

The Anglican Church of Canada

Group Policy Number: G0021057B

Class: Retirees of the Diocese of Rupert's Land

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Group Policy Effective Date: April 01, 1997

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

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

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

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Benefit Summary

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

This version of the Benefit Summary produced: December 18, 2015

Extended Health Care

Extended Health Care

The Benefit

Overall Benefit Maximum - \$50,000 per lifetime

Not applicable to:

Drugs

Deductible - Nil

Drug Deductible - \$1.00 per prescription (excluding Diabetic Supplies)

Benefit Percentage (Co-insurance) -

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

Note:

The Benefit Percentage for Drugs is shown below under ManuScript Generic Drug Plan 2 - Prescription Drugs, Payment of Covered Expenses.

Termination Age - upon the employee's death

ManuScript Generic Drug Plan 2 - Prescription Drugs

*Extended Health Care -
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

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 and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Benefit Summary

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

- Drug Maximums

- Drug Maximums

Fertility drugs - \$15,000 per lifetime

Anti-smoking drugs - \$300 per lifetime

Drugs used in the treatment of Sexual Dysfunction - \$1,000 per calendar year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

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

If there is no lower cost interchangeable product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- 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 lowest cost interchangeable drug that can legally be used to fill the prescription. The Provincial Drug Benefit Formulary indicates which drugs are considered interchangeable drugs.

If there is no lower cost interchangeable drug for the prescribed drug, the amount covered is the cost of the prescribed product.

Reimbursement at the cost of a prescribed drug, where a lower cost interchangeable drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lowest cost interchangeable 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 and the Co-insurance of 100%.

- Payment of Drug Claims

- Payment of Drug Claims

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

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

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.

Vision Care

***Extended Health Care -
Vision Care***

- eye exams, once per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$100 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 \$250 per 24 consecutive months
- visual training, to a maximum of \$200 per lifetime

Professional Services

***Extended Health Care -
Professional Services***

Services provided by the following licensed practitioners:

- Chiropractor - \$350 per calendar year(s)
- Osteopath - \$350 per calendar year(s)
- Podiatrist - \$350 per calendar year(s)
- Chiropodist - \$350 per calendar year(s)
- Psychiatrist - \$350 per calendar year(s)
- Massage Therapist - \$350 per calendar year(s)
- Naturopath - \$350 per calendar year(s)
- Speech Therapist - \$350 per calendar year(s)
- Physiotherapist - \$500 per calendar year(s)
- Psychologist/Psychotherapist - \$350 per calendar year(s)
- Acupuncturist - \$350 per calendar year(s)

Benefit Summary

Charges for x-rays are covered up to a maximum of 1 x-ray per calendar year for each practitioner

Dental Care

Dental Care
Dental Care - The
Benefit

The Benefit

Deductible - Nil

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

If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by Manulife Financial

Benefit Percentage (Co-insurance) -

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

\$1,000 per calendar year combined for Level I and Level II and Level III and Level IV

\$1,000 per lifetime for Level V

Termination Age - upon the employee's death

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

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

a detailed Table of Contents, allowing quick access to the information you are searching for,

Explanation of Common Insurance Terms, which provides a brief explanation of the insurance terms used throughout this Benefit Booklet,

a clear, concise explanation of your Group Benefits,

information you need, and simple instructions on how to submit a claim.

***Your Benefit Booklet
includes...***

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of The Anglican Church of Canada. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (available from your Plan Administrator), the terms of the Group Policy will apply.

Important Note

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

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

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

the Policy,

your application for group benefits, and

any Evidence of Insurability you submitted as part of your application for benefits.

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

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

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

Your Group Benefit Card

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

***Your Group Benefit
Card***

How to Use Your Benefit Booklet

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

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

Explanation of Common Insurance Terms

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

Benefit Percentage (Co-insurance)

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

**Benefit Percentage
(Co-insurance)**

Covered Expenses

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

Covered Expenses

Deductible

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

Deductible

Dependent

your Spouse or Child who resides with you, in Canada.

Dependent

- Spouse

the spouse of the insured employee who is a person legally married to the insured employee; or

the partner of the insured employee who is a person not legally married to the insured employee and who resides continuously with him or her in a sexual relationship, provided that a written request is made by the insured employee for extension of insurance under this policy for such individual.

NOTE: The above criteria is provided for determining eligibility for benefits only. The doctrinal position of the Anglican Church of Canada regarding marriage is contained in Canon XXI entitled "On Marriage in the Church".

- Child

your natural, adopted child or foster child, child of a partner or stepchild, who is dependent upon you for support and maintenance and who is:

- unmarried;

- under age 21, or under age 26 if a full-time student attending an accredited educational institution, college or university, provided that satisfactory proof of such attendance is submitted to Manulife Financial on request;

- attained or over age 21, and dependent upon you by reason of continued and demonstrable mental or physical infirmity.

Explanation of Common Insurance Terms

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

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

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

a stepchild must be living with you to be eligible.

Drug

Drug

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

Experimental or Investigational

Experimental or Investigational

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

Immediate Family Member

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 Drugs

Interchangeable Drugs

drugs that can legally be substituted for the prescribed drug, as specified by the provincial formulary in the province in which the drug is dispensed.

Licensed, Certified, Registered

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

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Medically Necessary

Medically Necessary

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

Provincial Plan

Provincial Plan

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

Explanation of Common Insurance 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; or

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

the maximum price established by law.

***Reasonable and
Customary***

Ward

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

Ward

Why Group Benefits?

Why Group Benefits?

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 Group Benefit Program is provided by The Anglican Church of Canada, in partnership with The Manufacturers Life Insurance Company.

The Plan Administrator

The Plan Administrator

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

As a member of the Group Benefits Program, it is up to you to provide your Diocese with the necessary information.

Your Plan Administrator is:
Phone Number:

Applying for Group Benefits

Applying for Group Benefits

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

Making Changes

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 Diocese. Such changes could include:

change in Dependent Coverage

applying for coverage previously waived

change in Name

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

The Claims Process

Naming a Beneficiary

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

Naming a Beneficiary

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

How to Submit a Claim

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

Payment of Extended Health Care and Dental Claims

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

Claim Payment

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 Plan Administrator 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 Plan Administrator.

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.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are insured for similar benefits under another Plan, Manulife Financial will take this into account when determining the amount of expenses payable under this Program.

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

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

The Claims Process

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

Order of Benefit Payment

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

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

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

- For Claims incurred by you or your dependent spouse:

The Plan insuring you or your dependent spouse as an employee/member pays benefits before the Plan insuring you or your spouse as a dependent.

In situations where you or your dependent 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 Claims Process

- 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 insured 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

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.

Who Qualifies for Coverage?

Eligibility

Eligibility

As a retiree of The Anglican Church of Canada you are eligible for Group Benefits.

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

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

Late Application

Late Application

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 60 days ; or

- re-apply for insurance on any person whose insurance had earlier been cancelled.

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

- apply for insurance more than 60 days after the date benefits terminated under your spouse's plan; or

- apply for insurance 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 Plan Administrator.

Further medical evidence may be requested by Manulife Financial.

Late Dental Application

Late Dental Application

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

Effective Date of Coverage

Effective Date of Coverage

Your Group Benefits become effective on the Group Policy Effective Date or the date you retire, whichever is later.

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

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

Who Qualifies for Coverage?

Termination of Insurance

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date,

the date your employer terminates coverage,

the date you enter the armed forces of any country on a full-time basis,

the date the Group Policy terminates or insurance on the class to which you belong terminates,

the date of your death.

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

Your Group Benefits

Extended Health Care

Extended Health Care

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

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

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

Drug Benefit for Quebec Residents

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

The Benefit

Overall Benefit Maximum - \$50,000 per lifetime

Not applicable to:
Drugs

Deductible - Nil

Drug Deductible - \$1.00 per prescription (excluding Diabetic Supplies)

Benefit Percentage (Co-insurance) -

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

Note:

The Benefit Percentage for Drugs is shown below under Manuscript Generic Drug Plan 2 - Prescription Drugs, Payment of Covered Expenses.

Termination Age - upon the employee's death

Covered Expenses

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

medically necessary for the treatment of sickness or injury and recommended by a physician

incurred for the care of a person while insured under this Group Benefit Program

reasonable taking all factors into account

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

Extended Health Care - The Benefit

Extended Health Care - Covered Expenses

Your Group Benefits

legally insurable

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

Advance Supply Limitation

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

- 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
- confinement in a convalescent care facility which starts within 14 days of discharge from a hospital, up to a maximum of 180 days per disability
- 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

***Extended Health Care -
Advance Supply
Limitation***

- Drug Expenses

***Extended Health Care -
Hospital Care***

***Extended Health Care -
ManuScript Generic
Drug Plan 2 -
Prescription Drugs***

Your Group Benefits

oral contraceptives

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 and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

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

- Drug Maximums

- Drug Maximums

Fertility drugs - \$15,000 per lifetime

Anti-smoking drugs - \$300 per lifetime

Drugs used in the treatment of Sexual Dysfunction - \$1,000 per calendar year

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

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

If there is no lower cost interchangeable product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- 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 lowest cost interchangeable drug that can legally be used to fill the prescription. The Provincial Drug Benefit Formulary indicates which drugs are considered interchangeable drugs.

If there is no lower cost interchangeable drug for the prescribed drug, the amount covered is the cost of the prescribed product.

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

Your Group Benefits

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

- Payment of Drug Claims

- Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

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

- 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.

Vision Care

Extended Health Care - Vision Care

- eye exams, once per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$100 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 \$250 per 24 consecutive months
- visual training, to a maximum of \$200 per lifetime

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$350 per calendar year(s)
- Osteopath - \$350 per calendar year(s)
- Podiatrist - \$350 per calendar year(s)
- Chiropodist - \$350 per calendar year(s)

Your Group Benefits

Psychiatrist - \$350 per calendar year(s)

Massage Therapist - \$350 per calendar year(s)

Naturopath - \$350 per calendar year(s)

Speech Therapist - \$350 per calendar year(s)

Physiotherapist - \$500 per calendar year(s)

Psychologist/Psychotherapist - \$350 per calendar year(s)

Acupuncturist - \$350 per calendar year(s)

Charges for x-rays are covered up to a maximum of 1 x-ray per calendar year for each practitioner

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

Extended Health Care - 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

- 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 in and out of hospital are subject to a maximum of \$5,000 per 12 consecutive month(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

Your Group Benefits

Pre-Determination of Benefits

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

Ambulance

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

- Ambulance

Medical Equipment

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

- Medical Equipment

- 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

**- Non-Dental
Prostheses, Supports
and Hearing Aids**

external prostheses (breast prostheses are subject to a maximum of \$150 every calendar year(s))

surgical stockings, up to a maximum of 4 pairs per calendar year

surgical brassieres, up to a maximum of 4 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) (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 \$500 per 3 calendar year(s) (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 \$400 every 60 consecutive month(s)

Other Supplies and Services

**- Other Supplies and
Services**

charges for obus form back supports if prescribed by a doctor

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

Your Group Benefits

wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$250 per lifetime

oxygen

microscopic and other similar diagnostic tests and services rendered in a licensed laboratory. Diagnostic tests are covered in all provinces.

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

Submitting a Claim

Extended Health Care - Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form which is available from your Plan Administrator.

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

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Extended Health Care - Exclusions

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

self-inflicted injuries

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

committing or attempting to commit an assault or criminal offence

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

Your Group Benefits

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

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

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 insured person, an immediate family member or a person who lives with the insured person

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

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

Continuation of Coverage

If a person is disabled when insurance under this Extended Health Care benefit terminates, covered expenses related to the treatment of the disability will continue to be payable by Manulife Financial, for up to 90 days. However, coverage will terminate if the disabled person becomes eligible for insurance under another group plan.

You will be considered disabled if you are unable to work at any occupation for which you are qualified or may reasonably become qualified by reason of training, education, or experience.

Your dependent will be considered disabled if he or she is receiving medical treatment from a physician and confined to a hospital or to his or her home.

Drug Benefit For Persons Who Reside In Quebec

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

***Extended Health Care -
Continuation of
Coverage***

***Drug Benefit For
Persons Who Reside In
Quebec***

Your Group Benefits

Covered Drug 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

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)

The following provisions apply only to the coverage of drugs that are on the RAMQ List, as legislated by An Act Respecting Prescription Drug Insurance (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 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 the portion of covered drug expenses 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

Your Group Benefits

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

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 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 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) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum 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) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

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

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms), and
- ii) age 26.

Drug coverage 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

the percentage payable by Manulife Financial for covered expenses is the percentage as set out by the then applicable Legislation.

Your Group Benefits

f) Termination Age

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) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the then applicable Legislation
- iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation
- iv) the premium required for the drug coverage is the premium for Extended Health Care

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

Dental Care

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

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

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

The Benefit

Dental Care - The Benefit

Deductible - Nil

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

If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by Manulife Financial

Benefit Percentage (Co-insurance) -

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

Your Group Benefits

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

\$1,000 per calendar year combined for Level I and Level II and Level III and Level IV

\$1,000 per lifetime for Level V

Termination Age - upon the employee's death

Covered Expenses

The following expenses are covered if they:

are incurred for the necessary dental care of an insured person while insured 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.

Dental Care - Covered Expenses

Alternate Treatment

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

Dental Care - Alternate Treatment

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 twice per calendar year, when the service is performed outside Quebec, or prophylaxis twice per calendar year, when the service is performed in Quebec

recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year

routine diagnostic and laboratory procedures

initial oral hygiene instruction, plus one recall

Dental Care - Level I - Basic Services

Your Group Benefits

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

- the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
- the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

pre-fabricated full coverage restorations (metal and plastic)

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

minor surgical procedures and post surgical care

extractions (including impacted and residual roots)

consultations, anaesthesia, and conscious sedation

denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Services

Dental Care - Level II - Supplementary Services

surgical procedures not included in Level I (excluding implant surgery)

periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

- scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year(s) ;
- provisional splinting; and
- occlusal equilibration, up to a maximum of 8 units per calendar year(s)

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

Your Group Benefits

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

**Dental Care - Level III -
Dentures**

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

**Dental Care - Level IV -
Major Restorative
Services**

Level V - Orthodontics

orthodontic services (for dependent children only, provided treatment commences prior to reaching age 18)

**Dental Care - Level V -
Orthodontics**

Late Entrant Limitation

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

**Dental Care - Late
Entrant Limitation**

Your Group Benefits

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Group Policy or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

Dental Care - Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form which is available from your Plan Administrator.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Dental Care - Exclusions

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

self-inflicted injuries

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

committing or attempting to commit an assault or criminal offence

dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured 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

Your Group Benefits

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 insurance

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 insured person, an immediate family member or a person who lives with the insured 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, Manulife Financial will consider benefits as if the least expensive of a denture or bridge were used

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

Survivor Extended Benefit

If you die while your dependents are insured under this Group Benefit Program, your surviving spouse has the option of continuing Extended Health Care and Dental Care benefits under this program with payment of premium, until the earliest of:

the date the surviving spouse passes away regardless of whether the surviving spouse remarries. (No coverage will be offered for the new spouse or new dependents as a result of the remarriage).

the date similar coverage is obtained elsewhere, or

the date the Group Policy terminates.

Note: Coverage for your dependent child terminates once the child is no longer a dependent according to the definition of dependent. See Explanation of Common Insurance Terms.

Your Group Benefit Program

Your Group Benefit Program is administered by:

The Pension Office
625 Church Street, Suite 401
Toronto, Ontario
M4Y 2G1
(416) 960 - 2484
Fax: (416) 968-7689
Toll free: 1 800-265-1070

