.

Second Event Cancer Benefit

We will pay a second event cancer benefit to an eligible insured person if:

- at least 60 months have gone by between the previous cancer and the new cancer;
- the insured person has not received any treatment relating directly or indirectly to the previous cancer within that 60-month period (treatment does not include preventative medications and follow up visits to the doctor);
- there is no evidence, of any continuing presence, recurrence or spread of the previous cancer;
- the insured person does not have any new symptoms during that 60-month period for which they sought medical investigation, diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused them to seek the above relating to a diagnosis of cancer; and
- the later diagnosis must be made while the insured person is covered under this policy.

Furthermore, for a Second Event Cancer Benefit to be paid out, the subsequent Cancer Diagnosis must:

- not be a secondary cancer or histologically related to the previous cancer; or
- for hematological cancers, the new cancer must be categorized or divided according to defined cell characteristics in a distinctly different manner to the previous cancer.

Covered Conditions by Categories

Group 1: Cancer
a) Cancer (Life-Threatening)

Group 2: Cardiovascular:
b) Aortic Surgery,
c) Coronary Artery Bypass Surgery,
d) Heart Attack,
e) Heart Valve Replacement or Repair,
f) Stroke

Group 3: All others:
g) Aplastic Anemia,
h) Bacterial Meningitis,
i) Benign Brain Tumour, Blindness,
j) Coma,
k) Deafness,
l) Dementia, including Alzheimer's Disease,
m) Kidney Failure,
n) Loss of Speech,
o) Loss of Limbs,
p) Major Organ Failure and on Waiting List,
q) Major Organ Transplant,
r) Motor Neuron Disease,
s) Multiple Sclerosis,
t) Occupational HIV,
u) Paralysis,
v) Parkinson's Disease and Specified Atypical Parkinsonian Disorders,
w) Severe Burns,
x) Loss of Independent Existence and other conditions if also added

What will not be paid under the Multiple Event Coverage

- Any future claim for loss of independent existence (LOIE) after an insured person has received an eligible claim payment from any covered condition category
- Any future claim after an insured person has received an eligible claim payout for LOIE.
- Any claim where, within the first 90 days following the date a previous critical illness condition was diagnosed, the insured person for whom a claim has been paid out has any of the following:
  - signs or symptoms that lead to a critical illness condition, regardless of the date when the diagnosis is made, or
  - medical consultations, tests or any form of medical evaluation, that lead to a critical illness condition, regardless of when the diagnosis is made; or
  - a critical illness condition
- A claim for a Child Critical Illness.

Geographic Limitations

Any critical illness diagnosed outside of Canada following an accident or an illness will only be assessed once the insured person has returned to Canada and has obtained a medical assessment of their condition.

Critical Illness Covered Conditions by Categories

	You and your spouse	Your Child
Cancer Critical Illness conditions		
Cancer (Life-Threatening)	X	X
Cardiovascular Critical Illness conditions		
Aortic Surgery	X	X
Coronary Artery Bypass Surgery	X	X
Heart Attack	X	X
Heart Valve Replacement or Repair	X	X
Stroke (Cerebrovascular Accident)	X	X
Congenital Heart Disease (for which corrective surgery has been performed)		X
Other Critical Illness conditions		
Aplastic Anemia	X	X
Bacterial Meningitis	X	X
Benign Brain Tumour	X	X
Blindness	X	X
Coma	X	X
Deafness	X	X
Dementia, including Alzheimer's Disease	X	X
Kidney Failure	X	X
Loss Of Independent Existence	X	X
Loss Of Limbs	X	X
Loss Of Speech	X	X
Major Organ Failure and On Waiting List	X	X
Major Organ Transplant	X	X
Motor Neuron Disease	X	X
Multiple Sclerosis	X	X
Occupational HIV Infection	X	X
Paralysis	X	X
Parkinson's Disease and Specified Atypical Parkinsonian Disorders	X	X
Severe Burns	X	X
Autism		X
Cerebral Palsy		X
Cystic Fibrosis		X
Down Syndrome		X
Muscular Dystrophy		X
Type 1 Diabetes Mellitus		X

Submitting a Claim

To submit a Critical Illness Insurance claim, the insured person must have survived their illness for 14 days or more past the date they were first diagnosed. Some Critical Illness conditions have a specific qualifying period. For those conditions, the survival period will be described in the covered conditions below.

For all Critical Illness coverage, we will need to receive your completed claim form within 180 days of date of diagnosis of the Critical Illness.

You can obtain a claim form directly from the **Forms and Brochures** section on the Manulife Group Benefits Employee Internet Site. Otherwise, you can get a form from your Plan Administrator.

The form shows all of the necessary documents you need to submit to support your claim.

Exclusions

No benefits are payable for any Critical Illness related to:

- any specific exclusions associated with a given condition set out in the Covered Critical Illness Conditions Appendix
- self-inflicted injuries or illnesses
- abuse of addictive substances, including drugs and alcohol, including single incidence abuse
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle, under the influence of drugs or alcohol as prohibited by law
- taking a poisonous substance or inhaling toxic gases or fumes
- a situation where your child is born and diagnosed with a condition within the first ten months of the effective date of child coverage
- a pre-existing condition incurred or diagnosed during the first 24 months of coverage or latest reinstatement of coverage, or an increase in Insurance where no evidence of insurability is required. This limitation applies whether or not the insured person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement

  A pre-existing condition is an illness or injury for which the insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a physician or has been prescribed medication - or where treatment would have been received by a prudent individual - during the 24 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness benefit.
- cancer or benign brain tumour, or Parkinson's disease and specified atypical parkinsonian disorders if within the **first 90 days** of your coverage effective date you have any of the following:
  - signs or symptoms that lead to a diagnosis of cancer or benign brain tumour, or Parkinson's disease and specified atypical parkinsonian disorders, regardless of the date when the diagnosis is made
  - medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or benign brain tumour, or Parkinson's disease and specified atypical parkinsonian disorders, regardless of when the diagnosis is made

    a diagnosis of cancer or benign brain tumour, or Parkinson's disease and specified atypical parkinsonian disorders

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.