

City of Toronto - Active Employees

Your Group Benefits Program:

Your Group Benefits Program is comprised of two sections:

- **Part I: Your Group Benefits Program**
 - A description of your general benefit provisions, including definitions and procedures for submitting claims.
- **Part II: Summary of Your Group Benefits**
 - A summary of your specific benefits, including Extended Health Care and/or Dental maximums.

Both Sections should be read carefully and are meant to be taken in conjunction with each other.

City of Toronto

Group Contract Numbers: GL & GH 39882, GL 39883, ASO 85900, ASO 85901 and ASO 85902

Employee Name: _____

Certificate Number: _____

Welcome to Part I: Your Group Benefits Program

Group Contract Effective Dates:

Employee Life, Accidental Death & Dismemberment, Hospital, Major Medical, Dental:
August 1, 2000

Long Term Disability: June 1, 2000

Employee Optional Life, Spousal Optional Life, Child Optional Life: July 20, 2005

As a valued employee, you are entitled to the medical and financial security of your Group Benefit Program, provided by City of Toronto 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.

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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 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 Hospital, Major Medical, Dental, and Long Term Disability Benefits are provided directly by City of Toronto. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of City of Toronto. The information in this booklet is a summary of the provisions of the Group Contract. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of City of Toronto and Manulife Financial are governed by the paper version of the Group Contract (available from your Plan Administrator). In the event of a discrepancy between this booklet (paper or electronic version) 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.

The benefits contained in this booklet are subject to the TCEU Local 416 Collective Agreement for Full Time Employees.

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

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

Explanation of Common Terms

Automobile	Automobile a motorized land vehicle which does not operate on rails or crawler treads, not including a two-wheeled vehicle, farm-type tractor, or any equipment which is primarily designed for off-road use.
Benefit year	Benefit year January 1st to December 31st.
Child(ren)	Child(ren) you or your spouse/partner's unmarried children who are: dependent on you for support; under age 21 (up to age 25 if evidence is supplied that the child is a full-time student and entirely dependent on you for support); incapable of self-support due to a physical or mental disability which began before age 21 (before age 25 if evidence is supplied that the child was a full-time student and entirely dependent on you for support at the time the disability began).
Deductible	Deductible the amount of eligible expenses for which you are responsible prior to consideration of payment of benefits.
Dependent	Dependent your Spouse or Child who are residing in Canada.
Drug	Drug medications that have been approved for use by the Federal Government of Canada and have a Drug Identification Number.
Earnings	Earnings for Full-time Employees, your gross earnings excluding bonus, commissions and overtime. for Part-time Employees, your average salary for the last 26 pay periods, excluding bonus, overtime and incentive pay.
Immediate family member	Immediate family member you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.
Medically necessary	Medically necessary broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Explanation of Common Terms

Spouse

a person who either:

Spouse

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

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 1 year:

- for Employee Life, Accidental Death & Dismemberment and Spousal Optional Life, at the time a claim is incurred.
- for Hospital, Major Medical and Dental, at the time of application.

The term conjugal relationship shall be deemed to include a conjugal relationship between partners of the same sex.

for Accidental Death & Dismemberment, is under age 65.

Totally disabled

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.

Totally disabled

Why Group Benefits?

Why Group Benefits?

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

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

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

Your Group Benefit Program is provided by City of Toronto, in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

Your Plan Administrator

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

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

Your Plan Administrator is _____
Phone Number: (_____) _____ - _____

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

Applying for Group Benefits

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Benefits Enrolment/Information Change form, available from your Plan Administrator.

Making Changes

Making Changes

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

- change in Dependent Coverage
- change of Beneficiary
- change in Name
- applying for coverage previously waived
- change in Marital Status
- change in Co-ordination of Benefits information

Why Group Benefits?

To make such changes, you must complete the Benefits Enrolment/Information Change form, available from your Plan Administrator.

The Claims Process

How to Submit a Claim

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.

Payment of Hospital, Major Medical and Dental Claims

Payment of Hospital, 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 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, Major Medical and Dental Benefits

Co-ordination of Hospital, Major Medical and Dental Benefits

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

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

The Claims Process

If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.

If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:
The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent. In situations where you or your Dependent Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:
 - The Plan where the person is covered as an active full-time employee, then
 - The Plan where the person is covered as an active part-time employee, then
 - The Plan where the person is covered as a retiree.
- For Claims incurred by your Dependent Child:
The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
However, if you and your Spouse are separated or divorced, the following order applies:
 - The Plan of the parent with custody of the child, then
 - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
 - The Plan of the parent not having custody of the child, then
 - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

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 insured person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

The Claims Process

Submitting a Claim for Co-ordination of Benefits

Submitting a Claim for Co-ordination of Benefits

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

As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

Submit all necessary claim forms and original receipts to the Primary Carrier.

Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a full-time employee and work at least the required number of hours,
- are a part-time employee and work at least the required number of hours,
- are younger than the Termination Age,
- are residing in Canada and
- have completed the Waiting Period.

The Waiting Period may vary from benefit to benefit. For this information, please see the section entitled Your Benefit Plan Summary.

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.

Eligibility

Evidence of Good Health

Medical evidence is required when you apply for Employee Optional Life, Spousal Optional Life or Child Optional Life coverage, or for any increase in such amount.

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 Insurability form available from your Plan Administrator. Further medical evidence may be requested by Manulife Financial.

Evidence of Good Health

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days; or
- 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 after the date benefits terminated under your spouse's plan; or
- apply for coverage and benefits under your spouse's plan have not terminated.

Late Application

Who Qualifies for Coverage?

Late Dental Application

Late Dental Application

If you apply for coverage for Dental coverage for yourself or your dependents late, the amount payable under Basic and Major Services will be limited to \$100 for each covered person for the first 12 months of coverage. For Orthodontic Services, the amount payable will be limited to \$100 for each covered person for the first 3 years coverage is in force.

Effective Date of Coverage

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

Your dependent's coverage becomes effective on the date the dependent becomes eligible, or the date any required 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.

Your dependent's coverage will not be effective prior to the date your coverage becomes effective. This does not apply to Child/Spousal Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.

Termination of Coverage

Termination of Coverage

Your Group Coverage will terminate on the earliest of:

- the date you cease to be an eligible employee,
- the date your employment terminates,
- the date you enter the armed forces of any country on a full-time basis,
- the date the Group Contract terminates,
- the last day of the month in which you reach age 65 or retire, 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.

Your Group Benefits

Employee Life Insurance

If so specified in Your Benefit Plan Summary, if you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

Employee Life Insurance

The Benefit

Benefit Amount - as specified in the Summary of Your Group Benefits Program.

Employee Life Insurance - The Benefit

Termination Age - as specified in the Summary of Your Group Benefits Program.

Waiting period- as specified in the Summary of Your Group Benefits Program.

Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

Employee Life Insurance - Submitting a Claim

A completed claim form should be submitted as soon as reasonably possible.

Conversion Privilege

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

Employee Life Insurance - Conversion Privilege

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

Employee Optional Life Insurance

If so specified in the Summary of Your Group Benefits Program, if you die while insured, 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.

Employee Optional Life Insurance

The Benefit

Benefit Amount - as specified in the Summary of Your Group Benefits Program.

Employee Optional Life Insurance - The Benefit

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

Your Group Benefits

Termination Age - as specified in the Summary of Your Group Benefits Program.

Waiting period - as specified in the Summary of Your Group Benefits Program.

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

Submitting a Claim

To submit an Employee 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 you become totally disabled, coverage for your Employee Optional Life Insurance will continue without payment of premium, provided the following conditions are met:

Total disability commences while you are insured and before you reach age 65.

Total disability exists for at least 6 months.

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 Employee Optional Life Insurance will be waived from the premium due date coincident with or immediately following 6 months after the date you became totally disabled 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 policy, if you were not totally disabled.

The date you reach age 65.

The date of your death.

***Employee Optional Life
Insurance - Submitting
a Claim***

***Employee Optional Life
Insurance - Waiver of
Premium***

***Employee Optional Life
Insurance - Waiver Of
Premium Conditions***

Your Group Benefits

Conversion Privilege

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

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

Employee Optional Life Insurance - Conversion Privilege

Exception

If your Employee Optional Life coverage has been in force less than 1 year, no benefit will be payable if death results directly or indirectly from suicide while sane or insane.

Employee Optional Life Insurance - Exception

Spousal Optional Life Insurance

If so specified in the Summary of Your Group Benefits Program, if your spouse dies while insured, the amount of this benefit will be paid to you.

Spousal Optional Life Insurance

The Benefit

Benefit Amount - You may elect multiples of \$10,000, to a maximum benefit of \$200,000.

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

Termination Age - as specified in the Summary of Your Group Benefits Program.

Waiting period - as specified in the Summary of Your Group Benefits Program.

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

Spousal Optional Life Insurance - The Benefit

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.

Spousal Optional Life Insurance - Submitting a Claim

Your Group Benefits

Waiver of Premium

Spousal Optional Life Insurance - Waiver of Premium

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

Exception

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

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

Manulife Financial approved your evidence of insurability.

Conversion Privilege

Spousal Optional Life Insurance - Conversion Privilege

If your spouse's life insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Application for the individual policy must be made, and the first monthly premium paid, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Spousal 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.

Exclusions

Spousal Optional Life Insurance - Exclusions

If your Spousal Optional Life coverage has been in force less than 1 year, no benefit will be payable if death results directly or indirectly from suicide while sane or insane.

Child Optional Life Insurance

Child Optional Life Insurance

If so specified in the Summary of Your Group Benefits Program, the following will be covered:

Benefit Amount - \$20,000.

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

Termination Age - as specified in the Summary of Your Group Benefits Program.

Waiting period - as specified in the Summary of Your Group Benefits Program.

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

Your Group Benefits

Submitting a Claim

To submit a Child 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.

*Child Optional Life
Insurance - Submitting
a Claim*

Waiver of Premium

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

*Child Optional Life
Insurance - Waiver of
Premium*

Exception

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

at the time you applied for Child Optional Life Insurance on your child, you also provided Manulife Financial with evidence of insurability on yourself, and

Manulife Financial approved your evidence of insurability.

Exclusions

If your Child Optional Life coverage has been in force less than 1 year, no benefit will be payable if death results directly or indirectly from suicide while sane or insane.

*Child Optional Life
Insurance - Exclusions*

Accidental Death and Dismemberment

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

*Accidental Death and
Dismemberment*

The Benefit

Benefit Amount - as specified in the Summary of Your Group Benefits Program.

AD&D - The Benefit

Termination Age - as specified in the Summary of Your Group Benefits Program.

Waiting period - as specified in the Summary of Your Group Benefits Program.

Your Group Benefits

Schedule of Losses

AD&D - Schedule of Losses

A loss shown in the schedule is covered provided it:

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

Loss - Amount Payable

- Loss of Life - 100%
- Both hands or both feet - 100%
- Sight of both eyes - 100%
- One hand and one foot - 100%
- One hand and sight of one eye - 100%
- One foot and sight of one eye - 100%
- One arm or one leg - 75%
- One hand or one foot - 66 2/3%
- Sight of one eye - 66 2/3%
- Thumb and index finger of the same hand - 33 1/3%
- At least four fingers of the same hand - 33 1/3%
- All toes of one foot - 25%
- Hearing in both ears and speech - 100%
- Speech - 66 2/3%
- Hearing in both ears - 66 2/3%
- Hearing in one ear - 25%
- Use of both hands or both feet - 100%
- Use of one arm or one leg - 75%
- Use of one hand or one foot - 66 2/3%
- Hemiplegia - 200%
- Paraplegia - 200%
- Quadriplegia - 200%

Your Group Benefits

If you suffer more than one loss as a result of the same accident, the total benefit payable will not exceed the benefit amount except for hemiplegia, paraplegia or quadriplegia in which case the total benefit will not exceed 200% provided such benefit is paid while you are living.

No more than one loss, the largest, is payable for multiple injuries to the same limb.

Exposure and Disappearance

The benefit for a loss will also be payable if, as a result of an accidental injury, you suffer a loss due to unavoidable exposure to the elements of nature, within 365 days of the accident.

AD&D - Exposure and Disappearance

If as a result of the disappearance, wrecking or sinking of the conveyance in which you were riding at the time of an accident, you disappear and the body is not found within 365 days following the accident, the benefit for loss of life will be payable on the presumption of death due to the accident.

Air Travel

Death as a direct result of a covered accident related to air travel is covered provided the accident occurs while and in consequence of:

AD&D - Air Travel

- a) riding in, boarding or leaving, as a passenger: any aircraft having a current and valid certificate of airworthiness and piloted by a person who holds a current and valid license to pilot such aircraft.
- b) riding in, boarding or leaving as a passenger: any aircraft operated by the Canadian Armed forces or similar military service of any other recognized country.

Rehabilitation Expenses

If, as a result of an accidental injury, you suffer a loss and must participate in a rehabilitation program in order to qualify for employment, reimbursement will be made for reasonable and necessary expenses actually incurred within 3 consecutive years of the accident.

AD&D - Rehabilitation Expenses

The maximum benefit is \$10,000. Travelling, clothing and living expenses are not eligible.

Repatriation Expenses

If you should die as a result of an accidental injury which occurs while travelling 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred for preparation of the body and transportation to the first resting place nearest home.

AD&D - Repatriation Expenses

The maximum benefit is \$10,000.

Your Group Benefits

Family Transportation Expenses

AD& D - Family Transportation Expenses

If you suffer a loss as a result of an accidental injury and are confined to a hospital which is 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred by an immediate family member as follows:

For hotel accommodation in the vicinity of the hospital.

For transportation to and from the hospital. When transportation is by other than a vehicle licensed for fare-paying passengers, \$0.20 per kilometer will be payable.

The maximum benefit is \$1,500.

Dependent Education Expenses

AD& D - Dependent Education Expenses

If you should die as a result of an accidental injury, reimbursement will be made for tuition expenses actually incurred after your death for each child who is enrolled as a full-time student at an accredited institute of higher learning above the secondary school level. Post-secondary tuition expenses will also be paid for each child who is enrolled at the secondary school level, provided the child enrolls as a full-time student at an institute above the secondary school level within 365 days after your death.

The maximum benefit per child per year is the lesser of \$5,000, or 5% of your benefit amount, for a maximum of 4 years. Travelling, clothing and living expenses are not eligible.

Spousal Occupational Training Expenses

AD& D - Spousal Occupational Training Expenses

If you should die as a result of an accidental injury and your spouse requires formal occupational training in order to qualify for employment in an occupation for which your spouse is not sufficiently qualified, reimbursement will be made for reasonable and necessary expenses actually incurred for such a program within 3 years following the accident.

The maximum benefit is \$10,000. Travelling, clothing and living expenses are not eligible.

Seat Belt Benefit

AD& D - Seat Belt Benefit

If you die as a result of an accidental injury while driving or riding in an automobile, an additional amount equal to 10% of the Principal Amount as specified in the Summary of Your Group Benefits Program will be paid, provided all the following conditions are met:

The automobile is equipped with seat belts.

The seat belt was in actual use and properly fastened at the time of the accident.

The position of the seat belt is certified in the official report of the accident or by the investigating police officer.

Your Group Benefits

Day-Care Expenses

AD&D - Day Care Expenses

If you should die as a direct result of an accidental injury, reimbursement will be made for day-care expenses incurred after your death, for each dependent child who:

Is enrolled in a legally licensed day-care centre on the date of the accident, or

Enrolls in a legally licensed day-care centre within 365 days after the date of your death, and

Is under 13 years of age.

The maximum benefit per child per year is the lesser of \$5,000, or 5% of your benefit amount, for a maximum of 4 years. Travelling, clothing and living expenses are not eligible.

Home Alteration And Vehicle Modification Benefit

AD&D - Home Alteration And Vehicle Modification Benefit

In the event you sustain a loss (or loss of use) of both feet or legs or become a quadriplegic, paraplegic or hemiplegic, and the use of a wheelchair to be ambulatory is subsequently required, payment will be made for reasonable and necessary expenses actually incurred within 3 years of the date of the accident causing such loss, for:

The cost of alterations to your principal residence, and/or

The cost of modifications to one motor vehicle utilized by you when such modifications are approved by licensing authorities where required,

for the purpose of making them wheelchair accessible.

The maximum benefit is \$10,000.

Non-Duplication of Expenses

AD&D - Non-Duplication of Expenses

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

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

Your employer will provide the necessary claim forms. Proof of claim should be submitted within 90 days of the following events:

for losses shown in the Schedule of Losses, the date of loss.

for Reimbursement Expenses - the date the expense was incurred

Your Group Benefits

Exceptions

AD&D - Exceptions

No benefit will be payable for any claim arising as a direct or indirect result of:

Any loss contributed to or caused by an infection (except pyogenic infections from an accidental cut or wound), illness, disease, bodily or mental infirmity.

Suicide or self-inflicted injuries while sane or insane.

War, or any act of war, whether declared or not.

Service in the armed forces of any country which is in a state of war.

Riding in, boarding or leaving, or descending from, any aircraft if:

- you are the pilot, the operator, or a member of the crew.
- the aircraft is owned, operated or leased by or on behalf of the employer.
- the aircraft is piloted by an unlicensed person.
- the aircraft does not have a valid certificate of airworthiness.

Hospital

The Benefit

Hospital - The Benefit

The enclosed Summary of Your Group Benefits Program shows the benefits for which you are eligible, benefit amounts and other important information.

Eligible Expenses

Hospital - Eligible Expenses

Hospital Care:

Hospital charges in excess of the charges for standard ward accommodation, up to the hospital maximum shown in the Summary of Your Group Benefits Program, provided:

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

the accommodation was specifically elected in writing by the covered person.

Submitting a Claim

Hospital - 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. Alternatively, you may assign benefits through the hospital who will submit the bill directly 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.

Your Group Benefits

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

Hospital - Expenses Not Covered

No payment will be made for expenses resulting from:

Self-inflicted injuries or illness while sane or insane.

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.

A disability for which the person is not under the continuing care of a physician.

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.

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

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.

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.

For any services, treatments or supplies eligible under any workers' compensation plan, Manulife Financial will consider, where permitted to do so by law, the amount of an eligible expense over and above what is or would be payable by such plan.

Your Group Benefits

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

The enclosed Summary of Your Group Benefits Program shows the benefits for which you are eligible, benefit amounts and other important information.

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 ManuAssist expenses, paramedical practitioners under Professional Services and Prostate Specific Antigen (PSA) tests under Medical Supplies and 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.

Note: Coverage is subject to Reasonable & Customary limitations. Reasonable & Customary limitations on TCEU Local 416 benefit coverage is currently at arbitration. Should an award result in the discontinuance of Reasonable & Customary limitations, you will be notified accordingly.

Manuscript Prescription Drug Plan

Drugs or medicine that are dispensed by a licensed pharmacist and which, by law or convention, requires the written prescription of a physician. Smoking cessation medications are subject to the maximum specified in the Summary of Your Group Benefits Program.

Injectable medications.

Life-sustaining drugs.

Charges for the following expenses are not covered:

The administration of injectable medications.

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

Major Medical - The Benefit

Major Medical - Eligible Expenses

Major Medical - Manuscript Drug Plan

Your Group Benefits

Preventive

Charges for oral contraceptives, intrauterine devices and diaphragms.

Sclerotherapy, maximum of \$15 per treatment.

Charges for preventive vaccines and medicines (oral or injected).

Diabetic Supplies

The cost of standard syringes, needles and diagnostic aids, if required for treating diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

Payment of Eligible Expenses

The maximum amount for any eligible expense is the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

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

If so specified in the Summary of Your Group Benefits Program, the amount payable is subject to the reimbursement percentage for drugs.

No Substitution Prescriptions

Where a prescription contains a written direction for the physician or dentist that the prescribed drug or medication is not to be substituted with another product, the full cost of the prescribed products is covered if it is an eligible expense under this benefit.

The amount payable is subject to any deductible, drug dispensing fee maximum, and the reimbursement percentage for drugs, as specified in the Summary of Your Group Benefits Program.

If you are eligible for a ManuScript drug card (Pay Direct drug card):

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:

Your Group Benefits

- 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 the Group Benefits secure Internet site.

Drug Expenses

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

- a) the quantity prescribed by the physician or dentist, or
- b) a 34 day supply.

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

Medical Transportation Services

Licensed ambulance service provided in the covered person's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available.

Medical Supplies and Services

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

Rental of Medical Equipment

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

- a) Mobility Equipment: crutches, canes, walkers, and wheelchairs; and
- b) Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals.

Non-Dental Prostheses and Supports

Artificial eyes, limbs, and breast prostheses.

Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints.

Surgical stockings, up to a maximum of 4 pairs per benefit year.

Surgical brassieres, up to a maximum of 4 per benefit year.

*Major Medical - Medical
Transportation*

*Major Medical - Medical
Supplies and Services*

Your Group Benefits

Other Supplies and Services

Ileostomy, colostomy and incontinence supplies.

Oxygen.

Medicated dressings and burn garments.

Wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$300 per person per benefit year.

Charges for Prostate Specific Antigen (PSA) tests and CA 125 (Ovarian) tests, each test is limited to one test per person per benefit year, up to a maximum payment of \$30 per test.

Orthopaedic Shoes

Charges for the following expenses, when recommended by a physician, podiatrist or chiropractist:

stock-item orthopaedic shoes: and

modifications or adjustments to stock-item orthopaedic shoes or regular footwear.

The maximum benefit is as specified in the Summary of Your Group Benefits Program. No contractual maximum applies for dependent children age 18 and under.

**Major Medical -
Orthopaedic Shoes**

Custom-Made Shoes

Charges for custom-made shoes, to a maximum of 1 pair per two benefit years. Shoes:

- Must be constructed by a certified orthopaedic footwear specialist;
- Must be medically necessary; and
- Cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe.

No contractual maximum applies for dependent children age 18 and under.

**Major Medical -
Custom-Made Shoes**

Orthotics

Charges for casted, custom-made orthotics which are recommended by a physician, podiatrist or chiropractist, to a maximum of 1 pair per benefit year. No contractual maximum applies for dependent children age 18 and under.

**Major Medical -
Orthotics**

Your Group Benefits

Dental Services

Major Medical - Dental Services

Charges for the treatment of accidental injuries to the natural teeth or jaw. The accident must be due to a force or blow external to the mouth and have occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 12 months of the accident.

Injuries due to biting or chewing are not covered.

Professional Services

Major Medical - Professional Services

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.

Eligible expenses are subject to a maximum specified in the Summary of Your Group Benefits Program (if applicable).

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.
- services 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. You can then be advised of the amount you are entitled to receive under this benefit.

Professional services of licensed certified or registered paramedical practitioners, as specified in the Summary of Your Group Benefits Program, (when operating within their recognized fields) up to the maximum specified in the Summary of Your Group Benefits Program.

- The recommendation of a physician is not required for Professional Services, except for services of a Massage Therapist, as specified in the Summary of Your Group Benefits Program.
- Expenses for some of these Professional Services may be payable in part by Provincial Plans.
- If any of these services are covered by a provincial health plan, payment will be made by this plan after the provincial health plan's maximum for that benefit year has been reached.

Your Group Benefits

Hearing Aids

Charges for cost, installation, repair, and maintenance of a hearing aid or aids (including charges for batteries), up to the maximum specified in the Summary of Your Group Benefits Program (if applicable).

Major Medical - Hearing Aids

Vision Care

Purchase and fitting of prescription glasses or contact lenses, as well as repairs, or laser vision correction procedures and ocular examinations, including refractions, limited to one in any 24 consecutive months, up to the overall maximum specified in the Summary of Your Group Benefits Program (if applicable).

Major Medical - Vision Care

Laser eye surgery, up to the maximum specified in the Summary of Your Benefits Program. Further vision claims will not be allowed for 48 months following the date of the laser eye surgery.

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

Outside Canada Coverage

If so specified in the Summary of Your Group Benefits Program:

Major Medical - Outside Canada Coverage

Charges incurred for treatment required as a result of a medical emergency arising while temporarily outside the province of residence, provided that the covered person who received the treatment is also covered by the Provincial Plan during the absence from the province of residence.

“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.

Expenses are payable up to the maximum specified in the Summary of Your Group Benefits Program (if applicable).

For all emergency treatment given out of Canada other than medical treatment, Manulife Financial:

- a) requires that it be recommended as necessary by a physician practising in Canada, and
- b) suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

Manulife Financial will then advise you of any benefit that will be provided.

Your Group Benefits

Charges for the following are payable under this expense:

Physicians' services.

Hospital room and board at standard ward rates.

The cost of special hospital services.

Hospital charges for out-patient treatment.

Licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available.

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

Eligible Expense will be limited to reasonable and customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

Note: Coverage is subject to Reasonable & Customary limitations. Reasonable & Customary limitations on TCEU Local 416 benefit coverage is currently at arbitration. Should an award result in the discontinuance of Reasonable & Customary limitations, you will be notified accordingly.

All other charges incurred while outside the province of residence are payable under the appropriate Eligible Expense on the same basis as if they were incurred in the province of residence.

ManuAssist

***Major Medical -
ManuAssist***

If so specified in the Summary of Your Group Benefits Program, the following expenses will be eligible:

ManuAssist 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 Out-Of-Province Coverage expense, provided under this benefit.

Medical Emergency Assistance

"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.

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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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.

Health Advice And Assistance

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

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

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

b) **Medical Advice:**

Medical advice will be provided on:

- i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;
- ii) the type of side effect to expect from a prescribed drug or medicine;
- iii) other health related services that may be requested or required by the covered person.

c) **Link to 911:**

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

d) **Follow-Up Call:**

Where appropriate, to monitor the care of the 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.

Your Group Benefits

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 ManuAssist - Your ManuAssist Card

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

If you do not have a ManuAssist 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

***Major Medical -
Submitting a Claim***

Submit the claim 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 resulting from:

***Major Medical -
Expenses not Covered***

Self-inflicted injuries or illness while sane or insane.

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

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.

Your Group Benefits

Cosmetic surgery or treatment (when so classified by Manulife Financial) except,

- Sclerotherapy or
- 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 charge for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except as specified under Health Eligible Expenses - Out-of Province or Out-of-Canada Coverage. Such expenses incurred outside Canada on an elective basis or on the referral of a physician located in Canada 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.

For any services, treatments or supplies eligible under any workers' compensation plan, Manulife Financial will consider, where permitted to do so by law, the amount of an eligible expense over and above what is or would be payable by such plan.

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

Dental Care - The Benefit

If so specified in the Summary of Your Group Benefits Program, the following expenses are covered.

The enclosed Summary of Your Group Benefits Program shows the benefits for which you are eligible, benefit amounts and other important information.

Your Group Benefits

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

Recall Limitations:

The following services will be eligible for payment according to the Recall Limitations listed in the Summary of Your Group Benefits Program, unless specifically listed here:

- Oral examinations, once every 12 months
- One unit of scaling and one unit of polishing (or prophylaxis {light scaling and polishing} when the service is performed in Quebec)
- Topical fluoride treatment
- Preventive recall packages
- Bite-wing x-rays
- Oral hygiene instruction/reinstruction

Diagnostic Services:

Full mouth series of x-rays, as specified in the Summary of Your Group Benefits Program

Consultation required by the attending dentist

Periodontal exam, previous patient

Specific oral examination

Emergency examination

Radiographic Examination (X-ray):

Periapical films

Occlusal films

Extra oral films

Sinus examination

Sialography

Dental Care - Eligible Expenses

Dental Care - Part I - Basic Services

Your Group Benefits

Use of radiopaque dyes to demonstrate lesions

Temporomandibular joint films

Panoramic film

Tomography

Cephalometric films

Tracing of radiographs

Interpretation of radiographs from another source

Hand and wrist (as diagnostic aid for dental treatment)

Test and Laboratory Examinations:

Bacteriologic cultures for determination of pathologic agents

Dental caries susceptibility tests

Biopsy, soft-hard tissue

Cytological examination

Pulp vitality tests

Preventive Services:

Provision of space maintainers for missing primary teeth

Pit and fissure sealants

Interproximal discing of teeth

Finishing restorations

Restorative Services:

Amalgam, silicate, acrylic and composite fillings

If so specified in the Summary of Your Group Benefits Program, bonded amalgams

Emergency treatment of dental pain (minor)

Caries/pain control

Pin reinforcement

Prefabricated metal and polycarbonate restorations

Your Group Benefits

Part II - Supplementary Basic Services

*Dental Care - Part II -
Supplementary*

Periodontal Services:

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.

Special periodontal appliances including occlusal guards (excluding TMJ related problems)

Maintenance, adjustment and repair to periodontal appliances (excluding TMJ related problems)

Application of displacement dressing

Management of acute infections and other oral lesions

Desensitization of tooth surface

Post surgical treatment - 4 occurrences every benefit year

Gingival curettage

Gingivoplasty and/or stomatoplasty

Gingivectomy

Surgical Services:

The following items required in relation to dental surgery:

- Diagnostic radiographs
- Laboratory procedures
- General anaesthetic or conscious sedation

Extractions (including extractions of impacted teeth)

Simple alveolectomy at the time of tooth extraction

Removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess

Your Group Benefits

Removal of erupted tooth (uncomplicated):

- Single tooth
- Each additional tooth in same surgical site

Removal of erupted tooth (complicated)

Removal of impacted tooth

Removal of residual roots

Vestibuloplasty

Alveoloplasty

Osteoplasty

Surgical excision

Surgical incision

Fractures and Dislocations

Frenectomy

Other necessary oral surgical procedures not specifically listed above

Endodontic Services:

Treatment of the diseases of the dental pulp (including root canal therapy)

Apexification

Periapical services

Root amputation

Hemisection

Banding of tooth to maintain sterile operating field

Intentional removal, apical filling and reimplantation

Emergency procedures

Chemical bleaching, excluding home bleaching

Adjunctive Services:

Injection of antibiotic drugs when prescribed by a dentist

Your Group Benefits

Part III - Dentures

*Dental Care - Part III -
Dentures*

Relining rebasing, and repairing an existing denture.

Creation of an initial partial or full upper and lower denture.

Replacement of an existing partial or full upper and lower denture will be considered if one of the following circumstances occurs:

- The existing denture is at least the number of years old as specified in the Summary of Your Group Benefits Program and cannot be made serviceable.
- The existing denture is temporary and is replaced with a permanent denture within 12 months of the installation of the temporary denture.

Precision attachments to dentures (including denture realignment).

Part IV - Major Restorative Services

*Dental Care - Part IV -
Major Restorative*

Crowns, including gold and porcelain, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative materials. When crowns are rendered on molar teeth, only the cost of metal material will be considered. If metal cannot be used due to a covered person's allergy to metal, acrylic will be considered.

Onlays when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using Basic Services.

Inlays when 3 or more surfaces are involved and the tooth cannot be restored using basic restorative materials.

If only 1 or 2 tooth surfaces are involved, the inlay will be considered for reimbursement under Basic Services and payment will be determined based on the cost of a comparable amalgam or composite restoration.

Repairs and recementation to crowns.

Precision attachment to crowns.

Creation of an initial fixed bridge.

Repairing an existing fixed bridge.

Recementing of an existing fixed bridge.

Replacement of an existing fixed bridge will be considered if one of the following circumstances occurs:

- The existing bridge is at least the number of years old as specified in the Summary of Your Group Benefits Program and cannot be made serviceable.
- The existing bridge is temporary and is replaced with a permanent denture within 12 months of the installation of the temporary bridge.

Your Group Benefits

Part V - Orthodontic Services

Dental Care - Part V - Orthodontic Services

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

Provision of habit-breaking appliances.

Charges for diagnostic orthodontic casts, or the control of harmful habits (myofunctional therapy) are not included.

Alternate Treatment

Dental Care - Alternate Treatment

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

Pre-Determination of Benefits

Dental Care - Pre-Determination

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

Extension of Benefits

Dental Care - 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

Dental Care - Submitting a Claim

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

Submit the claim to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it. Alternatively, you may assign benefits through your dental office who will submit the bill directly 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 for any reason, all claims must be submitted no later than 90 days from the termination date.

Your Group Benefits

Expenses not Covered

***Dental Care - Expenses
not Covered***

No payment will be made for expenses resulting from:

Self-inflicted injuries or illness while sane or insane.

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.

Implants, or any services rendered in conjunction with implants.

For any services, treatments or supplies eligible under any workers' compensation plan, Manulife Financial will consider, where permitted to do so by law, the amount of an eligible expense over and above what is or would be payable by such plan.

In the event that optional procedures are possible, the procedure involving the lowest fee will be considered as the eligible expense provided it is consistent with good dental care.

Your Group Benefits

Long Term Disability

Long Term Disability

If so specified in the Summary of Your Group Benefits Program, 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

Long Term Disability - Definition of Totally Disabled

Totally disabled means you are wholly and continuously disabled due to illness or bodily injury and, as a result, you are not physically or mentally fit to perform the essential duties of your normal occupation during the Qualifying Period and the succeeding 24 months. After this time, you will still be considered totally disabled provided you are unable to perform the essential duties of your normal occupation and any other occupation:

for which you are, or may become fitted, by education, training and/or experience, and

for which the current monthly earnings are 75% or more of the current monthly earnings for your normal occupation.

The availability of such occupations, jobs or work will not be considered in assessing your disability.

Confinement is not normally required. However, you must be under the regular care of a physician, and be prepared to attempt rehabilitative employment, or participate in a rehabilitation program considered appropriate by Manulife Financial.

If you must hold a government permit or license to perform your duties you will not be considered totally disabled solely because such permit or license has been withdrawn or not renewed.

The Benefit

Long Term Disability - The Benefit

Benefit Amount - as specified in the Summary of Your Group Benefits Program.

Qualifying Period - as specified in the Summary of Your Group Benefits Program.

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

employees who become disabled prior to age 63 - to age 65

employees who become disabled on or after age 63 - 18 months aggregate payments for the period from the date of disability up to age 70 (including recurrent and successive periods of disability), but in no event beyond age 70

Termination Age - as specified in the Summary of Your Group Benefits Program.

Your Group Benefits

Waiting period - as specified in the Summary of Your Group Benefits Program.

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 benefits or payments you receive or are entitled to receive from the following sources for the same or related disability:

Disability benefits payable under the Canada/Quebec Pension Plan, excluding benefits payable on behalf of your dependents.

Earnings or payments from any employer.

Disability benefits payable under any other group, association or franchise insurance plan.

Disability and income replacement benefits payable under any government plan (excluding Employment Insurance Benefits).

Benefits payable under any workers' compensation act.

Retirement or pension benefits provided by an employer and/or a government.

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).

The benefit, as calculated, will be further reduced by any amount by which such benefit, plus the income from all sources just outlined (including Canada/Quebec Pension Plan Benefits payable to you on behalf of your dependents), exceeds 85% of your pre-disability earnings.

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

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.

**Long Term Disability -
Amount of Disability
Benefits Payable**

**Long Term Disability -
Public Pension Plans**

Your Group Benefits

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.

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.

If the income you receive from rehabilitative employment equals 75% or more of the current monthly earnings for your normal occupation, your benefit payments will cease. Otherwise, while earning income from a Rehabilitation program, your income from all sources cannot be greater than 100% of your earnings prior to your disability.

***Long Term Disability -
Third Party Liability***

***Long Term Disability -
Tax Status of Benefits***

***Long Term Disability -
Rehabilitation***

Your Group Benefits

Cessation of Benefit Payments

Long Term 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 end of the month coincident with or next following the date you reach age 65. However, should you complete the qualifying period after your 63rd birthday but prior to your 65th birthday, the monthly income payments will continue as long as you are totally disabled, subject to a maximum of 18 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 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 are incarcerated in a prison or mental institution by authority of a criminal court.

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 elect to receive early retirement benefits under a benefit plan related to your retirement.

Recurrent Disabilities

Long Term Disability - 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 cease to be Totally Disabled at any time during the Qualifying Period and become totally disabled again, due to the same cause, within 3 weeks, the Qualifying Period will be extended by the number of days during which you were not Totally Disabled.

Waiver of Premium

Long Term Disability - Waiver of Premium

If so specified in the Summary of Your Group Benefits, the premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

Your Group Benefits

Extension of Benefits

Long Term Disability - 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

Long Term Disability - 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

Long Term Disability - Exceptions and Limitations

Disability Income is not payable for the following:

A disability caused by self-inflicted injuries or illness.

A disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot.

A disability resulting from alcoholism, drug addiction, or the use of any hallucinogen, unless you are participating in a therapeutic program recognized by Manulife Financial and are under the continuous care of a medical specialist in this field.

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.

Your Group Benefits

City of Toronto - Active Employees

Divisional Description: TCEU Local 416 - Division 8

Group Contract Numbers: GL 39882, GL 39883, ASO 85900, ASO 85901 and ASO 85902

Part II: Summary of Your Group Benefits Program

Group Contract Effective Dates:

June 1, 2000:

Long Term Disability - ASO 85902

August 1, 2000:

Employee Life, Accidental Death & Dismemberment - GL 39882

Hospital, Major Medical - ASO 85900

Dental - ASO 85901

July 20, 2005:

Employee Optional Life, Spousal Optional Life, Child Optional Life - GL 39883

This section is a summary of the provisions of the Group Contract. In the event of a discrepancy between this section and the Group Contract (available from your Plan Administrator), the terms of the Group Contract will apply.

Summary of Your Group Benefits

Employee Life

The Benefit

Employee Life - The Benefit

Benefit Amount: 2 times your annual earnings rounded to the next higher multiple of \$1,000.

Termination Age - coverage will cease at the end of the month coincident with attainment of age 65 or retirement, whichever is earlier.

Waiting Period: - 6 months of continuous or aggregate service.

Employee Optional Life

The Benefit

Employee Optional Life

- The Benefit

Benefit Amount: you may elect multiples of \$10,000, to a maximum benefit of \$200,000

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

Termination Age - coverage will cease at the end of the month coincident with attainment of age 70 or retirement, whichever is earlier.

Waiting Period:

for employees who normally work 7 hours per day - 6 months of continuous service in a permanent position or 910 hours of employment.

for employees who normally work 8 hours per day - 1040 hours of employment.

Spousal Optional Life

The Benefit

Spousal Optional Life - The Benefit

Benefit Amount: you may elect multiples of \$10,000, to a maximum benefit of \$200,000.

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

Termination Age - coverage will cease the earlier of:

the end of the month coincident with the employee's attainment of age 65;

the spouse's attainment of age 65; or

the employee's retirement.

Summary of Your Group Benefits

Waiting Period:

for employees who normally work 7 hours per day - 6 months of continuous service in a permanent position or 910 hours of employment.

for employees who normally work 8 hours per day - 1040 hours of employment.

Child Optional Life

The Benefit

Benefit Amount: \$20,000.

***Child Optional Life
- The Benefit***

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

Termination Age - coverage will cease at the end of the month coincident with employee's attainment of age 65 or employee's retirement, whichever is earlier.

Waiting Period:

for employees who normally work 7 hours per day - 6 months of continuous service in a permanent position or 910 hours of employment.

for employees who normally work 8 hours per day - 1040 hours of employment.

Accidental Death & Dismemberment

The Benefit

Benefit Amount: 2 times your annual earnings rounded to the next higher multiple of \$1,000, if not already a multiple thereof.

***Accidental Death &
Dismemberment - The
Benefit***

Termination Age - coverage will cease at the end of the month coincident with attainment of age 65 or retirement, whichever is earlier.

Waiting Period: - 6 months of continuous or aggregate service.

Summary of Your Group Benefits

Hospital

The Benefit

*Hospital
- The Benefit*

Deductible - Nil.

Benefit Percentage (Co-insurance) - 100% of eligible expenses.

Overall Benefit Maximum - Expenses incurred inside your province of residence are not subject to an overall maximum. Hospital charges incurred outside your province of residence are subject to an overall lifetime maximum of \$5,000,000 per person, combined with the Major Medical benefit.

Termination Age - coverage will cease at the end of the month coincident with employee's attainment of age 65 or employee's retirement, whichever is earlier.

Waiting Period - 6 months of continuous or aggregate service.

Eligible Expenses

*Hospital - Eligible
Expenses*

Hospital Care: 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. Charges for any portion of the cost of ward accommodation, utilization or copayment fees (or similar charges) are not eligible.

Major Medical

Benefits are subject to Reasonable and Customary Fee Guides, established by the benefit carriers by compiling and studying the range of charges for comparable services in the same geographical area. Published Fee Schedules and Surveyed Responses from practitioners are utilized in establishing these amounts. The Reasonable and Customary Fee Schedule is updated annually by the benefit carrier.

Note: Coverage is subject to Reasonable & Customary limitations. Reasonable & Customary limitations on TCEU Local 416 benefit coverage is currently at arbitration. Should an award result in the discontinuance of Reasonable & Customary limitations, you will be notified accordingly.

Summary of Your Group Benefits

The Benefit

Deductible - Nil.

Benefit Percentage (Co-insurance) - 100% of eligible expenses.

Overall Benefit Maximum - Expenses incurred inside your province of residence are not subject to an overall maximum. Expenses incurred outside your province of residence are subject to an overall lifetime maximum of \$5,000,000 per person combined with the Hospital benefit.

Termination Age - coverage will cease at the end of the month coincident with employee's attainment of age 65 or employee's retirement, whichever is earlier.

Waiting Period - 6 months of continuous or aggregate service.

Eligible Expenses

Drugs and Medicines

Pay Direct Drug card.

Drugs available only by prescription.

Drugs other than compound drugs are subject to a maximum dispensing fee of \$9.

The maximum amount for any eligible expense is the price of the lowest cost generic equivalent product. Where a prescription contains written direction for the physician or dentist that the prescribed drug or medication is not to be substituted with another product, the full cost of the prescribed product is covered if it is an eligible expense under this benefit.

Smoking cessation medications - \$300 per person per benefit year.

Medical Supplies and Services

Non-Dental Prosthesis and Supports:

Charges for casted, custom-made orthotics, to a maximum of 1 pair per benefit year (recommendation of a physician, podiatrist or chiropodist is required). No contractual maximum applies for dependent children age 18 and under.

Charges for stock-item orthopaedic shoes, including modifications or adjustments to stock-item orthopaedic shoes or regular footwear, to a maximum of 1 pair per 2 benefit years (recommendation of a physician, podiatrist or chiropodist is required). No contractual maximum applies for dependent children age 18 and under.

Charges for custom-made shoes, to a maximum of 1 pair per two benefit years.
Shoes:

- Must be constructed by a certified orthopaedic footwear specialist;

Major Medical - The Benefit

Major Medical - Eligible Expenses

Summary of Your Group Benefits

- Must be medically necessary; and
- Cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe.

No contractual maximum applies for dependent children age 18 and under.

Other Supplies:

Charges for Prostate Specific Antigen (PSA) tests and CA 125 (Ovarian) tests, each test is limited to one test per person per benefit year, up to a maximum payment of \$30 per test.

Professional Services

Private duty nursing, \$25,000 in any 3 benefit years.

Services of the following paramedical practitioners up to the levels specified below for each such practitioner. Reasonable and customary charges will not apply.

- Chiropractor - \$400 per person per benefit year.
- Massage Therapist - \$400 per person per benefit year (recommendation of a physician or osteopath is required, once per benefit year).
- Osteopath - \$400 per person per benefit year.
- Podiatrist - \$400 per person per benefit year.
- Chiropodist - \$400 per person per benefit year.
- Speech Therapist - \$400 per person per benefit year.

Alternatively, for the above practitioners, an employee may elect to use one paramedical practitioner only, up to a maximum of \$800 per person per benefit year.

- Psychologist - \$300 per person per benefit year.
- Physiotherapist - \$2,000 per person per benefit year.

If any of these services are covered by a provincial health plan, payment will be made by this plan after the provincial health plan's maximum for that benefit year has been reached.

Hearing Aids

Hearing aids - up to \$1,600 per person per 3 benefit years.

Vision Care

Purchase and fitting of prescription glasses or contact lenses, as well as repairs, or laser vision correction procedures and ocular examinations, including refractions, limited to one in any 24 consecutive months, up to an overall maximum of \$450 per person in any 24 consecutive months.

If you have received laser vision correction procedures, you may elect to receive an advance payment of up to the maximum benefit from your next vision care period in addition to the maximum for the current period.

Summary of Your Group Benefits

Laser eye surgery, up to a lifetime maximum of \$450. Further vision claims will not be allowed for 48 months following the date of the laser eye surgery.

You may elect to combine your prescription glasses maximum with your laser eye surgery maximum, and apply this combined \$900 maximum to one instance of laser eye surgery per lifetime per person. Further vision claims will not be allowed for 48 months following the date of the laser eye surgery.

Out-of-Province or Out-of-Canada Coverage

Expenses incurred outside your province of residence or outside of Canada are eligible. Expenses incurred outside your province of residence are subject to the maximum specified under Overall Benefit Maximum.

ManuAssist

Medical assistance, when required as a result of a medical emergency, which occurs while travelling outside your normal province of residence.

Dental Care

The Benefit

Dental Care - The Benefit

Deductible - Nil.

Benefit Percentage (Co-insurance):

Part I (Basic Services) and Part II (Supplementary Basic Services) - 100%.

Part III (Dentures) - 70%

Part IV (Major Restorative Services) - 60%.

Part V (Orthodontics) - 50%.

Benefit Maximums:

Parts I (Basic Services) and II (Supplementary Basic Services) - Unlimited.

Parts III (Dentures) and IV (Major Restorative Services) - Maximum of \$4,000 per person per benefit year (for both Parts combined).

Part V (Orthodontics) - Lifetime maximum of \$4,000 per person.

Dental Fee Guide - Fee Guide in effect 1 year prior to the current General Practitioners Dental Fee Guide of the Province of Ontario.

Termination Age - coverage will cease at the end of the month coincident with employee's attainment of age 65 or employee's retirement, whichever is earlier.

Waiting Period - 6 months of continuous or aggregate service.

Summary of Your Group Benefits

Dental Care - Eligible Expenses

Eligible Expenses

Recall Limitations

- Once every 6 months for dependent children under age 18
- Once every 9 months for any other person

Full mouth series of films - Once every 2 benefit years.

Restorative Services - The following charges are covered under Part I Services and will be subject to the maximum specified under Benefit Maximums:

Amalgams

Dentures - The following charges are covered under Part III Services and will be subject to the maximum specified under Benefit Maximums:

Replacement of an existing denture which is at least 5 years old.

Creation of Initial denture and repair of an existing denture.

Bridges - The following charges are covered under Part IV Services and will be subject to the maximum specified under Benefit Maximums:

Replacement of an existing bridge which is at least 5 years old.

Creation of Initial bridge and repair of an existing bridge.

Long Term Disability

The Benefit

Benefit Amount - 75% of your monthly earnings as of the date your disability commenced, rounded to the next higher multiple of \$1, if not already a multiple thereof.

Maximum Benefit Period

employees who become disabled prior to age 63 - to age 65

employees who become disabled on or after age 63 - 18 months aggregate payments for the period from the date of disability up to age 70 (including recurrent and successive periods of disability), but in no event beyond age 70

Termination Age - coverage will cease at the end of the month coincident with attainment of age 65 or retirement, whichever is earlier.

Waiting Period - 6 months of continuous or aggregate service.

Qualifying Period - 26 weeks.

Taxability of Benefits - taxable.

Long Term Disability - The Benefit

Summary of Your Group Benefits
