National Carriers' Conference Committee

Plan Document Number: G0050075

Plan B: Early Retirees

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: July 1, 2012

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

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

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

This booklet produced: January 10, 2020

Table of Contents

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

Extended Health Care

The Benefit

Overall Benefit Maximum - $171,100 per lifetime. However, up to $3,900 of your annual reimbursement will be re-established as part of your overall maximum.

Not applicable to:
Out of Province/Out of Canada

Deductible - $100 Individual, per calendar year

Not applicable to:
Drugs

Benefit Percentage (Co-insurance)

80% for
Hospital Care
Drugs
Vision Care
Professional Services
Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.

Termination Age - employee's age 65

Prescription Drugs

- drugs dispensed by a licensed pharmacist, and which by law or convention require a written prescription of a physician or dentist
- oral contraceptives
- injectable medications
- life-sustaining drugs
- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)

Charges for the following expenses are not covered:

- administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence

- drugs used in the treatment of a sexual dysfunction
- intrauterine devices and diaphragms

- Drug Maximums

Fertility drugs - $2,500 per lifetime

Anti-smoking drugs - $500 per lifetime

All other covered drug expenses - unlimited

Vision Care

- eye exams, $50 per 12 months for persons under age 18, and $50 per 24 months for persons age 18 and over

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: $500 per calendar year
- Osteopath: $500 per calendar year
- Podiatrist/Chiropodist: $500 per calendar year
- Naturopath: $500 per calendar year
- Speech Therapist: $500 per calendar year
- Physiotherapist: $500 per calendar year
- Psychologist: $500 per calendar year

Designed with Your Needs in Mind

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

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

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of National Carriers' Conference Committee. The information in this booklet is a summary of the provisions of the Plan Document for the Extended Health Care benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from your employer), the terms of the Policy or Plan Document will apply.

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

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

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

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

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

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

Your Group Benefit Card

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

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

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

Explanation of Commonly Used Terms

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

Adherence

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

Advisory Body

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

Benefit Percentage (Co-insurance)

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

Covered Expenses

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

Deductible

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

Dependent

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

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months. However, the cohabitation period will be waived if child is born to the common-law relationship.

- Child

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

  - unmarried

  - under age 26

  - not employed on a full-time basis, and

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

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

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

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

- a stepchild must be living with you to be eligible
- a newborn child shall become eligible from birth

Disease Management Programs

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

Drug

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

Due Diligence

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

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

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

Immediate Family Member

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

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.

Explanation of Commonly Used Terms

Medically Necessary

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

Patient Assistance Program

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

Pharmacoeconomics

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

Prior Authorization

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

Provincial Plan

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

Reasonable and Customary

the lowest of:

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

Ward

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

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

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

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

Your Employer's Representative

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

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

Your Employer's representative is _____

Phone Number: _____

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

Applying for Group Benefits

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

Making Changes

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

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

The Claims Process

How to Submit a Claim

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

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

Payment of Extended Health Care Claims

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

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

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

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

Co-ordination of Extended Health Care Benefits

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

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

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- ***For Claims incurred by you or your Dependent Spouse:***

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

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

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

- ***For Claims incurred by your Dependent Child:***

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

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

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

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

The Claims Process

Submitting a Claim for Co-ordination of Benefits

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

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Eligibility

You are eligible for Group Benefits if you:

- are a retired employee of National Carriers' Conference Committee
- are a member of an eligible class,
- are younger than the Termination Age, and
- are residing in Canada

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

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

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

Medical Evidence

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

Late Application

An application is considered late when you:

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

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

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

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

Who Qualifies for Coverage?

Effective Date of Coverage

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

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

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

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

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

Extended Health Care

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

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

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

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

Drug Benefit and Pharmacy Services for Quebec Residents

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

The Benefit

Overall Benefit Maximum - $171,100 per lifetime. However, up to $3,900 of your annual reimbursement will be re-established as part of your overall maximum.

Not applicable to:
- Out of Province/Out of Canada

Deductible - $100 Individual, per calendar year

Not applicable to:
- Drugs

Benefit Percentage (Co-insurance)

80% for
- Hospital Care
- Drugs
- Vision Care
- Professional Services
- Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.

Termination Age - employee's age 65

Covered Expenses

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

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required

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

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

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

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

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

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

Advance Supply Limitation

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

Hospital Care

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

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

  - the accommodation was specifically elected in writing by the patient

- semi-private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days and begins prior to the individuals 65th birthday, to a maximum of 180 days per disability. Subsequent confinement will be deemed a new disability following 90 days.

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

Prescription Drugs

- drugs dispensed by a licensed pharmacist, and which by law or convention require a written prescription of a physician or dentist

- oral contraceptives

- injectable medications

- life-sustaining drugs

- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)

Charges for the following expenses are not covered:

- administration of serums, vaccines, or injectable drugs

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

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

- drugs used in the treatment of a sexual dysfunction
- intrauterine devices and diaphragms

- Drug Maximums

Fertility drugs - $2,500 per lifetime

Anti-smoking drugs - $500 per lifetime

All other covered drug expenses - unlimited

Vision Care

- eye exams, $50 per 12 months for persons under age 18, and $50 per 24 months for persons age 18 and over

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: $500 per calendar year
- Osteopath: $500 per calendar year
- Podiatrist/Chiropodist: $500 per calendar year
- Naturopath: $500 per calendar year
- Speech Therapist: $500 per calendar year
- Physiotherapist: $500 per calendar year
- Psychologist: $500 per calendar year

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

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

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

Private Duty Nursing

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

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

Covered Expenses are subject to a maximum of $10,000 per calendar year.

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

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

Medical Equipment

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

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

  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings
- surgical brassieres
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- modifications or adjustments to stock item orthopedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required)
- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of $600 per calendar year combined for custom-made orthopaedic shoes and custom-made orthotics (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, to a maximum of $600 per calendar year combined for custom-made orthopaedic shoes and custom-made orthotics (recommendation of either a physician or a podiatrist/chiropodist is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $500 per 36 consectuive months

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment.
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec up to a maximum of $500 per calendar year.
- charges for the treatment of accidental injuries to natural teeth or jaw, up to a maximum of $5,000 per accident, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to a maximum of $50,000 per lifetime.

  A Medical Emergency is:

  - a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or
  - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

  - been treated or tested for any new symptoms or conditions
  - had an increase or worsening of any existing symptoms
  - changed treatments or medications (other than normal adjustments for ongoing care)
  - been admitted to the hospital for treatment of the condition

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

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

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

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

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

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

Submitting a Claim

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

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

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

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

Subrogation (Third Party Liability)

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

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

Exclusions

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

- for Out-of-Province or Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred, and
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

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

i) for any drugs on the RAMQ list which are not otherwise covered under the terms of the plan, the percentage as set out by the then applicable Legislation.

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

iii) for any drug on the RAMQ List which is covered under the terms of the plan, the greater of:

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

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

i) 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

ii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

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

c) **Deductible**

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

d) **Lifetime Maximums**

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

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

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

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

i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of 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 RAMQ List are covered, and

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

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

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation,

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

iv) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

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

Survivor Extended Benefit

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

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms)
- the date similar coverage is obtained elsewhere
- the date which you would have reached age 65, or
- the date the Plan Document terminates

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.