First Canada ULC

Plan Document Number: G0122300

Group Policy Number: G0122301

Plan 24: Unionized Maintenance Employees and Transit Drivers of First Canada ULC

Note: The above are the main numbers you should provide as a reference when contacting Manulife. Be sure to record these numbers and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Plan Document Effective Date: October 1, 2020

Group Policy Effective Date: October 1, 2020

This booklet produced: March 15, 2021

Table of Contents

Important information about your benefits:

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. Every effort has been made to describe the program accurately. However, should there be a question of interpretation, the terms outlined in the official plan documents will prevail.

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

a) the Group Policy and/or Plan Document;

b) your application for group benefits; and

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

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

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

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

Explanation of Commonly Used Terms

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

Adherence

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

Administrator

Manulife.

Advisory Body

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

Benefit Percentage (Co-insurance)

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

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 your employer.

Dependent

your Spouse or Child who resides in the same country as you and 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 for at least one year.

Only one Spouse will be eligible for coverage, and will be as indicated by you on your application for coverage. Where this information is not contained on your application, the person who qualifies last under this Plan's definition of Spouse will be the eligible Spouse.

- Child

your natural or adopted Child, foster Child or stepchild, who:

a) is unmarried;

b) relies on you for support;

c) is not employed for more than 30 hours per week;

d) is under age 21, or under age 25 if a full-time student; and

e) is not eligible for coverage as an employee under this or any other Group Benefit Program.

A newborn Child shall become eligible from the moment of birth.

A stepchild must be living with you to be eligible.

A Child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible Dependent. However, the Child must have been 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 you for support, maintenance and care, due to a mental or physical handicap.

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

Disease Management Programs

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

Drug

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

Due Diligence

a process employed by Manulife to assess new Drugs, existing Drugs with new indications, services or supplies to determine eligibility under the 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.

Earnings

your regular rate of pay from your employer (prior to deductions), excluding bonuses, overtime pay and commissions, based on your regularly scheduled work week.

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

a) the amount reported on your claim form; or

b) the amount reported by your employer to Manulife and for which premiums have been paid.

Exclusive Distribution

Manulife-approved vendors.

Explanation of Commonly Used Terms

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) a generic equivalent to the brand name Drug deemed to be interchangeable by law where the Drug is dispensed; or

b) a Drug that contains the same active ingredient that has not been deemed interchangeable in the province where the Drug is dispensed; but has been identified as interchangeable by Manulife.

Licensed, Certified, Registered

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

Life-Sustaining Drugs

non-prescription Drugs which are necessary to sustain life.

Lower Cost Alternative

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

Medically Necessary

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

Non-Evidence Limit

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

Patient Assistance Program

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

Pharmacoeconomics

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

Prior Authorization

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

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.

Reasonable and Customary

the lowest of:

a) the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife;

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

c) the maximum price established by law.

Take Home Pay (Net Earnings)

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

Total Disability or Totally Disabled

For Weekly Income

a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

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

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

For Long Term Disability

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

a) your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

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

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

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

Explanation of Commonly Used Terms

For Life Insurance

a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience.

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

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

Waiting Period

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

Ward

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

Eligibility

You are eligible for Group Benefits as of the first of the month following a Waiting Period of 30 consecutive days as long as you:

a) are younger than the Termination Age; and

b) are residing in Canada; and

c) are an active full-time employee of First Canada ULC. If you work at least 30 hours per week in more than one job classification with your employer, the job classification where you spend a majority of your time will be identified. If this job classification is a maintenance or transit position, then you are eligible for coverage. If you spend an equal amount of time in a maintenance or transit position and a salaried or administrative position, then you are eligible for coverage if you work at least 30 hours per week taking into account all job classifications worked with your employer and you are a resident on the Maintenance payroll. If you spend an equal amount of time in a maintenance or transit position and another job classification except a salaried or administrative position, then you are not eligible for coverage, regardless of the total number of hours worked for your employer.

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 when you apply for insurance in excess of the Non-Evidence Limit.

Medical evidence is also required for all benefits, except Dental, when you make a Late Application for coverage on any person.

In all cases, medical evidence can be submitted by completing the Evidence of Insurability form, available from your plan administrator, or at www.manulife.com/groupbenefits. Further medical evidence may be requested by Manulife*.*

Who Qualifies for Coverage?

Late Application

An application is considered late when you:

a) apply for coverage on any person after having been eligible for more than 31 days; or

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

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

a) apply for coverage more than 31 days after the date benefits terminated under your Spouse's plan; or

b) apply for benefits, and benefits under your spouse's plan have not terminated.

Applying for Long Term Disability Benefits

You may elect one of the Options outlined in the Schedule of Benefits. If you do not elect an Option at initial enrolment, you will be insured for Option 3 coverage.

If you elect to increase your Long Term Disability coverage and receive prior approval from your employer, Evidence of Insurability will be required and you may only elect to move up one Option.

You may elect to move down Options (reduce your level of coverage) at any time.

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, whichever is later.

You must be actively at work for 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, whichever is later.

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

For any changes in coverage (Dependent coverage, beneficiary information, name, applying for coverage that was previously waived), complete the Application for Change form, available at www.manulife.com/groupbenefits, or from your plan administrator.

Submitting a Claim

To submit a claim, you can do one of the following:

Submit Online (if applicable)

Sign up to use Manulife's Plan Member Secure Site at www.manulife.com/groupbenefits.

If your health care service provider cannot send Manulife electronic claim transmissions, you can still submit your claim electronically to us online, right from the Plan Member Secure Site.

For fast, easy and secure claim payments, we encourage you to sign up for direct deposit and electronic claim statements when you set up your access on the Plan Member secure site. Even if you mail us your claims, by providing your banking and email information, your claim payments can be deposited quickly to your bank account and you will receive an email notification, including a link to manulife.ca, where you can sign in to view your electronic claim statement.

By Mail

You must complete an applicable claim form and mail it to Manulife. Mailing instructions are included on the claim form.

Claim forms are available at www.manulife.com/groupbenefits, or from your employer.

Submission Requirements

Claims must be submitted within the following timeframes:

a) 12 months from the date of the loss, for claims for Life and Accidental Death and Dismemberment benefits;

b) 12 months from the date of disability, for claims for disability benefits other than Weekly Income benefits;

c) 90 days from the end of the Qualifying Period, for claims for Weekly Income benefits; and

d) 12 months from the date the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while coverage under the plan is in force. Upon termination of a person's coverage under this plan, proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

    i) 12 months from the date the expense was incurred; or

    ii) 90 days from the date of termination of coverage.

The Claims Process

For Life and AD&D claims, complete the Life Claim form.

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

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and (briefly) here's how it works:

If you have a claim for yourself: then submit to Manulife first. For any unpaid balances, send a copy of your Manulife claim statement and the other insurance carrier's claim form to the other insurance company for processing.

If you have a claim for your Spouse: then submit the claim to your Spouse's insurance company. For any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing.

If you have a claim for a dependent Child: then send the claim to the insurance carrier of the parent whose birthdate falls earliest in the calendar year first. Submit any unpaid balance to the other insurance company.

For complete details, please go to www.manulife.com/groupbenefits.

Naming a Beneficiary

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

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

Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against Manulife less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitation of Actions Act (NB)
Civil Code of Quebec (QC)

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

a) the date you cease to be an eligible employee;

b) the date you cease to be actively at work, unless the Group Policy or Plan Document allows for your coverage to be extended beyond this date;

c) the date your employer terminates coverage;

d) the date you enter the armed forces of any country on a full-time basis;

e) the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates;

f) the date you reach the Termination Age;

g) for Extended Health Care or Dental Care, the date you fail to make payment of a required contribution, or

h) the date of your death.

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

Life Insurance Benefit
(Employee Life, Employee Optional Life, Dependent Life)

Benefit Details

Employee Life

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

Benefit Amount - 1.5 times your annual Earnings, with a minimum benefit of $25,000

Non-Evidence Limit - not applicable

Benefit Reduction - your benefit amount reduces by 50% at age 65

Termination Age - your benefit amount terminates at retirement.

Employee Optional Life

Benefit Amount - increments of $25,000 to a maximum of $500,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability.

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

For Employee Life and Employee Optional Life

Qualifying Period for Waiver of Premium - 6 months

Optional Life Exclusion

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

For Your Dependents:

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

You may choose one of the following Options:

Benefit Amount:

Option 1: - $5,000 Spouse; $2,500 each dependent Child

Option 2: - $10,000 Spouse; $5,000 each dependent Child

Option 3: - $25,000 Spouse; $10,000 each dependent Child

Termination Age - employee's age 65 or retirement, whichever is earlier

Waiver of Premium - not applicable

Naming a Beneficiary (all Benefits)

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

Waiver of Premium

Not applicable to Dependent Life

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.

Entitlement Criteria

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

a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;

b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and

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

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

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

c) the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife;

d) the date you do not attend an examination by an examiner selected by Manulife;

e) the date of your death; or

f) the date of your 65th birthday.

Recurrent Disability

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

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

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

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

Compassionate Assistance Benefit

You may apply for an early payment of a portion of the life insurance benefit to the lesser of 50% or $50,000, provided:

a) a physician appointed by Manulife Financial determines you are certain to die within 24 months of the determination;

b) you are competent to act;

c) you are approved for Waiver of Premium benefits;

d) you request the benefit in writing, and

e) a consent is provided by any beneficiary designated as irrevocable by you.

Upon your death, the amount of the Compassionate Assistance benefit paid will be deducted from the Life Insurance benefit amount in effect at the time of death.

Conversion Privilege

If your or your Spouse's Group Benefits terminate or reduce, you and your Spouse may be eligible to convert your Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife within 31 days of the termination or reduction of your Life Insurance. If you or your Spouse die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

However, if you have received a Compassionate Assistance benefit, the conversion amount shall not exceed the benefit amount for which you were eligible on the date of termination, less any amount paid to you as Compassionate Assistance, unless you have reimbursed such amount.

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

Accidental Death and Dismemberment Benefit

(Accidental Death and Dismemberment, Employee Voluntary Accidental Death and Dismemberment, Dependent Voluntary Accidental Death and Dismemberment)

Benefit Details

For You:

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

Accidental Death and Dismemberment

Benefit Amount - 1.5 times your annual Earnings, with a minimum benefit of $25,000

Benefit Reduction - your benefit amount reduces by 50% at age 65

Termination Age - your benefit amount terminates at retirement.

Employee Voluntary Accidental Death and Dismemberment

Benefit Amount - increments of $25,000 to a maximum of $500,000

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

For Accidental Death and Dismemberment and Employee Voluntary Accidental Death and Dismemberment

Qualifying Period for Waiver of Premium - 6 months

For Your Dependents:

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.

Benefit Amount

- **Spouse** - 0.5 of the amount of the employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $250,000 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 $200,000 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 $75,000 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 $50,000 if there is a Spouse.

Qualifying Period for Waiver of Premium - 6 months

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

Schedule of Losses (for all Benefits)

A loss shown in this schedule is covered provided it:

a) is a direct result of the accidental injury;

b) occurs within 365 days from the date of the accidental injury; and

c) is total and irreversible or irrecoverable.

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

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

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66.67%
- Loss of Sight of One Eye - 66.67%
- Loss of Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%
- Loss of All Toes of One Foot - 16.67%
- Loss of Hearing in One Ear - 16.67%
- Hemiplegia, Paraplegia or Quadriplegia - 100%

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.

Exposure and Disappearance

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

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

Rehabilitation Expenses (Employee only benefit)

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

a) reasonable and necessary, as determined by Manulife; and

b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of $2,500 for the Accidental Death and Dismemberment benefit and $5,000 for the Employee Voluntary Accidental Death and Dismemberment Benefit.

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

Repatriation Expenses

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

The amount payable is subject to a maximum of $2,500 for the Accidental Death and Dismemberment benefit and $5,000 for the Employee Voluntary Accidental Death and Dismemberment Benefit.

Family Transportation Expenses

For Voluntary Accidental Death and Dismemberment benefit only

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

a) reasonable and necessary, as determined by Manulife;

b) for hotel accommodations in the vicinity of the hospital; and

c) for transportation by the most direct route to the hospital, including return fare.

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of $0.30 per kilometre travelled.

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

Dependent Education Expenses (Employee only benefit)

For Voluntary Accidental Death and Dismemberment benefit only

If you die as a direct result of an accidental injury, Manulife will pay the tuition for each Child who is under age 21 and enrolled as a full-time student:

a) in a school for higher learning above the secondary school level; or

b) at the secondary school level, but who 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:

a) 5% of your Accidental Death and Dismemberment benefit amount; or

b) $5,000.

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

No payment will be made for:

a) tuition expenses incurred prior to your death; or

b) room and board expenses, or other living, travelling or clothing expenses.

Spousal Occupational Training Expenses (Employee only benefit)

For Voluntary Accidental Death and Dismemberment benefit only

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

a) reasonable and necessary, as determined by Manulife; and

b) incurred within a period of 2 years from the date of the accidental injury.

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

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

Common Accident

If you and your Spouse die within 365 days of and as a direct result of a common accident, the amount of benefit payable for loss of your Spouse's life will increase to equal the amount payable for loss of your life.

The total amount paid for both lives is subject to a combined maximum of $500,000.

Permanent and Total Disability (Employee only benefit)

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

a) you become permanently and totally disabled within 365 days after the date of the accidental injury; and

b) you have been permanently and totally disabled for a continuous period of 12 months and remain so disabled at the end of this period.

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

- Definition of Permanent and Total Disability

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

Non-Duplication of Expenses

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

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

Naming a Beneficiary

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

Waiver of Premium

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

Exclusions

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

a) suicide or self-inflicted injuries;

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

c) an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity;

d) riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew;

e) riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer;

f) riding in any aircraft which is: being used for or in connection with acrobatic or stunt flying, racing or endurance tests; rocket-propelled; being used for or in connection with crop dusting or seeding or spraying, firefighting, exploration, pipe or power line inspection, any form of hunting, fowl or animal herding, aerial photography, banner towing or a test or experimental purpose; or engaged in any flight which requires a special permit or waiver from the civil aviation authority, even though granted, unless prior consent is given in writing by Manulife Financial;

g) committing or attempting to commit an assault or criminal offence; or

h) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol.

Extended Health Care

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

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

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

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

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - $9.00 per prescription

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs purchased through MediTrust
- Vision
- Professional Services
- Medical Services and Supplies

90% for
- Drugs not purchased through MediTrust

Note:
The Benefit Percentage for Out-of-Province/Out-of-Canada Emergency Medical Treatment is 100%. Out-of-Province/Canada Emergency Medical Treatment coverage is in place for business and vacation travel only and subject to a maximum trip duration of 60 days. No Out-of-Province/Canada Emergency Medical Treatment benefits are payable for Dependent students going to school outside Canada. The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's retirement

Covered Expenses

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

a) Medically Necessary for the treatment of an illness or injury and recommended by a physician;

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

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

e) legally insurable;

f) used as prescribed or recommended by a physician; and

g) associated with any Drug, supply or service that was subject to the Due Diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by 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 using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include as a covered expense, include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife maintains a list of Drugs, services and supplies that require Prior Authorization. Prior Authorization is applied to ensure that the therapy prescribed is Medically Necessary. Where there are Lower Cost Alternative treatments or prescribing guidelines recommend alternative Drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

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

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

Adherence

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

Patient Assistance Programs

Manulife may require you or your Dependents to apply to and participate in any Patient Assistance Program to which you or your Dependents are entitled. Manulife reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance you or your Dependents are entitled to receive under a Patient Assistance Program.

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife.

Manulife Vitality

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

How does it work?

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

a) **Know your health**

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

b) **Improve your health**

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

c) **Enjoy the rewards**

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

How do you get started?

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

a) Sign in to your Group Benefits site using your plan contract number and member certificate number.

b) Click "Sign up for Manulife *Vitality*"

c) Read the information. Then select "Sign up now!"

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

Advance Supply Limitation

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

- Drug Expenses

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

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

b) a 34-day supply.

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

Hospital Care

a) charges, in excess of the hospital's public Ward charge, for semi-private accommodation, to a maximum of $225 per day, provided:

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

   ii) the accommodation was specifically elected in writing by the patient

b) room, board and normal nursing care provided in a Licensed nursing home (for convalescent or chronic care, excluding custodial care), to a maximum of $10 per day up to $750 per calendar year. Expenses are eligible in conjunction with admittance to a hospital as an in-patient.

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

Drug Benefit and Pharmacy Services for Quebec Residents

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

a) Drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist;

b) oral contraceptives;

c) injectable medications including non-prescription injectable vitamins;

d) Life-Sustaining Drugs;

e) ileostomy and colostomy supplies;

f) preventive vaccines and medicines (oral or injected); and

g) standard syringes, needles and diagnostic aids, required for the treatment of diabetes.

Charges for the following expenses are **not** covered:

a) charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment;

b) charges made by a practitioner or physician to administer injectable medications;

c) Drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis;

d) Drugs determined to be ineligible as a result of Due Diligence; and

e) intrauterine devices and diaphragms.

- Drug Maximums

Fertility Drugs - $15,000 per lifetime

Anti-smoking Drugs - $300 per lifetime

All covered Drug expenses - $25,000 per calendar year

- Payment of Covered Expenses

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

Covered Expenses for any prescribed Drug will not exceed the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

Manulife can limit the covered expense for any Drug to that of a lower cost Interchangeable Drug at the time the Drug is purchased.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed Drug is not to be substituted with another product, 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.

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

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

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

To fill a prescription for covered Drug expenses:

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

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

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

a) you cannot locate a participating Pay Direct Drug pharmacy;

b) you do not have your Pay Direct Drug Card with you at that time; or

c) the prescription is not payable through the Pay Direct Drug Card system.

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

Vision Care

a) eye exams, up to $125 per 24 consecutive months;

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $250 per 24 consecutive months; and

c) contact lenses, or glasses, required after cataract surgery, to a maximum of $100 per eye per lifetime.

Professional Services

Services provided by the following licensed practitioners:

a) Chiropractor - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

b) Podiatrist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

c) Chiropodist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

d) Massage Therapist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

e) Speech Therapist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

f) Physiotherapist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

g) Mental Health Practitioner* - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

h) Naturopath - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

i) Acupuncturist - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

j) Dietitian - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

k) Nutritional Counsellor - $1,000 per calendar year combined for services of a chiropractor, podiatrist, chiropodist, naturopath, massage therapist, speech therapist, physiotherapist, mental health practitioner, acupuncturist, dietitian and nutritional counsellor

*Mental Health Practitioner includes services of a Clinical Counsellor, Marriage and Family Therapist, Psychoanalyst, Psychologist, Psychotherapist and Social Worker only

Recommendation by a physician for Professional Services is not required.

Expenses for Professional Services of a chiropractor, physiotherapist, podiatrist and chiropodist 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.

Expenses for Professional Services other than a chiropractor, physiotherapist, podiatrist and chiropodist may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

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

Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

a) a registered nurse; or

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

Covered Expenses are subject to a maximum of $25,000 per 3 calendar years.

Charges for the following services are **not** covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

c) service performed while the patient is confined in a hospital, nursing home, or similar institution; or

d) service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

Pre-Determination of Benefits

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

Ambulance

Charges for Licensed ground ambulance service to and from a local hospital. Charges for emergency transportation provided by any form of Licensed ambulance, including air ambulance, or by any vehicle normally used for public transportation, to and from the nearest hospital in which the required treatment can be provided, subject to one round trip per calendar year. Licensed ground ambulance service to and from the points of departure and arrival is also covered.

Medical Equipment

Charges for the rental or, when approved by Manulife or your employer, purchase of a wheelchair, hospital bed or respirator/ventilator. Electric and air-fluidized hospital beds are not covered.

Non-Dental Prostheses, Supports and Hearing Aids

a) external prostheses for a medical condition arrested by or corrected by surgery. In addition, charges for repairs and adjustments of prosthetic devices including their replacement when the item cannot be repaired or to accommodate a growing Child;

b) surgical stockings, up to a maximum of 2 pairs per calendar year;

c) braces (other than foot braces), trusses, collars, leg orthosis, casts, splints, traction appliances, spinal and abdominal medical supports, varco traction kits and similar appliances, neck braces and cervical collars;

d) stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of $150 per calendar year (recommendation of either a physician or a podiatrist is required);

e) custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, to a maximum of 1 pair per calendar year and $400 per pair (must be constructed by a certified orthopaedic footwear specialist);

e) casted, custom-made orthotics, up to a maximum of $400 per 3 calendar years (recommendation of either a physician or a podiatrist is required). For Dependent Children under 19 years of age, claims for additional orthotics required due to growth would be assessed on an individual basis. If the referral or documentation provided by the provider indicates that the new orthotics were required due to growth, a new claim shall be allowed; and

f) cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $500 per 5 calendar years.

Other Supplies and Services

a) incontinence supplies;

b) wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $500 per lifetime;

c) oxygen;

d) stump socks, to a maximum of 6 per calendar year;

e) diagnostic procedures, radiology and blood transfusions; and

f) charges for the treatment of accidental injuries to natural teeth or jaw, provided the accident occurs while the person is covered for this benefit and that treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing. In addition, charges for surgery involving the excision of cysts or tumors are also covered unless the person is covered under a dental plan providing such coverage.

Out-of-Province/Out-of-Canada

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

   A Medical Emergency is:

   i) 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

   ii) a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

i) been treated or tested for any new symptoms or conditions

ii) had an increase or worsening of any existing symptoms

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

iv) been admitted to the hospital for treatment of the condition

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

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

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

Charges for the following are payable under this expense:

a) physician's services;

b) hospital room and board at standard Ward rates. Charges in excess of Ward rates are payable, if hospital coverage is provided under this Benefit Program;

c) the cost of special hospital services;

d) hospital charges for out-patient treatment;

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

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

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

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

Emergency Travel Assistance

Emergency Travel Assistance is a travel assistance program available for you and your covered dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a medical emergency while travelling outside your province of residence, for the same period as specified under the Out-of-Province/Out-of-Canada benefit.

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) 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

b) a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

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

a) been treated or tested for any new symptoms or conditions;

b) had an increase or worsening of any existing symptoms;

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

d) been admitted to the hospital for treatment of the condition.

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

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

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

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the Administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

If Medically Necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

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

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

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.

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 plan administrator.

Subrogation (Third Party Liability)

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

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

Exclusions

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

a) for Out-of-Province/Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness;

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

c) committing or attempting to commit an assault or criminal offence;

d) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;

e) an illness or injury for which benefits are payable under any government plan or workers' compensation;

f) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

g) services or supplies provided by an employer's medical or dental department;

h) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

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

j) services or supplies which are not permitted by law to be paid;

k) services or supplies which are required for recreation or sports;

l) services or supplies which would have been payable by the Provincial Plan if proper application had been made;

m) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

n) medical or surgical care which is cosmetic;

o) 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;

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

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

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

a) Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List, provided such Drugs are on the list at the time the expense is incurred; and

b) covered pharmacy services that are to be paid when the Drug is on the Quebec Basic Prescription Drug Insurance Plan List; and

c) Drugs that are listed as a Covered Expense in this Benefit Booklet, but are not on the Quebec Basic Prescription Drug Insurance Plan List.

Coverage for Drugs on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services published for private plans

The following provisions apply to the coverage of Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act. Coverage for all other Drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered Drug expenses payable will be:

i) for any Drugs on the Quebec Basic Prescription Drug Insurance Plan List which are not otherwise covered under the terms of the plan, the percentage as set out by the then applicable Legislation.

ii) for any Legislated pharmacy services, which are not otherwise covered under the terms of the plan, the percentage payable is as set out by the then applicable Legislation.

iii) for any Drug on the Quebec Basic Prescription Drug Insurance Plan List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage stated under The Benefit, or

- the percentage as set out by the then applicable Legislation.

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

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

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

i) Deductible amounts, and

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

iii) covered pharmacy services that are performed by pharmacists for Drugs on the Quebec Basic Prescription Drug Insurance Plan List.

The annual out-of-pocket maximum for you and your Spouse is as stipulated in the Legislation and includes those portions of covered Drug expenses and covered pharmacy services relating to a Drug on the Quebec Basic Prescription Drug Insurance Plan List paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your Spouse, those portions of covered Drug expenses and covered pharmacy services paid for your dependent children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) **Deductible**

Deductible amounts (if any) for the Drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the Deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to Drugs on the Quebec Basic Prescription Drug Insurance Plan List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services that are performed for Drugs on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by 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 under Explanation of Commonly Used Terms), and

ii) age 26.

Drug coverage and covered pharmacy services provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services performed for a Drug on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by 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 as specified under the benefit is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered,

ii) only covered pharmacy services related to a Drug on the Quebec Basic Prescription Drug Insurance Plan List are covered,

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

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

v) the premium required for the Drug coverage is the premium for the Extended Health Care benefit.

Coverage for Drugs that are listed as a Covered Expense in this Benefit Booklet but are not on the Quebec Basic Prescription Drug Insurance Plan List

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

Dental Care Benefit

Your Dental Care Benefit is provided directly by First Canada ULC. Manulife 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 below, 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 below.

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

The Benefit

Deductible - Nil

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

Benefit Percentage (Co-insurance)

100% 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

Covered Expenses

The following expenses are covered if they:

a) are incurred for the necessary dental care of a covered person while covered under this benefit;

b) are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license;

c) are reasonable as determined by your employer or Manulife, taking all factors into account; and

d) do not exceed the fees recommended in the Dental Fee Guide, or Reasonable and Customary charges as determined by your employer or Manulife, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

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

Level I - Basic Services

a) complete oral exam, one per 5 months;

b) full-mouth x-rays, one per 24 consecutive months;

c) one unit of light scaling and one unit of polishing, once every 5 months when the service is performed outside Quebec, or prophylaxis (polishing), once every 5 months when the service is performed in Quebec;

d) recall exams, bitewing x-rays, and fluoride treatments, once every 5 months;

e) routine diagnostic and laboratory procedures;

f) oral hygiene instruction;

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

   i) the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam;

h) pre-fabricated full coverage restorations (metal and plastic);

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

j) minor surgical procedures and post-surgical care;

k) extractions (including impacted and residual roots);

l) consultations, anaesthesia, and conscious sedation;

m) necessary treatment for the relief of dental pain;

n) 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; and

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

Level II - Supplementary Basic Services

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

   i) scaling not covered under Level I, and root planing, up to a combined maximum of 8 occurrences or 16 units per calendar year,

   ii) provisional splinting,

   iii) occlusal equilibration, up to a maximum of 8 occurrences or 8 units per calendar year;

b) endodontic services which include root canals and therapy, root amputation, apexifications and periapical services:

   i) root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime.

   ii) re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Level III - Dentures

a) initial provision of full or partial removable dentures;

b) replacement of removable dentures, provided the dentures are required because:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 5 years old and cannot be made serviceable, or

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

Level IV - Major Restorative Services

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

b) crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;

c) inlays, covering at least 3 surfaces, provided the tooth cusp is missing;

d) initial provision of fixed bridgework;

e) replacement of bridgework, provided the new bridgework is required because:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 5 years old and cannot be made serviceable, or

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

Level V - Orthodontics

Orthodontic services for dependent children only, provided treatment commences prior to reaching age 18.

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 $100 for each covered person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $300, 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) will not be reimbursed, regardless of whether or not a treatment plan has been filed with Manulife, unless the Dependent incurred expenses after the date coverage ceased due to your death and the expenses are:

a) rendered within 90 days of your death; and

b) part of a series of planned dental treatment which had begun, or for which definite dental appointments had been made, while you were living.

Subrogation (Third Party Liability)

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

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

Exclusions

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

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

b) dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit and commences within 90 days of the accident;

c) anti-snoring or sleep apnea devices;

d) broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms;

e) services which are payable by any government plan;

f) services or supplies provided by an employer's medical or dental department;

g) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

h) treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction;

i) replacement of removable dental appliances which have been lost, mislaid or stolen;

j) exams required for the use of a third party;

k) laboratory fees which exceed Reasonable and Customary charges;

l) 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;

m) implants, or any services rendered in conjunction with implants;

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

o) 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 benefit without requiring any contribution from you, until the earliest of:

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

b) the date similar coverage is obtained elsewhere;

c) the date which is 3 months from your death; or

d) the date the Plan Document terminates.

Weekly Income (Short Term Disability)

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

The Benefit

Benefit Amount - 66.67% of weekly Earnings, to a maximum benefit of $1,500

Qualifying Period - none, if the disability is due to an Accident;
7 calendar days if the disability is due to a sickness

If hospitalized due to sickness prior to the end of the Qualifying Period, benefits are payable from the first day of hospitalization.

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

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period. Otherwise, benefits are not payable until the date you are first treated by your physician.

Maximum Benefit Period - 17 weeks

Termination Age - retirement

Entitlement Criteria

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

a) you must be continuously Totally Disabled throughout the Qualifying Period**;**

b) your employer or Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and

c) you must be receiving from a physician, regular, ongoing care and treatment for your disabling condition.

Periods for Which You are Not Entitled to Benefits

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

a) you are not receiving from a physician, regular, ongoing care and treatment for your disabling condition;

b) you do not supply your employer or Manulife with medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

c) after you fail to participate and cooperate in a medical, psychiatric, psychological and/or functional examination or evaluation by a medical examiner selected by your employer or Manulife;

d) you are receiving Employment Insurance maternity, parental, compassionate care or critically ill child benefits;

e) you are on lay-off during which you become Totally Disabled;

f) you are on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;

g) you are engaged in employment for wage or profit, except as provided for under the Rehabilitation Assistance provision; or

h) you are incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any amount you receive:

a) for the same or related disability:

   i) from Workers' Compensation or similar coverage;

   ii) from any provincial motor vehicle plan or motor vehicle insurance policy that does not take into account disability benefits payable under the Employment Insurance program;

   iii) from your employer-sponsored salary continuance or wage loss replacement plan; and

b) as earnings from your employer, including severance and vacation pay as set out in the Employment Insurance Program; and

c) from Canada or Quebec retirement or disability Pension Plan, excluding dependent benefits.

Benefit Calculation Rules

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

a) benefits payable from other sources which began before the commencement of your current disability will not be taken into account

b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by your Employer

c) for benefits payable other than on a weekly basis, a weekly equivalent of such benefit will be estimated by your employer or Manulife.

Subrogation

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

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

Tax Status of Benefits

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

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

Payment of Disability Benefits

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

Rehabilitation Assistance

Once your employer or Manulife determines that you are Totally Disabled, if appropriate, and at your employer or Manulife's discretion, you may be offered rehabilitation to assist you in returning to work.

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

a) the nature, extent and expected duration of your disability

b) your level of education, training or experience

c) the nature, scope, objectives and cost of a Vocational Plan.

- Vocational Plan

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

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

- Disability Benefits During Rehabilitation

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

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

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

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

b) the date on which benefits have been paid up to the Maximum Benefit Period for this benefit;

c) the date you retire;

d) the date of your death; or

e) the date you are laid off or terminated, if Total Disability started two months prior to the date of layoff or termination, and notice of layoff or termination had been given prior to the date of Disability.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 2 weeks from the end of the period for which Weekly Income benefits were paid, the disability will be treated as a continuation of your previous disability.

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

If the same disability recurs more than 2 weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

Exclusions

No benefits are payable for any disability related to:

a) any illness or injury which arises out of or in the course of employment, unless Workers' Compensation denies your claim;

b) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

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

d) medical or surgical care which is performed solely for cosmetic purposes, except if due to an illness or injury;

e) the committing of a criminal offence;

f) injuries sustained while operating a motor vehicle under the influence of drugs or alcohol as prohibited by law; or

g) abuse of drugs or alcohol, unless you are participating in an in-patient medical treatment program for substance abuse.

Long Term Disability

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

The Benefit

You may choose one of the following Options:

Benefit Amount

Option 1 - 50% of monthly Earnings, up to a maximum benefit of $10,000

Option 2 - 66.67% of monthly Earnings, up to a maximum benefit of $10,000

Option 3 - 75% of monthly Earnings, up to a maximum benefit of $10,000

Non-Evidence Limit - $10,000

Qualifying Period - 17 weeks or expiration of benefits under the employer's Short Term Disability plan, whichever is greater but not more than 30 weeks

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

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

Maximum Benefit Period - to age 65. However, if benefit payments commence during the 12 months immediately preceding your 65th birthday, benefit payments will continue during the Disability up to a maximum of 12 months.

Termination Age - age 65 or retirement, whichever is earlier

Entitlement Criteria

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

a) you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled;

b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and

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

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

Periods for Which You are Not Entitled to Benefits

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

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

b) receiving Employment Insurance maternity or parental benefits;

c) on lay-off during which you become Totally Disabled;

d) on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;

e) receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan;

f) working in any occupation, except as provided for under the Rehabilitation Assistance provision; or

g) incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

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

a) Workers' Compensation or similar coverage;

b) Canada or Quebec Pension Plans, excluding dependent benefits but including CPP/QPP Retirement benefits; and

c) any government motor vehicle automobile insurance plan or policy, unless prohibited by law.

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

a) any group, association or franchise plan;

b) any retirement or pension plan;

c) earnings or payments from any employer, including severance payments and vacation pay;

d) self-employment;

e) maternity benefits payable under the Employment Insurance benefit in accordance with the employer’s Supplementary Unemployment Benefits (SUB) plan currently registered with the Canada Employment and Immigration Commission;

f) any government plan, excluding Employment Insurance Benefits; and

g) Canada or Quebec Pension Plans' dependent benefits.

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

Benefit Calculation Rules

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

a) benefits payable from other sources which began before the commencement of your current disability will not be taken into account;

b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife;

c) subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;

d) benefits payable under individual disability income insurance will not be taken into account;

e) for benefits payable, other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife; and

f) if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife and assumed to be paid.

Subrogation

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

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

Tax Status of Benefits

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

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

Payment of Disability Benefits

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

Rehabilitation Assistance

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

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

a) the nature, extent and expected duration of your disability;

b) your level of education, training or experience; and

c) the nature, scope, objectives and cost of a Vocational Plan.

- Vocational Plan

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

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

a) with your employer;

b) with an alternate employer; or

c) in a self-employed capacity.

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced by 50% of your rehabilitation income. Your benefit will be further reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross Earnings; net Earnings if your benefit is not taxable.

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

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

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

c) the date you do not attend an examination by an examiner selected by Manulife;

d) the date on which benefits have been paid up to the Maximum Benefit Period for this benefit; or

e) the date of your death.

Recurrent Disability

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

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

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

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

Waiver of Premium

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

Exclusions

No benefits are payable for any disability related to:

a) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

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

c) medical or surgical care which is not medically necessary;

d) the committing of or the attempt to commit an assault or criminal offence;

e) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;

f) abuse of addictive substances, including Drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife; or

g) a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which Drugs were prescribed, within 90 days prior to the effective date of your coverage.

Notes

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