Winnipeg School Division

Group Policy Number: G0098240

Class: A - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Under Age 65

B - W.T.A. Retirees

D - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Age 65 and Over

H - Community Liaison Officer Retirees

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Group Policy Effective Date: February 01, 1999

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.

The W.T.A., with concurrence from Winnipeg School Division reserves the right to amend, modify, or revoke benefits at any time.

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: August 26, 2020

Extended Health Care

Extended Health Care

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Benefit Percentage (Co-insurance)

Class A,D

100% for - Hospital Care - Ambulance Services

80% for - Medical Services & Supplies - Professional Services - Drugs - Vision

Class B,H

100% for - Hospital Care - Ambulance Services

80% for - Medical Services & Supplies - Professional Services - Drugs

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% for Class A and D.
The Benefit Percentage for Drugs is shown below under ManuScript Provincial Drug Plan 1, Payment of Covered Expenses.

Termination Age
- employee's age 65 or retirement, whichever is earlier for Class A
- employee's retirement for Class D
- upon the employee's death for Class B and H

Benefit Summary

ManuScript Provincial Drug Plan 1

Extended Health Care - ManuScript Provincial Drug Plan 1

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

Note: Participation in the Manitoba Pharmacare program is MANDATORY as no drug expenses exceeding the Pharmacare deductible will be payable by Manulife Financial.

Drugs that are included as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary

Charges for preventive vaccines and medicines (oral or injected) for Employees in Classification Code A,D.

Charges for shingles and Hepatitis B vaccines only (oral or injected) for Employees in Classification Code B,H.

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

The following are not Covered Expenses:

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

charges made by a practitioner or physician to administer injectable medications

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

charges for drugs determined to be ineligible as a result of due diligence

charges for drugs used in the treatment of a sexual dysfunction

- 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, any maximum and the Benefit Percentage of 80%.

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 Manitoba Drug Benefits and Interchangeability Formulary.

If there is no generic equivalent product for the prescribed Drug or medicine and the Drug is listed as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary, the amount covered is the cost of the prescribed product.

Note: Claims are paid based on the Manitoba Formulary even if you reside outside Manitoba.

- 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 listed as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary, the full cost of the prescribed product is covered.

When you have a “no substitution prescription”, please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

- Payment of Drug Claims

- Payment of Drug Claims

Employees in Classification Code A,B,D,H

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

Class A and D

eye exams, once per 2 calendar year(s)

Benefit Summary

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Osteopath -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Podiatrist/Chiropodist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Massage Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Naturopath -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Speech Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Dietician -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Audiologist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Benefit Summary

Physiotherapist/Athletic Therapist/Occupational Therapist -

Class A,D

$1,000 per person per calendar year(s)

Note - Reasonable and Customary Limit is not applicable to Athletic Therapist

Physiotherapist/Athletic Therapist -

Class B,H

$1,000 per person per calendar year(s)

Occupational Therapist -

Class B,H

$850 per person per calendar year(s)

Psychologist/Social Worker/Clinical Counsellor/Marriage Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Acupuncturist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

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 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 or a retiree of Winnipeg School Division. 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 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.

How to Use Your Benefit Booklet

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

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

Your Group Benefit Card

Your Group Benefit Card

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. 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.

Adherence

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

Adherence

Advisory Body

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

Advisory Body

Benefit Percentage (Co-insurance)

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

Benefit Percentage (Co-insurance)

Covered Expenses

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

Covered Expenses

Deductible

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

Deductible

Dependent

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

Dependent

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least one year.

- Child

your natural or adopted child, stepchild, or a child for whom you are a legal guardian, who is:

- unmarried;

- under age 21, or under age 25 if a full-time student attending an accredited school, college or university;

- not employed on a full-time basis; and

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

a child who is incapacitated on the date he or she reaches the age when 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.

Disease Management Programs

Disease Management Programs

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

Drug

Drug

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

Due Diligence

Due Diligence

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

Exclusive Distribution

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

Experimental or Investigational

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

Explanation of Common Insurance Terms

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

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

Lower Cost Alternative

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

Medically Necessary

Medically Necessary

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

Patient Assistance Program

Patient Assistance Program

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

Pharmacoeconomics

Pharmacoeconomics

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

Explanation of Common Insurance Terms

Prior Authorization

Prior Authorization

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

Provincial Plan

Provincial Plan

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

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.

Why Group Benefits?

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

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

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

Your Group Benefit Program is provided by Winnipeg School Division, in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

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

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

For:
Class A - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Under Age 65

Class D - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Age 65 and Over

Class H - Community Liaison Officer Retirees:

Claims forms are available on-line at **www.manulife.ca** or by calling the **Benefits Section at Winnipeg School Division at (204) 775-0231**. When you have submitted a new claim for payment, Manulife will return a new claim form along with your processed claim.

If you have questions about your claims, your coverage or if you require a replacement wallet ID card, please contact **Manulife at 1-800-268-6195**. Detail coverage information is available on Manulife's Plan Member site at **www.manulife.ca**.

Why Group Benefits?

If you have questions about eligibility, enrolment, termination or general plan provisions that Manulife is unable to assist with, please contact the **Benefits Section at Winnipeg School Division at (204) 775-0231**.

If you would like to report a change from family to single status, a name change, applying for coverage previously waived due to duplicate spousal coverage, terminate your coverage (once you terminate your coverage you will not have the opportunity to re-enrol in the plan), have questions about your premium deductions, eligibility, enrolment, termination or general plan provisions, please contact the **Benefits Section at Winnipeg School Division at (204) 775-0231**. You will be required to complete an Application for Change formChanges in status are to be reported within 90 days of the Life Event.

For:
Class B - W.T.A. Retirees

Claims forms are available on-line at **www.manulife.ca** or by calling the **W.T.A. at (204) 831-7104**. When you have submitted a new claim for payment, Manulife will return a new claim form along with your processed claim.

If you have questions about your claims, your coverage or if you require a replacement wallet ID card, please contact **Manulife at 1-800-268-6195**. Detail coverage information is available on Manulife's Plan Member site at **www.manulife.ca**.

If you have questions about eligibility, enrolment, termination or general plan provisions that Manulife is unable to assist with, please contact the **W.T.A. at (204) 831-7104**, or e-mail at **wta@wta.mb.ca**.

If you would like to report a change from family to single status, a name change, terminate your coverage (once you terminate your coverage you will not have the opportunity to re-enrol in the plan), or if you have questions about your premium deductions, please contact the **TRAF at (204) 949-0048, 1-800-782-0714** or e-mail at **info@traf.mb.ca**. You will be required to complete an Application for Change formChanges in family status are to be reported within 90 days of the Life Event.

Applying for Group Benefits

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment form, available from your Plan Administrator (see above). Your Plan Administrator then forwards the application to Manulife Financial.

Naming a Beneficiary

Naming a Beneficiary

Manulife Financial does not accept beneficiary appointments for any benefits 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

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

Submit Online (if applicable)

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

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

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

The Claims Process

By Mail

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

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

Claims must be submitted within 12 months from the date the expense was incurred.

Payment of Extended Health Care 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 Manulife Financial's Group Benefits **Customer Service Centre at 1-800-268-6195** or go to the Manulife Plan Member site at **www.manulife.ca**.

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 Benefits

Co-ordination of Extended Health 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 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.

The Claims Process

– 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

Class A - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Under Age 65

Class D - Members of Winnipeg Teachers' Association (W.T.A.) and Community Liaison Officers, Age 65 and Over

You are eligible for Group Benefits if you:

are a member of the W.T.A., or a permanent employee of Winnipeg School Division,

are a member of an eligible class,

are younger than age 65 for Class A,

are not retired, and

are residing in Canada.

Participation in the Extended Health Care plan is mandatory for all new employees. Benefits may only be waived with proof that you are covered for Extended Health Care under your spouse's plan.

You may change dependent status within 90 days of one of the following Life Events:

legal separation,

marriage (including common-law after 1 year cohabitation),

divorce,

birth, legal guardianship or adoption of the first eligible child,

death of a spouse or dependent child,

termination of a common-law relationship,

involuntary loss of coverage under your spouse's benefit plan (example - job loss),

term teaching contract becoming permanent,

loss of spouse's benefits due to that spouse's retirement, or

if an employee does not report change from single to family within the allowable 90 day period, the member will be able to add their dependent, but they must wait one year from date of request.

Who Qualifies for Coverage?

Class B - W.T.A. Retirees

Class H - Community Liaison Officer Retirees

You are eligible for Group Benefits if you:

were a member of the W.T.A. and were an employee of Winnipeg School Division prior to retirement,

are a member of an eligible class, and

were insured as an Active member under the voluntary Extended Health Care plan for at least one year prior to your date of retirement.

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

Participation in the Extended Health Care plan is voluntary at retirement, if you are receiving a pension from the Teachers' Retirement Allowances Fund (TRAF). You must elect to continue to participate in the Plan within 90 days of your retirement date. In doing so, you are authorizing TRAF to deduct the premiums from your monthly pension when completing your TRAF application form. At that time, you will receive a retiree wallet ID card.

If you decline to participate in the Extended Health Care plan when you first retire, you will not be eligible to join at a later date.

If you choose to discontinue your participation in the Extended Health Care plan, you will not be eligible to re-join at a later date.

Enrolment Status Changes (Single or Family coverage)

Enrolment Status Changes (Single or Family coverage)

Active Employees only:

You are required to enrol in accordance with your true family status. You may however, choose to waive coverage if you are covered for similar benefits under your spouse's plan by declaring this on your enrolment form.

You will have the option to change your enrolment status (Single or Family) election following your initial enrolment only, when you have a Life Event (as defined earlier in this booklet).

Application for changing your enrolment status must be made within 90 days of the Life Event, along with confirmation of the date of the Life Event. Applications will not be accepted under this plan beyond 90 days following the Life Event.

Retirees only:

You are required to enrol in accordance to the status for which you were enrolled prior to your retirement date (Single or Family).

Should you no longer have any eligible dependents, you may change from Family to Single status following your enrolment into the Retiree plan. Once Single coverage is elected, you can no longer change your coverage to Family status following your retirement date.

Who Qualifies for Coverage?

Effective Date of Coverage

Effective Date of Coverage

Your Group Benefits will be effective on the date you are eligible.

Active Employees only:

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 and will not be effective prior to the date your insurance becomes effective.

Retirees only:

Your coverage becomes effective on the date you retire, provided proper application has been made.

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

Termination of Insurance

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

the date you cease to be an eligible employee for reasons other than retirement,

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. See Survivor Extended Benefit for retirees (Class B and H).

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 and Pharmacy Services for Quebec Residents

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Benefit Percentage (Co-insurance)

Class A,D

100% for - Hospital Care - Ambulance Services

80% for - Medical Services & Supplies - Professional Services - Drugs - Vision

Class B,H

100% for - Hospital Care - Ambulance Services

80% for - Medical Services & Supplies - Professional Services - Drugs

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% for Class A and D.
The Benefit Percentage for Drugs is shown below under ManuScript Provincial Drug Plan 1, Payment of Covered Expenses.

Termination Age
- employee's age 65 or retirement, whichever is earlier for Class A
- employee's retirement for Class D
- upon the employee's death for Class B and H

Waiting Period

none

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 an illness 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

used as prescribed or recommended by a physician

associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by Manulife Financial and shared with your employer as required

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

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

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

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

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

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

Advance Supply Limitation

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

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

charges for hostel care will be covered, payable at the usual, customary and reasonable daily room rate, provided the insured person is being treated or requires tests on the recommendation of a physician at a hospital which is located more than 60 kilometres from the insured person's residence. The person must be placed in a recognized medical hostel associated with the referring hospital.

ManuScript Provincial Drug Plan 1

Extended Health Care - ManuScript Provincial Drug Plan 1

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

Note: Participation in the Manitoba Pharmacare program is MANDATORY as no drug expenses exceeding the Pharmacare deductible will be payable by Manulife Financial.

Drugs that are included as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary

Charges for preventive vaccines and medicines (oral or injected) for Employees in Classification Code A,D.

Charges for shingles and Hepatitis B vaccines only (oral or injected) for Employees in Classification Code B,H.

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

The following are not Covered Expenses:

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

charges made by a practitioner or physician to administer injectable medications

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

charges for drugs determined to be ineligible as a result of due diligence

charges for drugs used in the treatment of a sexual dysfunction

- 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, any maximum and the Benefit Percentage of 80%.

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 Manitoba Drug Benefits and Interchangeability Formulary.

If there is no generic equivalent product for the prescribed Drug or medicine and the Drug is listed as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary, the amount covered is the cost of the prescribed product.

Note: Claims are paid based on the Manitoba Formulary even if you reside outside Manitoba.

- 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 listed as a benefit in the current Manitoba Drug Benefits and Interchangeability Formulary, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, any maximum and the Benefit Percentage of 80%.

- Payment of Drug Claims

- Payment of Drug Claims

Employees in Classification Code A,B,D,H

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

Class A and D

eye exams, once per 2 calendar year(s)

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Osteopath -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Podiatrist/Chiropodist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Massage Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Naturopath -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Speech Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Dietician -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Audiologist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Physiotherapist/Athletic Therapist/Occupational Therapist -

Class A,D

$1,000 per person per calendar year(s)

Note - Reasonable and Customary Limit is not applicable to Athletic Therapist

Physiotherapist/Athletic Therapist -

Class B,H

$1,000 per person per calendar year(s)

Occupational Therapist -

Class B,H

$850 per person per calendar year(s)

Psychologist/Social Worker/Clinical Counsellor/Marriage Therapist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

Acupuncturist -

Class A,D

$1,000 per person per calendar year(s)

Class B,H

$850 per person per calendar year(s)

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

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

Extended Health Care - Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs where no specific maximum is stated.

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 or a hospital by:

a registered nurse, or

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

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

In Home nursing care is provided to the above stated maximum, up to 12 months following the date of discharge from the hospital for the condition that was treated.

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

non-emergency ambulance within the patient's province of residence, up to a maximum of $500 per person per trip for Class A and D and $250 per lifetime per person for Class B and H, recommendation of a physician is required

emergency or non-emergency ambulance outside the patient's province of residence, up to a maximum of $500 Canadian Funds per person per trip for Class A and D and $250 Canadian Funds per trip for Class B and H

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

external prostheses

breast prosthesis, reasonable and customary

surgical stockings

surgical brassieres, up to a maximum of 4 per calendar year

braces (other than foot braces), lumbar-sacro supports (excluding Obus formes), corsets, traction apparatus equipment, crutches, 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 1 pair per calendar year when part of a brace, if not part of a brace, 50% of the cost of 1 pair per calendar year is covered, **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 **and must be constructed by a certified orthopaedic footwear specialist**

casted, custom-made orthotics, up to a maximum of $500 per person per calendar year(s) for Class A and D and $400 per 2 calendar year(s) for Class B and H, **recommendation of either a physician or a podiatrist is required**

cost and installation of hearing aids, to a maximum of $2,000 per person, every 5 calendar year(s)

custom ear plugs with a MD prescription, for Class A and D

Other Supplies and Services

- Other Supplies and Services

Cardiac Rehabilitation Treatment, up to a maximum of $300 per 2 calendar year(s) for Class A and D and $500 per lifetime for Class B and H, per person as part of a recognized cardiac rehabilitation program following one of the following conditions:

- myocardial infarction

- bypass surgery

- valve replacement

- management of angina pectoris or other cardiac disease

Assisted Care, provided by persons regularly employed as a Health Care Aid, Home Care Worker or Homemaker, up to a maximum of $30 per day, to a maximum of 14 days due to illness or injury, within 12 months following discharge from hospital

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 $1,000 per lifetime

oxygen

microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec, up to a maximum of $1,000 per calendar year

charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is commenced within 90 days of the accident, unless a longer period is required by legislation, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence for Class A,B and H, and which occurs during the first 60 days outside the province for Class D, 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 Unlimited for Class A and D.

expenses are payable up to a maximum of $2,500 per person, per calendar year for Class B and H.

referral outside Canada for treatment which is available in Canada, to a maximum of $3,000 every 3 calendar year(s) for Class A,D.

referral outside Canada for treatment which is available in Canada, to a maximum of $3,000 every 3 calendar year(s) subject to a maximum of $2,500 per calendar year for Class B,H.

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 Class A,D.

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) subject to a maximum of $2,500 per calendar year for Class B,H.

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

all other charges incurred while outside of your province of residence on the same basis as if they were incurred in your province of residence

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

All receipts for expenses incurred outside of your province of residence must be submitted on the Out of Province/Out of Canada Health Claim form in order to be considered under this Covered Expense.

Emergency Travel Assistance

Extended Health Care - Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

A medical emergency 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 - Out-of-Province/Out-of-Canada.

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

f) **Return of Dependent Children**

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

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

g) **Trip Interruption/Delay**

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

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

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

If an insured person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If an insured person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit an insured person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by Manulife Financial.

j) **Vehicle Return**

If an insured person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If an insured person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of an insured person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help an insured person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the insured person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the insured person plans to travel.

Health Advice and Assistance

The following services are available for an insured person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed drug or medicine; and

iii) other health related services that may be requested or required by the insured person.

c) **Link to 911**

If necessary, an insured person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the insured person, the registered nurse will follow-up with the insured person within 24 hours after the medical advice is provided.

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:

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

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

committing or attempting to commit an assault or criminal offence

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

Class A and D

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. Any claims will be subject to the time limitations as outlined under Submitting a Claim, unless a longer period is required by legislation. However, coverage will terminate if the disabled person becomes eligible for insurance under another group plan.

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

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

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered 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

covered pharmacy services that are to be paid when the drug is on the RAMQ List; and

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

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

The following provisions apply only to the coverage of drugs that are on the RAMQ List and pharmacy services, 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 Legislated pharmacy services which are not otherwise covered under the terms of the Policy, the percentage payable is as set out by the then applicable Legislation.

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

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

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

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

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

i) deductible amounts, and

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

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug and covered pharmacy services expenses and covered pharmacy services 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 or covered pharmacy services 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) covered pharmacy services that are performed for drugs on the RAMQ List

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

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

covered pharmacy services performed for a drug on the RAMQ List

- 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) only covered pharmacy services relating to a drug on the RAMQ List,

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

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

v) 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.

Survivor Extended Benefit

Survivor Extended Benefit

Class B and H

If you die while your dependents are insured under this Group Benefit Program, Manulife Financial will continue the Extended Health Care provided you have a surviving spouse and that spouse is eligible to receive your survivor pension. Coverage for the surviving spouse may be continued with payment of premium, for as long as the surviving spouse is alive and this Policy is in force. Coverage for any dependent child ceases prior to this:

- if the dependent child would cease to qualify as a Dependent, even if the retiree were still alive; or
- if the dependent child obtains similar coverage elsewhere.

In the event of remarriage of the surviving spouse, coverage may be continued for that spouse and his or her eligible dependent children, excluding the new spouse.

Your Group Benefit Program

Your Group Benefit Program has been arranged by:

Aon Consulting
Winnipeg, Manitoba

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.