The Anglican Church of Canada

Group Policy Number: G0021057

Class: All Active Employees of the Diocese of Niagara

Employee Name: _____

Certificate Number: _____

Effective Jan 1 2014

Welcome to Your Group Benefit Program

Group Policy Effective Date: April 01, 1997

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

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

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

Table of Contents

Benefit Summary

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

This version of the Benefit Summary produced: December 16, 2013

Employee Life Insurance

Employee Life Insurance

NOTE: The Employee Life Insurance and the Employee Optional Life Insurance benefit amounts are subject to a combined maximum of $500,000.

Benefit Amount - $90,000

Termination Age - your benefit amount reduces by 50% or to $50,000, whichever is greater, at age 65 and terminates on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Employee Optional Life Insurance

Employee Optional Life Insurance

NOTE: The Employee Life Insurance and the Employee Optional Life Insurance benefit amounts are subject to a combined maximum of $500,000.

Benefit Amount - increments of $10,000 to a maximum of $300,000

Termination Age - on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Dependent Optional Life Insurance

Dependent Optional Life Insurance

Benefit Amount - Spouse - increments of $10,000 to a maximum of $300,000
- Child - not applicable

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Benefit Summary

Accidental Death and Dismemberment

Accidental Death and Dismemberment

Benefit Amount - $100,000

Termination Age - your benefit amount reduces by 50% or to $50,000, whichever is greater, at age 65 and terminates on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Extended Health Care

Extended Health Care

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Deductible - $5.00 per prescription

Benefit Percentage (Co-insurance) -
100% for - Hospital Care - Medical Services & Supplies - Professional Services - Vision

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.
The Benefit Percentage for Drugs is shown below under Dynamic Therapeutic Formulary Drugs.

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier

Dynamic Therapeutic Formulary Drugs

- 100% for Dynamic Therapeutic Formulary Drugs and 80% for ManuScript Generic Drug Plan 2

Dynamic Therapeutic Formulary

Extended Health Care - Dynamic Therapeutic Formulary

Charges incurred for any drug, medicine or diabetic supply, which is included as a benefit in the current Dynamic Therapeutic Formulary, are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

Charges for the following expenses are not covered:

- charges made by a practitioner or Physician to administer injectable medications; and
- charges for Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for a patient's use at home.

- Drug Maximums

- Drug Maximums

Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the higher Co-insurance for the Dynamic Therapeutic Formulary and any maximum for the Dynamic Therapeutic Formulary.

Covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Dynamic Therapeutic Formulary.

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

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the higher Co-insurance for the Dynamic Therapeutic Formulary and any maximum for the Dynamic Therapeutic Formulary.

Benefit Summary

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)
- Charges for drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home are not covered.

- Drug Maximums
Fertility drugs - $15,000 per lifetime

- Drug Maximums

Anti-smoking drugs - $300 per lifetime

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

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the lower Co-insurance for the ManuScript Generic Drug Plan 2 and any maximum for the ManuScript Generic Drug Plan 2.

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

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

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lowest cost Interchangeable drug that can legally be used to fill the prescription. The Provincial Drug Benefit Formulary indicates which drugs are considered Interchangeable Drugs.

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

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the lower Co-insurance for the ManuScript Generic Drug Plan 2 and any maximum for the ManuScript Generic Drug Plan 2.

Benefit Summary

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

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

Vision Care

Extended Health Care - Vision Care

- eye exams, once per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $250 per 24 consecutive months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $250 per 24 consecutive months
- visual training, to a maximum of $200 per lifetime

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $1,000 per calendar year(s)
- Osteopath - $1,000 per calendar year(s)
- Podiatrist -$1,000 per calendar year(s)
- Chiropodist - $1,000 per calendar year(s)
- Psychiatrist - $1,000 per calendar year(s)
- Massage Therapist - $1,000 per calendar year(s)
- Naturopath - $1,000 per calendar year(s)
- Speech Therapist - $1,000 per calendar year(s)
- Physiotherapist - $1,000 per calendar year(s)
- Psychologist - $1,000 per calendar year(s)
- Acupuncturist - $1,000 per calendar year(s)

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

Dental Care

Dental Care
Dental Care - The Benefit

The Benefit

Deductible - Nil

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

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

Benefit Percentage (Co-insurance) -

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

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

$1,000 per lifetime for Level V

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

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

Your Benefit Booklet includes...

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

Important Note

Important Note

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

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

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

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

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

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

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

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

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card

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

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

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

Explanation of Common Insurance Terms

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

Accident

Accident

an unexpected or unforeseen happening or event involving an external force, causing loss or injury independently of all other causes.

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

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

Covered Expenses

Covered Expenses

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

Deductible

Deductible

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

Explanation of Common Insurance Terms

Dependent

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

- Spouse

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

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

- Child

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

  - unmarried;

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

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

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

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

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

- a stepchild must be living with you to be eligible.

Drug

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

Explanation of Common Insurance Terms

Dynamic Therapeutic Formulary

Dynamic Therapeutic Formulary

a listing of all drug products and diabetic supplies which qualify for payment under ESI Canada Inc.'s Dynamic Therapeutic Formulary (DTF).

The Formulary, compiled and maintained by ESI Canada Inc., includes all drug products and diabetic supplies eligible for reimbursement, available strengths and dosage forms, the drug identification numbers, and the cost for each product.

Experimental or Investigational

Experimental or Investigational

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

Immediate Family Member

Immediate Family Member

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

Licensed, Certified, Registered

Licensed, Certified, Registered

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

Life-Sustaining Drugs

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Medically Necessary

Medically Necessary

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

Non-Evidence Limit

Non-Evidence Limit

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

Provincial Plan

Provincial Plan

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

Qualifying Period

Qualifying Period

a period of continuous and total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Explanation of Common Insurance Terms

Reasonable and Customary

Reasonable and Customary

the lowest of:

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

Waiting Period

Waiting Period

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

Ward

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.

Why Group Benefits?

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

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

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

The Plan Administrator

The Plan Administrator

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

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

Your Plan Administrator is:
Phone Number:

Applying for Group Benefits

Applying for Group Benefits

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

Making Changes

Making Changes

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

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

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

The Claims Process

Naming a Beneficiary

Naming a Beneficiary

Manulife Financial does not accept beneficiary appointments for any benefits other than Employee Life Insurance and Accidental Death and Dismemberment under this Plan.

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

How to Submit a Claim

How to Submit a Claim

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

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

Payment of Extended Health Care and Dental Claims

Claim Payment

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 Plan Administrator will help explain.

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

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

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.
  - For Claims incurred by you or your dependent spouse:

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

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

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

- For Claims incurred by your dependent child:

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

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

  - The Plan of the parent with custody of the child, then
  - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the dependent child), then
  - The Plan of the parent not having custody of the child, then
  - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the dependent child).

- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the insured person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

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

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

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you:

- are a full-time employee of The Anglican Church of Canada and work at least the Required Number of Hours, and:

a) were insured prior to April 1, 1978;

b) were not insured prior to April 1, 1978 and have not retired and are actively in the paid service of the Church for at least 20 hours per week, and;

   i) are ordained, entered on the Clerical Register of a Diocese participating under this Policy and are actively discharging your chosen vocation under the Jurisdiction of his Bishop;

   ii) are a salaried lay officer;

   iii) are a lay employee and a member of the Pension Plan of the Anglican Church of Canada.

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

Required Number of Hours

Required Number of Hours

Full-time employee - 20 hour(s) per week

Evidence of Insurability

Evidence of Insurability

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 insurance, when you make a Late Application for insurance on any person.

Late Application

Late Application

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 60 days ; or
- re-apply for insurance on any person whose insurance had earlier been cancelled.

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

- apply for insurance more than 60 days after the date benefits terminated under your spouse's plan; or
- apply for insurance and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your Plan Administrator.

Further medical evidence may be requested by Manulife Financial.

Late Dental Application

Late Dental Application

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

Effective Date of Coverage

Effective Date of Coverage

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

You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

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

Your dependent's insurance will not be effective prior to the date your insurance becomes effective. (This does not apply to Dependent Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.)

Who Qualifies for Coverage?

Termination of Insurance

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

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

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

Employee Life Insurance

Employee Life Insurance

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.

Naming a Beneficiary

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

You should review your beneficiary designation to be sure that it reflects your current intent.

The Benefit

Employee Life Insurance - The Benefit

NOTE: The Employee Life Insurance and the Employee Optional Life Insurance benefit amounts are subject to a combined maximum of $500,000.

Benefit Amount - $90,000

Termination Age - your benefit amount reduces by 50% or to $50,000, whichever is greater, at age 65 and terminates on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date
30 calendar days for all other employees

Submitting a Claim

Employee Life Insurance - Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 180 days from the end of the qualifying period.

Total Disability Benefit/Waiver of Premium

Employee Life Insurance - Total Disability Benefit/Waiver of Premium

The expression "total disability" and "totally disabled" as used herein shall mean a state of bodily incapacity.

i) If you are an employee who is registered under the Long Term Disability Plan of the Anglican Church of Canada:
- which results in a benefit being granted to you under the Long Term Disability Plan of the Anglican Church of Canada

ii) If you are an employee who is not registered under the Long Term Disability Plan of the Anglican Church of Canada:
- such that you are thereby wholly prevented from engaging in any occupation or performing any work for compensation or profit

a) If you have been granted a benefit under the Long Term Disability Plan of the Anglican Church of Canada and become totally disabled prior to attainment of normal retirement age under such pension plan, your insurance will continue in force, subject to surrender for cancellation of any policy issued under the Conversion Privilege hereof, until:

i) the date of attainment of age 70, if you became insured hereunder prior to January 1, 1971

ii) the last day of the calendar month in which you would have qualified for normal retirement pension under such pension plan if you became insured hereunder on or after January 1, 1971

iii) the date of attainment of age 65 if you are an employee who has completed 40 years of participation in such pension plan.

No further premium payments will be required in respect of such insurance as long as you continue to be disabled and thereby continue to receive such benefits. Premium payments will be resumed, however, at any time that your benefit is discontinued because of discontinuance of total disability.

b) If prior to attainment of age 65, you, if you are not covered under (a) above, become totally disabled and if such disability continues after discontinuance of premium payments for your insurance, subject to surrender for cancellation of any policy issued under the Conversion Privilege hereof, the insurance hereunder will be extended, without payment of such premiums during the continuance of such total disability for a period of one year. Subject to the following paragraph hereof, such insurance will be extended

   i) for successive further periods of one year each in respect of any disability which commenced prior to April 1, 1976

   ii) for successive further periods of one year each but not beyond the first day of the month coinciding with or next following the date of attainment of age 65, in respect of any disability which commences on or after April 1, 1976

provided there is submitted to the head office of Manulife Financial proof satisfactory to Manulife Financial of continuance of such total disability. Such proof must be submitted within the three months immediately preceding each such year without further notice on the part of Manulife Financial.

You will be entitled to waiver of premium the first of the month following your last day worked.

Insurance under the Total Disability Benefit shall become effective only if written notice of your disability is received by Manulife Financial within 12 months of the date of such disability.

Insurance under the Total Disability Benefit shall cease 31 days after the date on which you cease to be totally disabled, the date of failure to furnish Manulife Financial with satisfactory proof of continuance of such total disability as required above, or the date of failure by you to submit to a medical examination by Manulife Financial (Manulife Financial hereby reserving the right to examine you at any time during the disability), whichever date shall first occur. During the 31 days following the earliest of the above dates, you are covered under the Total Disability Benefit and will be entitled to apply for an individual policy in accordance with the Conversion Privilege hereof as though your insurance had been terminated by reason of termination of employment at the beginning of such 31 days.

Insurance under the Total Disability Benefit shall be payable only if written notice of death is received by Manulife Financial within 12 months of the date of death.

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.

Recurrent Disability

Employee Life Insurance - Recurrent Disability

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

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

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

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

Conversion Privilege

Employee Life Insurance - Conversion Privilege

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

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

Employee Optional Life Insurance

Employee Optional Life Insurance

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

Naming a Beneficiary

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

You should review your beneficiary designation to be sure that it reflects your current intent.

The Benefit

Employee Optional Life Insurance - The Benefit

NOTE: The Employee Life Insurance and the Employee Optional Life Insurance benefit amounts are subject to a combined maximum of $500,000.

Benefit Amount - increments of $10,000 to a maximum of $300,000

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

Termination Age - on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date
30 calendar days for all other employees

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

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

Waiver of Premium

Employee Optional Life Insurance - Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

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.

Recurrent Disability

Employee Optional Life Insurance - Recurrent Disability

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

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

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

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

Exclusions

Employee Optional Life Insurance - Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than 2 years will not be payable.

Dependent Optional Life Insurance

Dependent Optional Life Insurance

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

The Benefit

Dependent Optional Life Insurance - The Benefit

Benefit Amount - Spouse - increments of $10,000 to a maximum of $300,000
- Child - not applicable

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

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date
30 calendar days for all other employees

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

Submitting a Claim

Dependent Optional Life Insurance - Submitting a Claim

To submit a Dependent Optional Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Dependent Optional Life Insurance - Waiver of Premium

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

- Exception

If you are not insured for Employee Optional Life, the Waiver of Premium provision will not apply to your spouse's Dependent Optional Life Insurance, unless:

- at the time you applied for Dependent Optional Life Insurance on your spouse, you also provided Manulife Financial with evidence of insurability for yourself, and
- Manulife Financial approved your evidence of insurability

Conversion Privilege

Dependent Optional Life Insurance - Conversion Privilege

For more information on the conversion privilege, please refer to Dependent Life Insurance.

Exclusions

Dependent Optional Life Insurance - Exclusions

If death results from suicide any amount of Dependent Optional Life Insurance that has been in effect for less than 2 years will not be payable.

Accidental Death and Dismemberment

Accidental Death and Dismemberment

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.

Naming a Beneficiary

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

You should review your beneficiary designation to be sure that it reflects your current intent.

The Benefit

AD& D - The Benefit

Benefit Amount - $100,000

Termination Age - your benefit amount reduces by 50% or to $50,000, whichever is greater, at age 65 and terminates on the last day of the year in which you attain age 71 or retire, whichever is earlier. If you have been granted an exemption from the General Synod Pension Plan, insurance shall terminate when you attain age 66.

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date
30 calendar days for all other employees

Schedule of Losses

AD& D - Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

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

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

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

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

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

Exposure and Disappearance

AD& D - Exposure and Disappearance

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

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

Submitting a Claim

AD& D - Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form.

Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

AD& D - Waiver of Premium

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

Exclusions

AD& D - Exclusions

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

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence

Extended Health Care

Extended Health Care

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

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

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

Drug Benefit for Quebec Residents

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Deductible - $5.00 per prescription

Benefit Percentage (Co-insurance) -
100% for - Hospital Care - Medical Services & Supplies - Professional Services - Vision

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.
The Benefit Percentage for Drugs is shown below under Dynamic Therapeutic Formulary Drugs.

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date
30 calendar days for all other employees

Covered Expenses

Extended Health Care - Covered Expenses

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

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred for the care of a person while insured under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable

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

Advance Supply Limitation

Extended Health Care - Advance Supply Limitation

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

- Drug Expenses

- 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

Extended Health Care - Hospital Care

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

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

  - the accommodation was specifically elected in writing by the patient

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

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

Dynamic Therapeutic Formulary Drugs

- 100% for Dynamic Therapeutic Formulary Drugs and 80% for ManuScript Generic Drug Plan 2

Dynamic Therapeutic Formulary

Extended Health Care - Dynamic Therapeutic Formulary

Charges incurred for any drug, medicine or diabetic supply, which is included as a benefit in the current Dynamic Therapeutic Formulary, are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

Charges for the following expenses are not covered:

- charges made by a practitioner or Physician to administer injectable medications; and

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

- Drug Maximums
Unlimited

- Drug Maximums

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the higher Co-insurance for the Dynamic Therapeutic Formulary and any maximum for the Dynamic Therapeutic Formulary.

Covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Dynamic Therapeutic Formulary.

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

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the higher Co-insurance for the Dynamic Therapeutic Formulary and any maximum for the Dynamic Therapeutic Formulary.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)
- Charges for drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home are not covered.

- Drug Maximums

- Drug Maximums

Fertility drugs - $15,000 per lifetime

Anti-smoking drugs - $300 per lifetime

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

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the lower Co-insurance for the ManuScript Generic Drug Plan 2 and any maximum for the ManuScript Generic Drug Plan 2.

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

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

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lowest cost Interchangeable drug that can legally be used to fill the prescription. The Provincial Drug Benefit Formulary indicates which drugs are considered Interchangeable Drugs.

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

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the lower Co-insurance for the ManuScript Generic Drug Plan 2 and any maximum for the ManuScript Generic Drug Plan 2.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

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

Vision Care

Extended Health Care - Vision Care

- eye exams, once per calendar year
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $250 per 24 consecutive months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $250 per 24 consecutive months
- visual training, to a maximum of $200 per lifetime

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $1,000 per calendar year(s)
- Osteopath - $1,000 per calendar year(s)
- Podiatrist -

$1,000 per calendar year(s)

- Chiropodist - $1,000 per calendar year(s)
- Psychiatrist - $1,000 per calendar year(s)
- Massage Therapist - $1,000 per calendar year(s)
- Naturopath - $1,000 per calendar year(s)
- Speech Therapist - $1,000 per calendar year(s)
- Physiotherapist - $1,000 per calendar year(s)
- Psychologist - $1,000 per calendar year(s)
- Acupuncturist - $1,000 per calendar year(s)

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

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable only after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

Extended Health Care - Medical Services and Supplies

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

Private Duty Nursing

- Private Duty Nursing

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

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

Covered Expenses in and out of hospital are subject to a maximum of $5,000 per 12 consecutive month(s).

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

- 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

- Medical Equipment

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

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

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

Non-Dental Prostheses, Supports and Hearing Aids

- Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses (breast prostheses are subject to a maximum of $150 every calendar year(s))
- surgical stockings, up to a maximum of 4 pairs per calendar year
- surgical brassieres, up to a maximum of 4 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of $100 per calendar year(s) (recommendation of either a physician or a podiatrist is required)
- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of 1 pair per calendar year (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, up to a maximum of $500 per 3 calendar year(s) (recommendation of either a physician or a podiatrist is required)
- cost, installation, repair and maintenance of hearing aids (including charges for batteries), to a maximum of $400 every 60 consecutive month(s)

Other Supplies and Services

- Other Supplies and Services

- charges for obus form back supports if prescribed by a doctor
- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $250 per lifetime
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

- 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 insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

  A medical emergency condition:

a) Coverage is for immediate medical treatment required for:
   - a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or
   - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

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

c) Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.

Stable means in the 90 days before departure, the insured person 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 dependent) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

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

- expenses are payable up to a maximum of $5,000,000 per lifetime
- referral outside Canada for treatment which is available in Canada, to a maximum of $3,000 every 3 calendar year(s).

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

For all non-emergency medical treatment out of Canada, Manulife Financial:

- requires that it be recommended by a physician practicing in Canada, and
- suggests that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be advised of any benefit that will be provided.

Charges for the following are payable under this expense:

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

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

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

Emergency Travel Assistance

Extended Health Care - Emergency Travel Assistance

Emergency Travel Assistance is a travel assistance program available for you and your insured 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 which occurs during the first 60 days while travelling outside your province of residence:

Medical Emergency Assistance

A medical emergency condition:

i) Coverage is for immediate medical treatment required for:
- a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

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

iii) Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.

Stable means in the 90 days before departure, the insured person 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 dependent) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their 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 insurance coverage, is provided.

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer an insured person to and from the nearest medical facility or to a medical facility in the insured person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Ambulance.

If medically necessary for a qualified medical attendant to accompany the insured person, expenses incurred for round-trip transportation will be paid.

Exceptions

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

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

How to Access Emergency Travel Assistance - Your 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 group policy number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have a Emergency Travel Assistance Card, please contact your Plan Administrator.

Submitting a Claim

Extended Health Care - Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, 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 Plan Administrator.

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

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

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)

Subrogation (Third Party Liability)

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

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

Exclusions

Extended Health Care - Exclusions

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

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

Continuation of Coverage

Extended Health Care - Continuation of Coverage

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

You will be considered disabled if you are eligible for disability benefits under any other provision of this Group Benefit Program.

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

Drug Benefit For Persons Who Reside In Quebec

Drug Benefit For Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

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

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

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

a) **Benefit Percentage**

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

i) For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation.

ii) For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:

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

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

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

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

i) deductible amounts, and

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for your dependent children.

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

c) **Deductible**

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

d) **Lifetime Maximums**

Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum stated under The Benefit is reached is subject to the following conditions:

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

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

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

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

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

f) **Termination Age**

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

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

ii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the then applicable Legislation

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

iv) the premium required for the drug coverage is the premium for Extended Health Care

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

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

Dental Care

Dental Care

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

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

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

The Benefit

Dental Care - The Benefit

Deductible - Nil

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

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

Benefit Percentage (Co-insurance) -

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

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

$1,000 per lifetime for Level V

Termination Age - on the last day of the year in which the employee attains age 71, or retirement, whichever is earlier

Waiting Period

30 calendar days for employees hired on or prior to the Group Policy Effective Date

30 calendar days for all other employees

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of an insured person while insured under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by Manulife Financial, taking all factors into account, and
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

Dental Care - Alternate Treatment

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

Level I - Basic Services

Dental Care - Level I - Basic Services

- complete oral exam, one per 2 calendar years
- full-mouth x-rays, one per 2 calendar years
- one unit of light scaling and one unit of polishing twice per calendar year, when the service is performed outside Quebec, or prophylaxis twice per calendar year, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction, plus one recall
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultations, anaesthesia, and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Services

Dental Care - Level II - Supplementary Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

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

  - provisional splinting; and

  - occlusal equilibration, up to a maximum of 8 units per calendar year(s)

- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
  - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
  - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Level III - Dentures

Dental Care - Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable;

  - the existing appliance is at least 60 months old and cannot be made serviceable; or

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

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable;

  - the existing appliance is at least 60 months old and cannot be made serviceable; or

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

Level V - Orthodontics

Dental Care - Level V - Orthodontics

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

Late Entrant Limitation

Dental Care - Late Entrant Limitation

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

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

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

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

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Dental Care - Exclusions

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person

- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Your Group Benefit Program

Your Group Benefit Program is administered by:

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

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.