New Brunswick Teachers' Federation Group Insurance Plan Provided by the NBTF Group Insurance Trustees and Administered by Johnson Inc.

NBTF
GROUP INSURANCE
TRUSTEES

FIDUCIAIRES
DE L'ASSURANCE
COLLECTIVE DE LA FENB

JOHNSON

Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund

Description: NBTF Group Insurance Plan - All Active and Retired Members

Group Contract Numbers: GL & GH 11338, GH 14035, GL 17589, GH 37481, G0038602, MPP 84532

Member Name: _____

Certificate Number: _____

Welcome to Your Group Benefits Program

Group Contract Effective Dates:

Life, Dependent Life: December 1, 1965

Hospital, Drugs, Vision Care, Major Medical: January 1, 1971

Member Optional Life, Spousal Optional Life: March 1, 1981

Long Term Disability: October 1, 1986

Dental: January 1, 1993

Pay Direct Drug: October 1, 1995

Critical Illness: September 1, 2011

As a valued member, you are entitled to the medical and financial security of your Group Benefit Program, provided by Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund in partnership with Manulife Financial.

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 also 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.

This booklet produced: June 29, 2023

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How to Use Your Benefit Booklet

Designed with Your Needs in Mind

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

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

Important Note

Your Pay Direct Drug Benefit is provided directly by Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following standard coverage rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

The purpose of this booklet is to outline the benefits for which you are eligible as a member of Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund. The information in this booklet is a summary of the provisions of the Group Contract. The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund and Manulife Financial are governed by the Group Contract (available from your Plan Administrator). In the event of a discrepancy between this booklet and the Group Contract, the terms of the Group Contract will apply. No alteration of this booklet is permitted by any person, except by an authorized representative of Manulife Financial.

Possession of this booklet alone does not mean that you or your dependent(s) are covered. The Group Contract must be in effect and you must satisfy all the requirements of the Contract.

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

- the Group 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 Group 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.

Child(ren)

- your unmarried children (including adopted, foster and step-children) who are less than 21 years of age and, for all other benefits other than Dental, are defined as your dependent, as per the Income Tax Act. Unmarried children, who are full-time students and dependent upon you for support, will be eligible until age 27. Children are covered from birth.

- any mentally or physically handicapped child may remain covered past the maximum age. The child, upon reaching maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

Deductible

the amount of eligible expenses for which you are responsible prior to consideration of payment of benefits.

Disease

a change in the physiology or structure at the tissue or organ system level, which is demonstrated by standard medical procedures, including but not limited to, laboratory analyses and x-rays.

Disorder

a disturbance of the body's physical or psychiatric function and/or structure.

Drug

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

Earnings

your gross earnings excluding bonus, commissions and overtime.

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.

Impairment

a loss or abnormality of body structure or of a physiological or psychological function.

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.

Remarriage

either of the following arrangements that your surviving spouse enters into subsequent to your death:

- a marriage through an ecclesiastical or civil ceremony.

- although not legally married to you, continuously cohabits with you in a conjugal relationship, which is recognized as such in the community in which you reside, for at least 12 months at the time a claim is incurred. The term conjugal relationship shall be deemed to include a conjugal relationship between partners of the same sex.

Explanation of Common Insurance Terms

Spouse

a person who:

- either:

    1. is married to you through an ecclesiastical or civil ceremony, or

    2. although not legally married to you, continuously cohabits with you in a conjugal relationship, which is recognized as such in the community in which you reside for at least 12 months at the time a claim is incurred. The term conjugal relationship shall be deemed to include a conjugal relationship between partners of the same sex.

Totally disabled

for active members, except for Long Term Disability, you are unable to work and earn an income due to sickness or bodily injury that leaves you wholly and continuously disabled.

for retired members, wholly and continuously disabled by sickness or bodily injury which prevents one from engaging in duties or activities (household or otherwise) which could be considered normal for a person of the same age and sex.

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 Trustees of the New Brunswick Teachers' Federation Group Insurance Trust Fund, in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

Your Plan Administrator is responsible for ensuring that all members 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.

Your Plan Administrator is Johnson Inc

Claims administration department:
Phone: 1-800-442-4428
Email: fredericton@johnson.ca

Benefit administration department:
Phone: 1-888-851-5500
Email: pbadminnb@johnson.ca

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

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Reinstatement Application form, available from your Plan Administrator.

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 Plan Administrator. 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 Plan Administrator.

The Claims Process

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits other than Life Insurance.

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

How to Submit a Claim

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed. Remember, always provide your Group Contract Number and your Certificate Number to avoid any unnecessary delays in the processing of your claim.

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

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.

Payment of Hospital, Drugs, Vision Care, Pay Direct Drugs, Major Medical and Dental Claims

Once the claim has been processed, Manulife Financial will send an Explanation of Benefits 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.

Co-ordination of Hospital, Drugs, Vision Care, Pay Direct Drugs, Major Medical and Dental Benefits

If you or your dependents are covered 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 covered 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

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 member, then
    - The Plan where the person is covered as an active part-time member, 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).

- A claim for accidental injury to natural teeth will be determined under 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 covered person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

The Claims Process

Submitting a Claim for Co-ordination of Benefits

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

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

Eligibility

You are eligible for Group Benefits if you:

- are a member of the New Brunswick Teachers' Association or l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick.
- are an associate member of the New Brunswick Teachers' Association or l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick.
- are a member of the New Brunswick Teachers' Association, l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick, the New Brunswick Teachers' Federation, the NBTF Group Insurance Trust Fund or the NBTA Credit Union.

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

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

Evidence of Good Health

Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit. Any increases in coverage will also require medical evidence.

However, evidence of insurability will be waived for amounts of insurance shown under Critical Illness Insurance benefit, if you elect Member Critical Illness Insurance at initial enrolment and apply for Member Optional Critical Illness or Spousal Critical Illness Insurance within 31 days of first becoming eligible. If you do not elect Member Critical Illness Insurance at initial enrolment, evidence of insurability will be required for all amounts of Member Optional Critical Illness or Spousal Critical Illness Insurance.

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

Medical evidence can be submitted by completing the Evidence of Good Health form available from your Plan Administrator. Further medical evidence may be requested by Manulife Financial.

Who Qualifies for Coverage?

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days for Critical Illness Insurance, and 60 days for all other benefits; or

- apply for coverage on any person which 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 coverage more than 31 days for Critical Illness Insurance, and 60 days for all other benefits, after the date benefits terminated under your spouse's plan; or

- apply for coverage and benefits under your spouse's plan have not terminated.

However, evidence of insurability will not be required if you return from an approved leave of absence and re-enrol for long term disability benefits which had previously been terminated under this policy, provided you were continuously insured during the approved leave for long term disability benefits under another mandatory employer plan, and that you re-enrol for long term disability benefits within 31 days of the date of return from the approved leave of absence.

Applying for Benefits

You must be insured for Member Life Insurance in order to be eligible for Dependent Life Insurance.

You must be insured for Member Optional Life Insurance in order to be eligible for Spousal Optional Life Insurance.

If you choose to be insured for Major Medical or Dental Care Benefits, you must remain insured under that benefit for at least 12 months.

Effective Date of Coverage

If Evidence of Good Health is not required, your Group Benefits will be effective on the date you are eligible.

If Evidence of Good Health 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.

For all benefits except dental: A change in coverage will commence on the first day the member is actively employed coincident with or immediately following the date the member is eligible for such change. However, the actively employed requirement will be waived for the change to the Cost of Living Benefit under Long Term Disability effective January 7, 2019.

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

If one of your dependents (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Once you are covered for dependent coverage, additional dependents will be covered from the date eligible, regardless of hospital confinement.

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

Termination of Coverage

Your Group Coverage will terminate on the earliest of:

- the date you cease to be an eligible member,
- the date you enter the armed forces of any country on a full-time basis,
- the date the Group Contract terminates,
- the date you reach the Termination Age, or
- the date any required contribution is due but not paid.

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

Life Insurance

If you die while covered, 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.

The Benefit

Benefit Amount

Active and Non-Retired Members under age 70

Active and non-retired members up to the end of the month following age 70, except those members employed prior to January 1, 1982 and who elected to retain their amount of coverage in force prior to January 1, 1982 - $50,000

Non-retired members up to the end of the month following age 70 who were employed prior to January 1, 1982 and who elected to retain their amount of coverage in force prior to January 1, 1982 shall be covered for $20,000 or $30,000, whichever amount of coverage was covered for immediately prior to January 1, 1982.

Note: you may later elect to be covered for the amount specified for members who did not elect to retain their amount of coverage in force prior to January 1, 1982.

Non-Retired Members age 70 and over

Male members who are covered under the Great West Life - an amount of Life Coverage equal to the amount for which you were covered immediately prior to age 70

All other members: $15,000

Retired Members under 70

Members who, at the end of the month following 65 years of age on or after January 1, 2003 and who retire prior to the end of the month following age 70 will remain covered for an amount of Life Insurance equal to the amount for which you were covered immediately prior to retirement.

Retired Members age 70 and over

$15,000

Termination Age - upon your death

Waiting Period - none

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.

If you have not appointed a beneficiary under this policy, but you had appointed a beneficiary under a prior policy where you were covered prior to becoming covered under this policy, then the most recently appointed beneficiary under that prior policy is considered your beneficiary under this policy.

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

Submitting a Claim

To submit a Member 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 should be submitted as soon as reasonably possible.

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.

Waiver of Premium

If you become totally disabled, coverage for your Member Life Insurance will continue without payment of premium, provided the following conditions are met:

- Total disability commences while you are covered and before you reach age 65.
- Total disability exists for at least 6 months or following expiration of sick leave, whichever is later.
- You submit proof of this disability within 12 months of the date total disability commenced.

Waiver Of Premium Conditions

Once your application for Waiver of Premium is approved, premiums for your Member Life Insurance will be waived from the contribution due date coincident with or immediately following the later of:

- six months from the date you became totally disabled, or
- the expiration of paid-sick leave,

until the earliest of the following events:

- You are no longer totally disabled.
- You fail to submit further proof of total disability, if requested.
- You fail to take a physical examination and/or a mental evaluation, if requested.
- You are no longer under satisfactory and continuing medical supervision and treatment.
- Your coverage would normally cease, for any reason other than termination of the contract, if you were not totally disabled.
- The date of your death.

Conversion Privilege

Not applicable to Retired Members age 70 and over

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance to an individual contract, without medical evidence. You must apply for the individual contract and pay the first monthly contribution within 31 days of the termination of your Member Life Insurance. If you die during this 31-day period, the amount of Member 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.

Member Optional Life Insurance

If you die while covered, the amount of this benefit will be paid to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - you may elect multiples of $5,000, to a maximum benefit of $100,000

Non-Evidence Limit - all benefit amounts are subject to Evidence of Good Health.

Termination Age - age 65

Waiting Period - none

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

Submitting a Claim

To submit a Member Optional 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 should be submitted as soon as reasonably possible.

Waiver of Premium

If your Life Insurance contribution is waived because you are totally disabled, the contribution for this benefit will also be waived. (See Life Insurance).

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Optional Life Insurance to an individual contract, without medical evidence. You must apply for the individual contract and pay the first monthly contribution within 31 days of the termination of your Member Optional Life Insurance. If you die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

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

Dependent Life Insurance

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

The Benefit

Benefit Amount

Non-Retired Members

- $10,000 spouse, $5,000 each dependent child

Termination Age - at the end of the month in which a non-retired member reaches age 70, or a retired member reaches age 65

Waiting Period - none

Submitting a Claim

To submit a Dependent 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 should be submitted as soon as reasonably possible.

Waiver of Premium

If your Member Life Insurance contribution is waived because you are totally disabled, the contribution for this benefit will also be waived. (See Member Life Insurance).

Conversion Privilege

If your spouse's life coverage terminates, he or she may be eligible to convert the terminated coverage to an individual contract, without medical evidence. Application for the individual contract must be made, and the first monthly contribution paid, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

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

Spousal Optional Life Insurance

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

The Benefit

Spouse - 25% of the amount for which you are is covered

Non-Evidence Limit - all benefit amounts are subject to Evidence of Good Health.

Termination Age - member's age 65 or death of the member

Waiting Period - none

To apply for Spousal Optional Life Insurance you must complete the Application for Optional Life form, which is available from your Plan Administrator. For your spouse to be eligible for Spousal Optional Life Insurance, you must be covered for Member Optional Life Insurance.

Submitting a Claim

To submit a Spousal 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 should be submitted as soon as reasonably possible.

Waiver of Premium

If your Life Insurance contribution is waived because you are totally disabled, the contribution for this benefit will also be waived. (See Life Insurance).

Conversion Privilege

If your spouse's life coverage terminates, he or she may be eligible to convert the terminated coverage to an individual contract, without medical evidence. Application for the individual contract must be made, and the first monthly contribution paid, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Optional Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

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

Hospital

If you, or a covered dependent, are confined in a licensed hospital, you will be reimbursed for room and board charges in excess of ward accommodation up to the level of semi-private accommodation, plus the daily co-insurance charge (if applicable). If confined in a private room, payment will be based on the hospital's charge for semi-private room and board.

If you, or a covered dependent, are confined in a licensed hospital, you will be reimbursed for room and board charges in excess of semi-private accommodation up to $10,000 per period of disability. Charges for any portion of the cost of ward accommodation, utilization or copayment fees (or similar charges) are not eligible.

Outside Canada Maximum - Hospital charges incurred outside Canada are subject to an overall lifetime maximum of $1,000,000 per person, combined with Drugs, Vision Care and Major Medical benefits.

Waiting Period - none

Recurrent Disabilities

Once you have been disabled and have received benefits under this plan, a later disability will be defined as recurrent when it is separated from the previous one by less than 2 weeks of full-time active employment at your usual place of employment.

Recurrent disabilities can also apply to your dependents. For dependents, the two periods of disability must be separated by less than 3 months during which your dependent is free of any disability.

A disability will not be considered to be recurrent if it results from an injury or sickness which is entirely unrelated to the causes of the previous disability.

If any period of disability is classified as recurrent, it will be treated as a continuation of the previous disability. For instance, any maximums which apply may already be partly used up.

Submitting a Claim

To submit a Hospital Claim, have the hospital complete their section of the claim form and give it to you for completion. When completed, submit the form to Manulife Financial.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your coverage, 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.

Expenses Not Covered

No payment will be made for expenses resulting from:

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.
- Examinations required for the use of a third party.
- Travel for health reasons.
- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Any charges for services, treatment or supplies:
    - for which there would be no charge except for the existence of coverage.
    - which are performed or provided by an immediate family member or a person who lives with the patient.
    - which are provided while confined in a hospital on an in-patient basis.
    - which are not specified as an Eligible Expense under this plan.
- if you are a resident of the United States, no payment will be made for expenses incurred which, for Canadian residents, would be payable by, or insurable only by a government under any government plan or health coverage.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.

Extension of Benefits

If you are totally disabled when your Hospital Benefit terminates, benefits will be payable, as long as you remain disabled, up to a maximum period of 90 days after termination. However, coverage will terminate if you become eligible for coverage under another group plan.

If one of your covered dependents is hospitalized when your coverage terminates, then benefits will be payable in the same manner as your own or until your dependent is discharged from the hospital, whichever is earlier.

Extension of the Hospital benefit will cease if the Contract should terminate.

Drugs

The Benefit

Overall Benefit Maximum charges incurred outside Canada are subject to an overall lifetime maximum of $1,000,000 per person, combined with Hospital, Vision Care and Major Medical benefits.

Deductible - nil

Benefit Percentage (Co-insurance)

80% of the purchase price per item

Waiting Period - none

Eligible Expenses

- Drugs, medicines, sera and injectables available only on a prescription* by a physician or dentist and dispensed by a pharmacist, dentist or a physician. Anti-smoking drugs are subject to a lifetime maximum of $300 per person. Fertility drugs will be payable at 12 cycles per drug, limited to a lifetime maximum of two fertility drugs. Sexual dysfunction drugs are subject to a maximum of $750 per person per calendar year.

**Those drugs which legally require a written prescription in order to be purchased.*

- Drugs and supplies of a non-prescription nature required as a result of a colostomy, cecostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease.

- Charges for oral contraceptives, intrauterine devices and diaphragms.

- Life sustaining drugs and antihistamines.

Expenses Not Covered

No payment will be made for the following items:

- items for which the cost is payable under any government plan or law.

- atomizers, appliances, prosthetic devices and first aid or diagnostic supplies, except for supplies described above.

- condoms, contraceptive jellies or appliances normally used for contraception whether or not such prescription is given for a medical reason, except orally administered contraceptives.

- Vitamins (other than injectables) and dietary supplements whether or not such prescription is given for a medical reason, except where federal or provincial law requires a prescription for their sale.

- Proprietary and patent medicines which are:

    - defined as products registered under Division Ten of the Food and Drugs Act - Canada,

- bear a general public (GP) number on their label, and
- do not bear a drug identification number (DIN) on their label.

- Drugs for hair loss.

Vision Care

The Benefit

Overall Benefit Maximum charges incurred outside Canada are subject to an overall lifetime maximum of $1,000,000 per person, combined with Hospital, Drugs and Major Medical benefits.

Deductible - nil

Benefit Percentage (Co-insurance)

100% for contact lenses for special conditions

100% for foldable contact lenses

80% for all other expenses

Waiting Period - none

Eligible Expenses

- Purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, up to a maximum of $350 per person every 12 consecutive months for dependent children under age 21 and 24 consecutive months for any other person.

- Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, provided vision can be improved to at least the 20/40 level by contact lenses (but cannot be improved to that level by regular glasses). Payment will be made up to $250 per person every 24 consecutive months.

- Foldable lenses for those who have cataract surgery limited to once every 24 consecutive months.

- Ocular examinations (including refraction) - up to $84 per examination, limited to one every 12 consecutive months.

- Services for visual training or remedial exercises.

- treatment to the eye for accidental injury or disease if not otherwise provided for under this benefit.

Vision Care expenses are eligible when recommended by a physician (including an ophthalmologist) or an optometrist.

Expenses not Covered

No payment will be made for expenses or for claims resulting from:

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.
- Examinations required for the use of a third party.
- Travel for health reasons.
- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of coverage.
  - which are performed or provided by an immediate family member or a person who lives with the patient.
  - which are provided while confined in a hospital on an in-patient basis.
  - which are not specified as an Eligible Expense under this plan.
- Expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (Major Medical Eligible Expenses - Referral Treatment and Outside Canada Coverage). Such expenses incurred outside Canada on an elective basis are not payable.
- Drugs, sera, injectables and supplies which are not approved by Health and Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.
- Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.

Extension of Benefits

If you are totally disabled when your Major Medical benefit terminates, benefits for such disability will be payable, as long as you remain disabled, up to a maximum period of 365 days after termination. However, coverage will terminate if you become eligible for coverage under another group plan.

If one of your covered dependents is hospitalized when your coverage terminates, then benefits will be payable in the same manner as your own or until your dependent is discharged from the hospital, whichever is earlier.

Extension of the Vision Care benefit will cease if the Contract should terminate.

Major Medical

If you or one of your dependents incurs charges for any of the Eligible Expenses specified, your Major Medical benefit can provide financial assistance.

The Benefit

Overall Benefit Maximum

Non-Emergency Medical Expenses - unlimited

Referral Treatment - $5,000 per person per calendar year.

Emergency Medical Expenses - charges incurred outside Canada and International Travel Assistance are subject to an overall lifetime maximum of $1,000,000 per person combined with the Hospital, Drugs and Vision Care benefits.

Deductible - nil

Benefit Percentage (Co-insurance)

Non-Emergency Medical Expenses and Referral Treatment - 80% of eligible expenses

Emergency Medical Expenses - 100% of eligible expenses

Waiting Period - none

Eligible 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 (except for International Travel Assistance expenses, and paramedical practitioners under Professional Services),
- incurred for the care of a person while covered under this Group Benefit Program, and
- not covered under the Provincial Plan or any other government-sponsored program.

Non-Emergency Medical Expenses

Health Care Facilities

- Hospital charges incurred as an out-patient for necessary medical or surgical treatment (excluding physicians' fees, and special nurses' fees).
- Room, board and normal nursing care provided in a licensed nursing home (for convalescent or chronic care, but excluding custodial care), up to $20 per day. This expense is not available to retired members or their dependents.

Ambulance Services

- Emergency transportation by a licensed ambulance to and from the nearest medical facility for immediate treatment. When a Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.) or a Certified Nursing Assistant (C.N.A.) is in attendance while the claimant is being transported in the ambulance, the cost of returning the nurse to the point of departure will be paid. The maximum payment is $500 per person, per calendar year.

Medical Supplies and Services

- Diagnostic procedures, radiology, blood transfusions and oxygen (including the equipment necessary for its administration).
- Purchase of trusses, braces excluding foot braces, crutches and artificial limbs or eyes.
- Purchase of a mastectomy bathing suit, with a physician's prescription, to a maximum payment of $125 every 24 consecutive months.
- Elastic support stockings, up to $25 per calendar year.
- Purchase of casted, custom-made orthotics which are recommended by a physician or podiatrist, to a maximum of 2 pairs per person in any 3 consecutive years.
- Orthopaedic shoes on a written prescription, to a maximum payment of $125 per person every 12 consecutive months.
- Rental, or, at Manulife Financial's option, purchase of a wheelchair, hospital bed or respirator/ventilator.
- purchase of a maxi-mist type machine requiring a written prescription by a physician.
- purchase of transcutaneous nerve stimulators.
- purchase of blood pressure monitors, limited to one every five consecutive calendar years.
- wigs or hairpieces required as a result of medical treatment, illness or injury up to a total payment per person of $1,500 every three consecutive calendar years. Maintenance to wigs or hairpieces up to a total payment of $300 per person, per calendar year.
- purchase of burn pressure garments (special made-to-measure dressings), up to a maximum payment of $400 per person per calendar year.
- purchase of ear plugs, including for non-medical reasons.
- purchase of speech aid equipment up to a maximum payment of $400 per person per lifetime.
- rental, or at Manulife Financial's option, purchase of a Seasonal Affective Disorder Unit, subject to a maximum of $300 per calendar year.
- removal of skin tags.
- Nambudripads Allergy Elimination Technique (NAET) to a maximum payment of $500 per calendar year, on the referral of a physician. NAET must be rendered by a certified NAET practitioner.

- purchase of an electric hospital bed at the member's request.

- Sclerotherapy, subject to a maximum of $50 per treatment.

- Cardiac Care/Rehabilitation Therapy, subject to a maximum of $500 per person per calendar year.

- Active Release Therapy, subject to a maximum of $500 per person per calendar year.

- Manual Lymph Drainage treatment for Lymphedema, subject to a maximum of $500 per person per calendar year.

Dental Services

- Dental treatment, including implants, for the repair of damage resulting directly from an accidental injury to natural teeth. The treatment must be rendered within 6 months following the accident, and your coverage, as well as the contract, must still be in force. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result. The accident must be the result of a direct accidental blow and not by an object wittingly or unwittingly placed in the mouth.

Professional Services

- Professional services of a physician (where this coverage is permitted by law). Treatment by a psychiatrist while not confined to a hospital, is subject to a maximum payment of $30 for each treatment.

- Charges for one medical check-up per calendar year (which is not eligible under the Provincial Health Plan), up to a maximum payment of $50.

- 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.

  Charges for the following services are not eligible:

  - service provided for custodial care, homemaking duties or supervision.

  - service performed by a nursing practitioner who is an immediate family member or 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.

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

- Services of any practitioner (such as a dermatologist) to administer laser treatment for rosacea, subject to a maximum of $250 per calendar year.

- Professional services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields) up to a total payment of $4,000 per person per calendar year for all practitioners combined:

  Psychologist, Speech Therapist, Massage Therapist, Hypnotherapist, Athletic Therapy, Reflexology, Nutritionist, Physiotherapist, Podiatrist/Chiropodist*, Chiropractor**, Osteopath**, Acupuncturist, Naturopath, Counsellor*** and Occupational Therapist.

  * Includes up to $100 for the surgical removal of toe nails or the excision of plantar warts. Routine footcare provided by a VON is considered eligible.

  ** Includes up to a total payment of $25 for one x-ray per calendar year.

  *** Only Services of a Counsellor with a Masters degree in Social Work or a Masters degree in Education with a major in counselling are eligible.

  Under some circumstances, benefits may not be payable until the government plan concerned has paid its yearly maximum. Check with your Plan Administrator if you require further details.

Hearing Aids

- Hearing aids, up to $1,000 for each hearing aid, per ear, per person in every 24 consecutive months

Referral Treatment

- Expenses incurred outside the claimant's province of residence for physicians' services, where permitted by law, for medically necessary treatment on the referral of a physician located in the member's province of residence, limited to reasonable and customary charges for the area in which the treatment is rendered, up to a maximum payment of $5,000 per person per calendar year.

Outside Canada Coverage

"Medical emergency" means a sudden, unexpected injury which occurs or an unforeseen illness which begins, while a covered person is travelling outside his normal province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the covered person is able to return to his normal province of residence.

In the event of a medical emergency which occurs while a claimant is travelling, vacationing or otherwise temporarily residing outside Canada, the following items will be considered as eligible expenses:

- Drugs, medicines, sera and injectables available only on a prescription* by a physician or dentist and dispensed by a pharmacist, dentist or a physician. Anti-smoking drugs are subject to a lifetime maximum of $300 per person. Fertility drugs will be payable at 12 cycles per drug, limited to a lifetime maximum of two fertility drugs. Sexual dysfunction drugs are subject to a maximum of $750 per person per calendar year.

**Those drugs which legally require a written prescription in order to be purchased.*

- Drugs and supplies of a non-prescription nature required as a result of a colostomy, cecostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease.

- Life sustaining drugs and antihistamines.

- Charges for oral contraceptives, intrauterine devices and diaphragms.

The above drug coverage is subject to the following limitation regarding generic product substitution. Wherever an interchangeable generic product is available, but not dispensed, eligible expenses shall be limited to the cost of the lowest priced item in the appropriate generic category that is suitable for the drug that was dispensed. However, such limitation shall be subject to special authorization process.

- Hospital charges incurred as an out-patient for necessary medical and surgical treatment (excluding physician, where permitted by law)

- Professional services of a physician, where permitted by law.

- Diagnostic procedures, radiology, blood transfusions and oxygen (including the equipment necessary for its administration)

- Rental, or purchase of a wheelchair, crutches or canes.

- 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.

  Charges for the following services are not eligible:

  - service provided for custodial care, homemaking duties or supervision.

  - service performed by a nursing practitioner who is an immediate family member or 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.

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

- Transportation by a licensed ground ambulance services to and from the nearest medical facility for immediate treatment.

  If medically necessary, transportation by any form of licensed ambulance (including air ambulance) or by any vehicle normally used for public transportation, for:

  - transfer to the nearest appropriate medical facility or hospital for necessary treatment, and/or

  - medical evacuation for admission to hospital in the province where the patient normally resides.

Ground transportation to and from the hospital and airport, at the point of departure and arrival, is also eligible.

- Dental treatment for the repair of damage resulting directly from an accidental injury to natural teeth. The treatment must be rendered within 6 months following the accident, and your coverage, as well as the contract, must still be in force. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result. The accident must be the result of a direct accidental blow and not by an object wittingly or unwittingly placed in the mouth. This expense is subject to a maximum payment of $1,000 per person per lifetime.

- Professional services of the following licensed, certified or registered chiropractor, chiropodist/ podiatrist and physiotherapist, (while operating within their recognized fields of expertise). Benefits may not be payable until the provincial plan, where applicable, has paid its yearly maximum.

International Travel Assistance

International Travel Assistance is a travel assistance program available for you and your covered dependents. The assistance is delivered through an international organization, specializing in travel assistance.

The following assistance services are provided, when required as a result of a medical emergency which occurs while travelling outside your normal province of residence. The services are available during the period that the covered person is covered for the Outside Canada Coverage expense, provided under this benefit.

Medical Emergency Assistance

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your dependent) is travelling outside of his province of residence, or

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

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

- been treated or tested for any new symptoms or conditions

- had an increase or worsening of any existing symptoms

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

- been admitted to the hospital for treatment of the condition

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

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

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

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 covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this plan. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered 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 covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's normal province of residence. Expenses incurred for the medical transportation will be paid, as described under Eligible Expenses – Medical Transportation Services.

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

f) **Return of Dependent Children**

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

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

g) **Trip Interruption/Delay**

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

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

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

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

i) **Visit of a Family Member**

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

j) **Vehicle Return**

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

k) **Identification of Deceased**

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

l) **Meals and Accommodation**

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

Non-Medical Assistance

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

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his normal 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 Documentation and Ticket Replacement**

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

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-Trip Assistance Service**

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

g) **Link to 911**

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

h) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered 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 a covered person to obtain medical treatment or emergency assistance services for any reason.

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

How to Access International Travel Assistance - Your International Travel Assistance Card

Your International 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 International Travel Assistance card also lists your ID number and group policy number, which the travel assistance organization needs to confirm that you are covered by International Travel Assistance.

If you do not have an International Travel Assistance Card, please contact your Plan Administrator.

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.

Submit the claim to your employer for validation, and your employer will then forward it to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your coverage, 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.

Expenses not Covered

No payment will be made for expenses or for claims resulting from:

- For Outside Canada Coverage and International Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness.

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.

- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.

- Examinations required for the use of a third party.

- Travel for health reasons.

- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.

- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.

- Any charges for services, treatment or supplies:

    - for which there would be no charge except for the existence of coverage.

    - which are performed or provided by an immediate family member or a person who lives with the patient.

    - which are provided while confined in a hospital on an in-patient basis.

    - which are not specified as an Eligible Expense under this plan.

- Expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (Major Medical Eligible Expenses - Referral Treatment and Outside Canada Coverage). Such expenses incurred outside Canada on an elective basis are not payable.

- Drugs, sera, injectables and supplies which are not approved by Health and Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.

- Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.

- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.

- if you are a resident of the United States, no payment will be made for expenses incurred which, for Canadian residents, would be payable by, or insurable only by a government under any government plan or health coverage.

Extension of Benefits

If you are totally disabled when your Major Medical benefit terminates, benefits for such disability will be payable, as long as you remain disabled, up to a maximum period of 365 days after termination. However, coverage will terminate if you become eligible for coverage under another group plan.

If one of your covered dependents is hospitalized when your coverage terminates, then benefits will be payable in the same manner as your own or until your dependent is discharged from the hospital, whichever is earlier.

Extension of the Major Medical benefit will cease if the Contract should terminate.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and

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

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

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

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

a) **Benefit Percentage**

Prior to the Annual Out-Of-Pocket Maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

i) for any drugs on the RAMQ List which are 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 plan, 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; or
- the percentage as set out by the then applicable Legislation.

After the Annual Out-Of-Pocket Maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

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

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

i) deductible amounts, and

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

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

The Annual Out-Of-Pocket Maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

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

c) **Deductible**

Deductible amounts (if any) for the drug benefit will apply, until the Annual Out-Of Pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

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

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

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

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:

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

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

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

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

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

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

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

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

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

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

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

Pay Direct Drug Benefit

The Benefit

Overall Benefit Maximum - unlimited

Deductible - nil

Benefit Percentage (Co-insurance)

80% of the purchase price per item

Termination Age - upon your death

Waiting Period - none

Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. 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 the 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, or
- 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.

Eligible Expenses

- Drugs, medicines, sera and injectables available only on a prescription by a physician or dentist and dispensed by a pharmacist, dentist or a physician. Anti-smoking drugs are subject to a lifetime maximum of $300 per person. Fertility drugs will be payable at 12 cycles per drug, limited to a lifetime maximum of two fertility drugs. Sexual dysfunction drugs are subject to a maximum of $750 per person per calendar year.

Those drugs which legally require a written prescription in order to be purchased.

- Drugs and supplies of a non-prescription nature required as a result of a colostomy, cecostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease.
- Charges for oral contraceptives, intrauterine devices and diaphragms.
- Life sustaining drugs and antihistamines.

The above drug coverage is subject to the following limitation regarding generic product substitution. Wherever an interchangeable generic product is available, but not dispensed, eligible expense shall be limited to the cost of the lowest priced item in the appropriate generic category that is suitable for the substitution of the drug that was dispensed. However, such limitation shall be subject to special authorization process.

Expenses Not Covered

No payment will be made for the following items:

- items for which the cost is payable under any government plan or law.
- atomizers, appliances, prosthetic devices and first aid or diagnostic supplies, except for supplies described under above.

- condoms, contraceptive jellies or appliances normally used for contraception whether or not such prescription is given for a medical reason, except orally administered contraceptives.
- Vitamins (other than injectables) and dietary supplements whether or not such prescription is given for a medical reason, except where federal or provincial law requires a prescription for their sale.
- Proprietary and patent medicines which are:
  - defined as products registered under Division Ten of the Food and Drugs Act - Canada,
  - bear a general public (GP) number on their label, and
  - do not bear a drug identification number (DIN) on their label.
- Drugs used strictly for cosmetic purposes.
- Drugs for hair loss.

Dental Care

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

The Benefit

Deductible - nil

Dental Fee Guide - 2022 General Practitioners Dental Fee Guide or the minimum fee specified in the 2022 Denturist Fee Guide of your province of residence.

Benefit Percentage (Co-insurance)

80% for Basic expenses

80% for Major expenses

50% for Orthodontic expenses

Benefit Maximums

unlimited for Basic expenses

$3,500 per person per calendar year for Major expenses

$5,000 per lifetime for Orthodontic expenses

Termination Age - upon your death

Waiting Period - first day of the month following receipt of application

Eligible Expenses

Eligible expenses are those which are recommended as necessary by a physician or dentist and are not in excess of the Dental Fee Guide.

Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of his license.

There are several dental procedures which are covered by Provincial Health Plans up to certain maximums. If the dentist or dental surgeon chooses to charge more than the amount payable by the Provincial Plan, legislation in some provinces does not permit the excess charges to be eligible under this Plan.

Part I - Basic Services

- Complete oral examination of a new patient, once every 5 months
- Limited oral exam of a new patient
- Recall oral examination, once every 5 months
- Recall periodontal examination, once every 5 months
- Specific oral examination
- Emergency examination
- General periodontal examination
- Orthodontic examination
- Full mouth series, including bitewings, once every 5 months
- Single periapical film
- Each additional film to a total of fifteen
- One to four occlusal films, limited to six in any 5 month period
- One to four posterior bitewing films, limited to six in any 5 month period
- Extra Oral Films, in any 5 month period
- Temporomandibular joint films
- Panoramic film, one in any 12 month period
- One to five cephalometric films, limited to five in any 24 month period
- Interpretation of radiographs from another source.
- Pulp vitality tests
- Diagnostic photographs
- Diagnostic casts unmounted
- Diagnostic casts mounted
- Treatment planning
- Consultation with patient

- One unit of scaling and one unit of polishing (or prophylaxis {light scaling and polishing} when the service is performed in Quebec), once every 5 months
- Topical fluoride treatment, once every 5 months.
- Nutritional counselling
- Oral hygiene instruction/plaque control
- Finishing restorations
- Pit and fissure sealants:
- Protective athletic appliance, one in any 12 month period
- Space Maintainers
- Amalgam, silicate, acrylic and composite filings
- Retentive Pins
- Endodontic Treatment (i.e. The treatment of diseases of the dental pulp including root canal therapy.)
- Periodontic Treatment of diseases of the gums and other supporting tissue of the teeth including:

    - scaling not covered under Preventive Services, and root planing, up to a combined maximum of 16 units per calendar year;
    - provisional splinting; and
    - occlusal equilibration, up to a maximum of 8 units per calendar year.

    However, procedures for guided tissue regeneration are considered eligible only if performed in conjunction with the following periodontal surgical procedures: Flap approach or Osseous grafts – autografts or allografts, provided natural teeth are involved.

- Relining, rebasing or the repair of an existing denture or existing bridge.
- Diagnostic x-ray and laboratory procedures required in relation to dental surgery.
- General anaesthetic or conscious sedation required in relation to dental surgery.
- Surgical extractions, including extractions of impacted teeth.
- Simple alveolectomy (incision into tooth socket) at time of tooth extraction.
- Surgical removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess.

Part II - Major Services

- Tooth coloured or amalgam core, in conjunction with crown
- Prefabricated, metal (permanent teeth)
- Prefabricated, plastic (permanent teeth)

- Veneer application
- Metal inlay (three surfaces)
- Composite inlay
- Porcelain/Ceramic inlay
- Metal onlay (per tooth)
- Composite onlay
- Porcelain/Ceramic onlay
- Retentive pins for inlays, onlays and crowns
- Posts, cast metal
- Posts, prefabricated

Crowns (includes temporization):

- Plastics
- Plastic, transitional
- Porcelain/Ceramic
- Metal (full cast)
- Metal (3/4 cast) partial veneer
- Crown, made to existing denture

Prosthodontic Services:

Prosthodontic services for the replacement of an existing fixed or removable prosthesis will be considered if one of the following circumstances occurs:

a) replacement is necessitated by the extraction of additional natural teeth while covered under this plan.

b) the existing prosthesis is at least 3 years old and cannot be made serviceable.

c) the existing prosthesis is temporary and is replaced with a permanent prosthesis within 12 months of when the temporary one was installed.

- Complete denture
- Immediate complete denture
- Temporary complete denture
- Complete overdenture

- Immediate complete overdenture (inclusive)
- Temporary partial denture
- Immediate partial denture
- Partial overdenture (plastic)
- Partial free end
- Immediate partial free end
- Partial tooth borne
- Immediate partial tooth borne
- Partial opposing arch
- Partial overdenture (cast)
- Immediate partial overdenture (cast)
- Remake
- Pontics

Retainers - Crowns:

- Plastic/Acrylic
- Porcelain/Ceramic
- Metal cast

Retainers - Inlays and Onlays:

- Metal inlay
- Metal onlay
- Metal onlay (acid etch bonded)
- Abutment preparation
- Retentive pins
- Transplantation of erupted tooth
- Alveoloplasty
- Removal of bone, exostosis
- Gingivoplasty
- Vestibuloplasty

- Surgical incision and drainage
- Fractures, Reductions, Alveolar
- Replantation, repositioning
- Repairs, lacerations
- Antral surgery
- Adjunctive Services - Drugs

Part III - Orthodontic Services

- All necessary dental treatment which has as its objective the correction of malocclusion of the teeth.

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.

Extension of Benefits

Eligible expenses incurred after the date coverage ceased will not be reimbursed, regardless of whether or not a treatment plan has been filed with Manulife Financial, unless the expenses are the result of either of the following situations:

- An impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date coverage ceased and the denture, bridge, crown, inlay or onlay is installed within 30 days after the coverage ceased.
- Coverage ceased due to your death, and, within 90 days following the death, your dependent has dental work done which is part of a series of planned dental treatment which had begun, or for which definite dental appointments had been made, while you were living.

Submitting a Claim

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

Submit the claim to your employer for validation, and your employer will then forward it to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your coverage for any reason, all claims must be submitted no later than 90 days from the termination date.

Expenses not Covered

No payment will be made for expenses resulting from:

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.
- Examinations required for the use of a third party.
- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of coverage.
  - which are performed or provided by an immediate family member or a person who lives with the patient.
  - which are not specified as an Eligible Expense under this plan.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
- The replacement of an existing dental appliance which has been lost, mislaid or stolen.
- Dental services and supplies rendered for full-mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction.
- Treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, Manulife Financial will continue the Hospital, Drugs, Vision Care, Major Medical and Dental Care benefits until the earliest of:

- the date your dependent is no longer a dependent, according to the definitions of child and spouse (see Explanation of Common Insurance Terms),
- the date similar coverage is obtained elsewhere,
- for Dental, remarriage.

Long Term Disability

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

Definition of Totally Disabled

For the first twenty-four (24) consecutive months of benefit payment, “Totally disabled” shall mean that you:

- have a disease, disorder, or injury that can be diagnosed and demonstrated by objective and/or medically determinable standards, and;
- have impairments of physical and/or mental functioning caused by that disease, disorder, or injury which impairments are measurable by objective and medically accepted examination and/or investigation, techniques.

The impairments referred to in the bullet above must be such that they cannot be reasonably accommodated by your employer and they must result in your inability to perform any and every duty of your occupation (irrespective of the availability of employment).

After such 24 months, “totally disabled” as defined above shall mean your inability to perform any and every duty or any occupation (irrespective of availability of employment) for which you are reasonably qualified by education, training or experience.

Benefits will be payable for each month or partial month that such total disability continues beyond the applicable qualifying disability period. Benefits will not be payable for more than the applicable maximum benefit period.

The Benefit

Benefit Amount - 60% of your monthly earnings as of the date your disability commenced

Non-Evidence Limit - not applicable

Qualifying Period - 180 days or the duration of accumulated sick leave, whichever is greater

- Benefits are payable from the end of the Qualifying Period. Benefits are not payable during the Qualifying Period.
- You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Maximum Benefit Period - to age 65

Termination Age - to age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period - none

Entitlement Criteria

To be entitled to Long Term Disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period, and
- you must be under the continuing care of a physician.

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

Amount of Disability Benefits Payable

The Benefit Amount will be reduced by any benefit or payments you receive or are entitled to receive from the following sources for the same or related disability:

- Income payable to the member under the Teachers' Pension Act of the Province of New Brunswick.
- Benefits payable under any workers' compensation act.
- Disability benefits payable under the Canada/Quebec Pension Plan, excluding benefits payable on behalf of your dependents.

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

- Disability benefits payable under any other group, association or franchise insurance plan, but excluding payments for one-time retirement allowances.
- Retirement or pension benefits provided by an employer and/or a government.
- Earnings or payments from any employer.
- Disability and income replacement benefits payable under any government plan (excluding Employment Insurance Benefits).
- Disability benefits payable under the Canada/Quebec Pension Plan, payable to you on behalf of your dependents.
- Income replacement indemnity payable under any plan of automobile insurance.
- Earnings recovered through a legally enforceable cause of action against some other person or corporation (in accordance with provisions under Third Party Liability). Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Public Pension Plans

The Benefit Amount will not be affected by changes in your Canada or Quebec Pension Plan benefit unless the changes result from:

- A correction due to an error made when your award was originally determined.
- A change of 10% or more in the benefit formula under the government plan.
- A change in dependent status (where applicable).

The Benefit Amount will not be reduced by disability benefits payable under a public pension plan (CPP/QPP) until actual determination of the award has been made, if, at the time you submit your claim, you sign an agreement to reimburse Manulife Financial.

Otherwise, CPP/QPP benefits which have not been determined by the time your benefit is payable will be estimated and deducted from your monthly benefit. Adjustments to correct such payments will be made after the award has been determined.

Cost of Living Adjustment

After two full years of total disability, and annually thereafter, you are eligible for a Cost Of Living Adjustment. Increases will commence with your January payment. Your initial Benefit Amount will be increased by benefits equal to the change in the Consumer Price Index, or 3% whichever is less.

Immediately following commencement of cost of living benefits, your benefit payment will be adjusted to reflect any changes in the Consumer Price Index for the previous 12 months ending January 1st, to a maximum of 10% during the total benefit period.

The adjustment used to determine the cost of living benefit in any particular year will be the higher of the adjustment reached in the current year or that reached in any previous year. Should the Consumer Price Index decrease, your monthly benefit will remain at its present level.

Third Party Liability

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

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

Tax Status of Benefits

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

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

Rehabilitation

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

In order to participate in a Rehabilitation program not developed by Manulife Financial, Manulife Financial must approve the program.

Although most income reduces your benefit payment, for up to 24 months only half of your income from a Rehabilitation program will be used to reduce your payments.

While earning income from a Rehabilitation program, your income from all sources cannot be greater than 100% of your net earnings prior to your disability.

Cessation of Benefit Payments

Your monthly payments will cease on the earliest of the following events:

- The date you are no longer totally disabled.
- The date you reach age 65. However, should you complete the qualifying period after your 64th birthday but prior to your 65th birthday, the monthly income payments will continue beyond age 65 as long as you are totally disabled, subject to a maximum of 12 monthly payments.

- The date you fail to undergo, when requested by Manulife Financial, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by Manulife Financial.

- The date you are incarcerated in a prison or mental institution by authority of a criminal court.

- The date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program or alcoholism, drug addiction or substance abuse treatment program when recommended by Manulife Financial.

- The date you refuse to complete and return a Reimbursement Agreement/Direction form or comply with the terms of a signed Reimbursement Agreement/Direction form, when requested, in accordance with the provisions under Third Party Liability.

- The date you die.

- The date you retire.

Recurrent Disabilities

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

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

If you become Totally Disabled from a different and unrelated cause within 180 days immediately following the period for which you received benefits for a previous disability, you will only have to satisfy a 14 day qualifying period.

Waiver of Premium

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

Extension of Benefits

Long Term Disability benefits will extend beyond your termination date provided you became disabled while you were still insured. Benefits will continue to be paid according to the contract provisions regardless of the subsequent termination of the Group Policy.

Manulife Financial reserves the right to request proof of the continuance of total disability, and to require you to submit to an examination by Manulife Financial's medical advisors when requested.

Submitting a Claim

To submit a claim, you must complete the Long Term Disability 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 to Manulife Financial within 6 months from the end of the Qualifying Period.

Exceptions and Limitations

Disability Income is not payable for the following:

- A disability during which the member is not under treatment by a physician.
- A disability caused by self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.
- A disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot.
- A disability which is the direct or indirect result of committing a criminal offense.

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for benefits at any time when you are on pregnancy leave of absence or could be placed on such leave by your employer in accordance with relevant government legislation or the leave agreed upon by you and your employer.

Critical Illness Benefits

Please refer to your **Critical Illness Member Brochures** for more details on this benefit.

Note: All Optional and Spousal Benefit Types will match to the Basic Benefit Types. For instance, if your Basic Benefit Type is Primary, then your Optional and Spousal Benefit Type will be Primary too. If your Basic Benefit Type is Comprehensive, then your Optional and Spousal Benefit Type will be Comprehensive.

Member Critical Illness Insurance

For Active Members Only

If, while you are insured for this benefit, you are diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Basic Critical Illness benefit. You must have survived your illness for 30 days or more past the date you were first diagnosed. We will evaluate your claim using the Entitlement Criteria.

The Benefit

Benefit Type - Comprehensive

Benefit Amount - $10,000

Termination Age - your benefit terminates at the earlier of age 75, your retirement or your Critical Illness benefit is paid out in each of the 4 Multiple Event Coverage Groups

Waiting Period - none

Member Optional Critical Illness Insurance

If, while you are insured for this benefit, you are diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Member Optional Critical Illness benefit. You must have survived your illness for 30 days or more past the date you were first diagnosed. We will evaluate your claim using the Entitlement Criteria.

The Benefit

Benefit Type - Comprehensive

Benefit Amount - increments of $10,000, to a maximum of $300,000 (minimum benefit of $10,000)

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, for Active Members, evidence of insurability will be waived for an amount which is $50,000 or less if applied for within 31 days of the date eligible.

Termination Age - your benefit amount reduces by 50% at your age 65, to a maximum of $50,000 for Active Members, $20,000 for Retired Members (minimum benefit of $10,000), and terminates at the earlier of age 75, or your Critical Illness benefit is paid out in each of the 4 Multiple Event Coverage Groups. The reduced maximum cannot be increased at a later date.

Waiting Period - none

Spousal Critical Illness Insurance

If, while you are insured for this benefit, your spouse is diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Spousal Critical Illness benefit. Your spouse must have survived his or her illness for 30 days or more past the date he or she was first diagnosed. We will evaluate your claim using the Entitlement Criteria.

The Benefit

Benefit Type - Comprehensive

Benefit Amount - increments of $10,000, to a maximum of $300,000 (minimum benefit of $10,000)

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, for Active Members, evidence of insurability will be waived for an amount which is $50,000 or less if applied for within 31 days of the date eligible.

Termination Age - your spouse’s benefit amount reduces by 50% at your spouse’s age 65, to a maximum of $50,000 for spouse’s of Active Members, $20,000 for spouse’s of Retired Members (minimum benefit of $10,000), and terminates at the earlier of your or your spouse’s age 75, or your Spousal Critical Illness benefit is paid out in each of the 4 Multiple Event Coverage Groups. The reduced maximum cannot be increased at a later date.

Waiting Period - none

Child Critical Illness Insurance

If, while you are insured for this benefit, your child is diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Child Critical Illness benefit. Your child must have survived his or her illness for 30 days or more past the date he or she was first diagnosed. We will evaluate your claim using the Entitlement Criteria.

The Benefit

Benefit Type - Comprehensive

Benefit Amount - $10,000 each child

Termination Age - your benefit terminates at the earlier of your age 75, your child's limiting age as specified under Definitions or your Child Critical Illness benefit is paid out

Waiting Period - none

Explanations of Terms Associated with Critical Illness Benefits

Child

you or your spouse's natural or legally adopted child, or stepchild who:

- is insured under the provincial plan;
- is unmarried;
- is not employed on a full-time basis;
- is not eligible for insurance as a member under this or any other group policy;
- relies on you for financial support; and
- under age 21, or under age 27 if a full-time student.

Immediate Family Member

an Immediate Family Member is a person who is:

- the Member; or
- the Member's Spouse or Child.

Member

the person having the primary relationship with the policyholder and:

- for an active member:
  - is one of the following:
    - a Member of the New Brunswick Teachers' Association or l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick;

    - an associate member of the New Brunswick Teachers' Association or l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick; and

    - a Member of the New Brunswick Teachers' Association, l'Association des enseignantes et des enseignants francophones du Nouveau-Brunswick, the New Brunswick Teachers' Federation, the NBTF Group Insurance Trust Fund or the NBTA Credit Union.

  - is at least 18 years old but less than 75 years old;

  - is directly employed by the policyholder on a permanent and full-time basis;

  - is compensated for services by the policyholder; and

  - is residing in Canada or the United States.

- is retired and is a resident of Canada or the United States.

Physician

a doctor of medicine, licensed to practice medicine in the place in Canada where the services are provided.

Spouse

a Spouse is your legal spouse, or the person who has, for at least 12 months, been continuously living with you in a role like that of a marriage partner, who is insured under the provincial plan. The spouse you indicate on your application for Spousal Critical Illness Insurance will be the only one spouse eligible for Spousal Critical Illness Insurance under this policy. For this coverage, we will not consider a person you have divorced, a person cohabiting with you who is not in the role of a marriage partner, or a person you are separated from, (regardless of whether or not there is a court order or formal separation agreement).

Entitlement Criteria

Manulife Financial will apply the following criteria in determining your entitlement to Critical Illness Benefits:

- Manulife Financial receives medical evidence documenting your diagnosis of a covered Critical Illness condition;

- the diagnosis of any Critical Illness is made by a Physician, practicing medicine in Canada in a specialty relating to the applicable Critical Illness.

At any time, Manulife Financial may require you to submit to a medical examination or evaluation by an examiner selected by Manulife Financial.

Critical Illness Covered Conditions

Further detail on these conditions is available in the Covered Critical Illness Conditions Appendix.

Covered Critical Illness conditions are outlined in the Table at the end of this booklet.

Further detail on these conditions is available in the Covered Critical Illness Conditions Appendix.

Multiple Event Coverage Benefit

Not applicable to Child Critical Illness

This benefit is designed to provide a payout in the event that you or your spouse is diagnosed with two or more of the Covered Critical Illness Conditions. Each condition is assigned to one of the four Multiple Event Coverage Groups specified below. You and your spouse may claim once for a Covered Critical Illness under each of the Multiple Event Coverage Groups. You and your spouse may not claim more than once in any coverage group.

In order to be eligible for a Multiple Event Benefit payment, you or your spouse must be:

- for active members, declared stable and have been Actively at Work for a period of at least 60 consecutive calendar days following the date of diagnosis of the initial critical illness diagnosis; and

- for retired members, declared stable for a period of at least 365 consecutive calendar days following the date of diagnosis of the initial critical illness diagnosis.

If your spouse is not employed, then he must not have any physical or mental conditions that would prevent him from being employed if he chose to engage in an occupation.

Multiple Event Coverage Groups

- Cancer and Benign Brain Tumour

- Stroke, Heart Attack, Coronary Artery Bypass Surgery, Heart Valve Replacement, Aortic Surgery, Dilated Cardiomyopathy, Loss of Speech, Coma, Paralysis, Motor Neuron Disease, Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Primary Pulmonary Hypertension, Loss of Independent Existence, Bacterial Meningitis and Muscular Dystrophy

- Kidney Failure, Major Organ Transplant, Major Organ Failure on Waiting List, Aplastic Anemia, Blindness and Fulminant Viral Hepatitis

- Deafness, Severe Burns, Loss of Limbs and Occupational HIV Infection

Conversion Privilege

If you are under age 65 and your Group Benefits terminate, you may be eligible to convert the Critical Illness Insurance on you and/or your dependents to a Personal Critical Illness policy, without medical evidence. You must apply for the coverage within 31 days of the termination of your Critical Illness Insurance. If you are diagnosed with a covered Critical Illness condition during this 31-day period, the amount of Critical Illness Insurance available for conversion will be payable, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator.

Submitting a Claim

To submit a Critical Illness Insurance claim, the person must have survived their illness for 30 days or more past the date they were first diagnosed.

For all Critical Illness coverage, we will need to receive your completed claim form within 90 days of date of diagnosis of the Critical Illness.

You can obtain a claim form directly from the **Forms and Brochures** section on the Manulife Financial Group Benefits Member Internet Site. Otherwise, you can get a form from your Plan Administrator.

The form shows all of the necessary documents you need to submit to support your claim.

Exclusions

No benefits are payable for any Critical Illness related to:

- any specific exclusions associated with a given condition set out in the Covered Critical Illness Conditions Appendix
- self-inflicted injuries or illnesses
- abuse of addictive substances, including drugs and alcohol
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury
- taking a poisonous substance or inhaling toxic gases or fumes
- a situation where your child is born and diagnosed with a condition within the first ten months of the effective date of child coverage
- for active members, a pre-existing condition incurred or diagnosed during the first 12 months prior to the effective date of coverage or latest reinstatement of coverage. This limitation applies whether or not the insured person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement.

  A pre-existing condition is an illness or injury for which the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication - or where treatment would have been received by a prudent individual - during the 12 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness Benefit.

- for retired members, a pre-existing condition incurred or diagnosed during the first 24 months prior to the effective date of coverage or latest reinstatement of coverage. This limitation applies whether or not the insured person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement.

  A pre-existing condition is an illness or injury for which the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication - or where treatment would have been received by a prudent individual - during the 24 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness Benefit.

- cancer or benign brain tumour if within the **first 90 days** of your coverage effective date you have any of the following:

  - signs or symptoms that lead to a diagnosis of cancer or benign brain tumour, regardless of the date when the diagnosis is made

  - medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or benign brain tumour, regardless of when the diagnosis is made

  - a diagnosis of cancer or benign brain tumour

Group Critical Illness Covered Conditions	You and your spouse	Your child
Alzheimer's Disease	X	X
Aortic Surgery	X	X
Benign Brain Tumour	X	X
Blindness	X	X
Cancer (Life-Threatening)	X	X
Coma	X	X
Coronary Artery Bypass Surgery	X	X
Deafness	X	X
Heart Attack (Myocardial Infarction)	X	X
Heart Valve Replacement	X	X
Kidney Failure (End Stage Renal Disease)	X	X
Loss Of Limbs	X	X
Loss Of Speech	X	X
Major Organ Failure On Waiting List For Transplant	X	X
Major Organ Transplant	X	X
Motor Neuron Disease	X	X
Multiple Sclerosis	X	X
Occupational HIV Infection	X	X
Paralysis	X	X
Parkinson's Disease	X	X
Severe Burns	X	X
Stroke (Cerebrovascular Accident)	X	X
Autism		X
Cerebral Palsy		X
Congenital Heart Disease (for which corrective surgery has been performed)		X
Cystic Fibrosis		X
Down Syndrome		X
Muscular Dystrophy		X
Type 1 Diabetes Mellitus		X

Basic and Voluntary Accidental Death & Dismemberment

Policy No.: BSC 9424810
Policy No.: PAI 9424811

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences, even for a two income family. A serious injury may prevent you and your loved ones from meeting your financial obligations. And your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer has provided for you Accident Insurance coverage. And your employer is also offering you through the benefit of group buying power, the opportunity to purchase simple and affordable Personal Accident Insurance coverage. Both coverages are underwritten by AIG Insurance Company of Canada. Each policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident or if you or your eligible insured dependants should suffer loss of life, or 'living benefits' should a covered accident result in paralysis or loss of use of a limb, sight, speech or hearing.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

How It Works

Under the Basic Accident Insurance BSC 9424810

You are automatically covered if you are an active member or retired member of the Policyholder, under the age of 70. You are insured for an amount of $50,000.

Under the Voluntary Accidental Insurance PAI 9424811

You choose a Principal sum amount for yourself and your eligible Dependents, which is set out on your application to enroll. You are eligible to enroll if you belong to one of the following classes:

Class I: All active members or retired members of the Policyholder, under the age of 70
.
Class II: All Class I Members, their Spouses and eligible Dependent Children.

For a Principal amount of:

Class I: a minimum of $ 10,000 and a maximum of $ 500,000 in units of $ 10,000
Class II: a minimum of $ 10,000 and a maximum of $ 500,000 in units of $10,000

If the insured Member enrolls for Family coverage and the Insured has:

(a) a spouse only with no Dependent Children, the Spouse's Principal sum is 60% of the Insured Member's Principal sum; or
(b) a spouse with Dependent Children, the spouse's Principal sum is 50% of the Insured Member's Principal sum and each Dependant Child's Principal sum is 15% of the Insured Member's Principal sum; or

(c) dependent Children with no spouse, each Dependant child's Principal sum is 20% of the Insured Member's Principal sum.

Definitions

"Insured Member" means you, if you are an active member of the Policyholder who is under the age of 70.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation under the Basic Accident Insurance BSC 9424810

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Beneficiary Designation under the Voluntary Accidental Insurance PAI 9424811

You may designate a beneficiary to receive the amount payable under this policy in case of your accidental death. If there is no written designation then the benefit will be paid to your estate. The amount payable for the loss of life of your insured dependents is payable to you.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses

Loss of life……..The Principal Sum
Loss of both hands or both feet……..The Principal Sum
Loss of entire sight of both eyes……The Principal Sum
Loss of one hand and one foot……...The Principal Sum
Loss of one hand and the entire sight of one eye .....The Principal Sum
Loss of one foot and the entire sight of one eye……..The Principal Sum
Loss of one arm or one leg……Four-fifths of the Principal Sum
Loss of one hand or one foot……Three-quarters of the Principal Sum
Loss of the entire sight of one eye……..Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand…….One-third of the Principal Sum

Loss of speech and hearing……The Principal Sum
Loss of speech or hearing……Three-quarters of the Principal Sum
Loss of hearing in one ear……Two-thirds of the Principal Sum
Loss of four fingers of one hand……One-third of the Principal Sum
Loss of all toes of one foot……One-quarter of the Principal Sum

Loss of Use
Loss of use of both arms or both hands……The Principal Sum
Loss of use of one hand or one foot……Three-quarters of the Principal Sum
Loss of use of one arm or one leg……Four-fifths of the Principal Sum

Paralysis
Quadriplegia (total paralysis of both upper and lower limbs) .....
Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs) .....
Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body).....
Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.
"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Permanent and Total Disability Indemnity
If you suffer an injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable for the same loss. Permanent and Total Disability means that as a result of an injury, you are unable to perform at least two of the Activities of Daily Living described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

Activities of Daily Living are:

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $20,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $25,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit

Pays a benefit of up to $20,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $20,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Felonious Assault Benefit
Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.

Serious Illness Benefit (Non-Cancer)
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson's Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Coma Benefit
Pays a monthly benefit of 1% of your Principal Sum for a maximum of 100 months after 6 months in a continuous coma caused by an accident. Please see the Policy for details.

Burn Benefit
Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the Policy for details.

Common Disaster Benefit (under the Voluntary Accidental Death and Dismemberment Only)
If you and your Insured Spouse both are injured in the same accident and both die within 90 days of the accident as a direct result of such injuries, your Spouse's Principal Sum amount will be increased to equal yours.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage
Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Extended Family Coverage
If you die, the coverage of your insured Spouse and/or insured Dependent Children will continue for up to 6 months, subject to payment of premium.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:

(i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
(ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
(iii) riding as a passenger in an aircraft owned or leased by the Policyholder;

(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date under the Basic Accident Insurance BSC 9424810

Your coverage begins on the date you satisfy the definitions of “Insured Member”.

Effective Date under the Voluntary Accidental Insurance PAI 9424811

Coverage for an Insured Member, Spouse, or Dependent Child begins on the latest of: (1) the policy effective date; (2) the first day of the month following receipt of your completed application by your Human Resources Department; or (3) the date such person satisfies the definition of “Insured Member”, “Spouse” or “Dependent Child”.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Member; or

4. the first day of the month following the date you no longer belong to an Eligible Class of Members as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.