Maritime Resident Doctors

Group Policy Number: G0066597
Class: A - All Members/Residents of Maritime Resident Doctors

A message from your plan sponsor

Maritime Resident Doctors is pleased to be able to offer you medical and financial security by sponsoring your group benefits program. We have selected Manulife Financial as a partner to help us deliver the program. They are committed to providing excellent service for us.

At this point, you will have received some basic information about how you can connect with Manulife Financial and how to submit claims. Now, I would encourage you to spend a few moments reviewing our plan's coverage so you can better understand what's available. You'll learn about not only the more routine things, but also about some of the benefits available that you may need to draw on in a time of crisis. Your plan is here to offer you some support in the event you encounter unforeseen circumstances in the future.

After reviewing the coverage, if you have any questions, email Leanne@mardocs.ca.

Sincerely,

Leanne Bryan
Manager, Health & Wellness

Your Group Benefit Program

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What you need to know about your plan

Who and what your plan covers

We are Manulife Financial, your plan sponsor's partner in supporting the group insurance benefits you receive at work. We know how important your coverage is and that you count on us to give you great tools to help you understand what you have.

Your dependents - your spouse, child or children who are insured under the Provincial Health Plan - may also be eligible for some of the coverage provided through this benefits program. Your plan sponsor's plan must be in effect and you and your dependents must have satisfied all of the participation requirements first, for your coverage to be active.

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

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. It doesn't include reference to all of the plan details, limitations and exclusions or terms and conditions your employer has arranged. Those are set out in your plan sponsor's group benefits plan documents (for example, the policy or plan document and any plan amendments). Manulife's administrative team will refer to those plan documents when evaluating claims, your eligibility for coverage, and for the general administration of the program. In the event of a discrepancy between this coverage overview and the plan documents, the terms outlined in the plan documents will apply.

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

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

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

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

Time Limit on Legal Action
Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Your plan sponsor is Maritime Resident Doctors

This booklet produced: August 22, 2019

Your plan number is G0066597
This is the main number you should provide as a reference when contacting Manulife Financial. Be sure to record this number and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Your coverage class is A - All Members/Residents of Maritime Resident Doctors

The plan effective date is January 01, 2006

This is the official day when all of the coverage and services your plan sponsor has arranged with us begins. Coverage starts on the date you start your residency.

Your plan may include a waiting period for some benefits.

The day after the waiting period has finished is the earliest date you can use this coverage.

Enhanced information is also available on the Internet
There may be times when you may not have coverage details with you, but you need to find out about some portion of your coverage quickly. Know that you can always find the most up-to-date plan information - including an electronic version of this document - on the Plan Member Secure Site. Once registered, you can log-in any time from any Internet connection. Go to **www.manulife.ca/groupbenefits** and input your plan number and plan member certificate number. The site will tell you everything else you need to do to finish the registration process.

The electronic version also includes links to definitions, forms, and enhanced information that may help you understand how your benefits program can support you.

HOW LONG COULD IT TAKE TO HAVE MY CLAIM PROCESSED?

This will depend largely on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form. Be sure to record your plan contract number and plan member certificate number on all correspondence and claim forms.

QUESTIONS? Call Customer Service at 1-800-268-6195. Have your plan contract and plan member certificate numbers handy when you call.

USE MORE THAN ONE PLAN TO GET MORE MONEY BACK
Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works.

CLAIM IS FOR...	FIRST...	THEN...
You	submit to Manulife	for any unpaid balance, send a copy of your Manulife claim statement and the other insurance company's claim form to the other insurance company for processing.
Your spouse	submit claim to spouse's insurance company	for any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing
Your children	send to the insurance company of the partner who has the earlier birth month and day	submit any balance to the other insurance company

Manulife Financial does not accept beneficiary appointments for any benefits other than Life Insurance under this Plan.

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

Core Coverage and Services

Your plan sponsor has chosen to offer the following benefits to form the coverage in this program.

Dental

Benefit Details	Your Plan's Coverage
Waiting Period	none
Plan Year Start Date Deductible	July 01 None
Dental Fee Guide	Current Fee Guide for General Practitioners for the Province in which the services are rendered
Coverage ends	At the earlier of age 65 or your retirement
Combined Maximum applies to: Level I Level II Level III Level IV	$1,500 per Plan Year
Level I - Basic Services Includes items such as: • complete oral exam, one per 2 plan year(s) • full-mouth x-rays, one per 2 plan year(s) • one unit of light scaling and one unit of polishing twice per plan year(s), when the service is performed outside Quebec, or prophylaxis twice per plan year(s), when the service is performed in Quebec • recall exams, bitewing x-rays, and fluoride treatments, twice per plan year(s) • initial oral hygiene instruction, plus one recall • routine diagnostic and laboratory procedures • fillings, retentive pins and pit and fissure sealants Replacement fillings are covered provided: - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam • pre-fabricated full coverage restorations (metal and plastic) • space maintainers (appliances placed for	80% to a combined maximum of $1,500 per Plan Year

orthodontic purposes are not covered) • minor surgical procedures and post surgical care • extractions (including impacted and residual roots) • consultations, anaesthesia, and conscious sedation • denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture • injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery	
Level II - Supplementary Services Includes items such as: • surgical procedures not included in Level I (excluding implant surgery) • periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including: - scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per Plan Year ; - provisional splinting; and - occlusal equilibration, up to a maximum of 8 units per Plan Year • endodontic services which include root canals and therapy, root amputation, apexifications and periapical services • root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime • re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment	80% to a combined maximum of $1,500 per Plan Year
Level III - Dentures Includes items such as: • initial provision of full or partial removable dentures • replacement of removable dentures, provided the dentures are required because: - a natural tooth is extracted and the	50% to a combined maximum of $1,500 per Plan Year

existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation • dentures required solely to replace a natural tooth which was missing prior to becoming insured for this eligible expense, are not covered	
Level IV - Major Restorative Services Includes items such as: • crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay • inlays, covering at least 3 surfaces, provided the tooth cusp is missing • initial provision of fixed bridgework • replacement of bridgework, provided the new bridgework is required because: - a natural tooth is extracted and the existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation • bridgework required solely to replace a natural tooth which was missing prior to becoming insured under this Plan is not covered	50% to a combined maximum of $1,500 per Plan Year

Exclusions

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

- *war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion*
- *the committing of or the attempt to commit an assault or criminal offence*
- *injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol*
- *dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit*
- *anti-snoring or sleep apnea devices*
- *broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms*
- *services which are payable by any government plan*

- *services or supplies provided by an employer's medical or dental department*
- *services or supplies for which no charge would normally be made in the absence of insurance*
- *treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction*
- *replacement of removable dental appliances which have been lost, mislaid or stolen*
- *laboratory fees which exceed reasonable and customary charges*
- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *implants, or any services rendered in conjunction with implants*
- *treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition*
- *services or supplies which are not specified as a covered expense under this benefit*

If you anticipate charges for any treatment to exceed $500, please submit a pre-treatment plan before receiving the service so you can understand what portion your plan may cover.

Your plan will pay benefits for the least expensive course of treatment when there are two or more courses of treatment covered that would produce professionally adequate results for a given condition. Manulife's professional dental consultant will aid in evaluating the various courses of treatment available to determine which is professionally adequate.

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

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

Extended Health Care Benefit

This benefit has many components that extend your coverage to a wide variety of health care providers and services. Under the broad category there may be coinsurances, deductibles, maximums and limitations that apply to specific components of the coverage.

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

Benefit Details	Your Plan's Coverage
Waiting Period	none
Plan Year Start Date	July 01
Maximum	Unlimited
Plan Year Start Date Deductible	July 01 Nil
Co-insurance	100% for Hospital Care, Medical Services & Supplies, Professional Services, Vision, Drugs
Coverage Ends	At the earlier of age 65 or your retirement

Exclusions

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

(not applicable to Health Service Navigator®)

- *for Medical Travel Emergencies and Emergency Travel Assistance only, self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness*
- *war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion*
- *committing or attempting to commit an assault or criminal offence*
- *injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol*
- *an illness or injury for which benefits are payable under any government plan or workers' compensation*
- *charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms*
- *services or supplies provided by an employer's medical or dental department*
- *services or supplies for which no charge would normally be made in the absence of insurance*
- *services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance*

- *services or supplies which are not permitted by law to be paid*
- *services or supplies which are required for recreation or sports*
- *services or supplies which would have been payable by the Provincial Plan if proper application had been made*
- *medical treatment which is not usual or customary, or is experimental or investigational in nature*
- *medical or surgical care which is cosmetic*
- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *services or supplies which are provided while confined in a hospital on an in-patient basis*
- *services or supplies which are not specified as a covered expense under this benefit*

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

EHC - Drugs

100% **Co-insurance**

Benefit Details	Your Plan's Coverage
Prescription Drugs with **Generic Substitution** Includes the following drug classes: • oral contraceptives • life-sustaining drugs • preventive vaccines and medicines (oral or injected) • injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered) • standard syringes, needles and diagnostic aids, required for the treatment of diabetes No coverage for / excludes: • sexual dysfunction drugs • drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis • drugs determined to be ineligible as a result of due diligence • cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment used in the treatment of diabetes • charges to administer serums, vaccines & injectable drugs • experimental or investigational drugs not approved as an effective, appropriate and essential treatment of an illness or injury • natural health products (products with a NPN)	Drug deductible 20% of the total cost of each prescription, up to a maximum of $25.00 per prescription $15,000 lifetime maximum on fertility drugs $300 lifetime maximum on anti-smoking prescription drugs *No Substitution Prescriptions - If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, then the full cost of the prescribed product is covered.* *There is a limitation on quantity of drugs that can be dispensed and claimed at one time, to the lesser of:* *a) the quantity prescribed by the Physician or Dentist; or* *b) a 34 day supply; or* *c) up to a 100 day supply may be payable in long term therapy where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.* *If you are a Quebec resident, your plan's coverage will coordinate with **RAMQ**.*

EHC - Vision

100% **Co-insurance**

Benefit Details	Your Plan's Coverage
Prescription Glasses, Occupational Glasses,, Contact Lenses, Laser Eye Surgery, Eye Exams, Visual Training	$250 per 2 Plan Year(s) (per Plan Year if under 18) for prescription glasses, elective contact lenses , repairs and elective laser vision correction procedures If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per Plan Year for persons under age 18 and $200 per 2 Plan Year(s) for persons age 18 and over Eye Exams - once per Plan Year Visual Training - $200 per lifetime

EHC - Health Care Professionals (Professional Services)

100% **Co-insurance**

Benefit Details	Your Plan's Coverage
Services provided by the following licensed practitioners: Chiropractor, Osteopath, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Speech Therapist, Physiotherapist, Psychologist/Registered Counselling Therapist(RCT)/Social Worker, Dietician, Audiologist, Occupational Therapist, Acupuncturist	Combined maximum of $1,500 per plan year(s) for all practitioners Each of the following practitioner has an individual maximum of $1,000 per plan year(s): Chiropractor, Osteopath, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Speech Therapist, Physiotherapist, Dietician, Audiologist, Occupational Therapist and Acupuncturist; and an individual maximum of $2,500 per plan year(s) for Psychologist/Registered Counselling Therapist(RCT)/Social Worker. Note: x-rays are covered for Chiropractor, Osteopath and Podiatrist/Chiropodist, subject to a maximum of $35 per plan year(s).
	Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses prior to reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this benefit program are payable after the Provincial Plan's maximum for the benefit year has been paid. *Recommendation by a physician for Professional Services is not required.*

EHC - Medical Supplies and Services

100% **Co-insurance** (unless otherwise stated)

For all medical equipment and supplies, coverage is limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Benefit Details	Your Plan's Coverage
Private Duty Nursing Services Provided by a registered nurse or registered nursing assistant who has completed an approved medications training program Excludes: • custodial care, homemaking duties or supervision • services performed by a nurse practitioner who is an immediate family member or who lives with the patient • services performed while confined to a hospital, nursing home or other similar institution • services that could be performed by a person with lesser qualifications, a relative, a friend or a member of the patient's household	$10,000 per Plan Year(s) *Submit a detailed treatment plan estimate before Private Duty Nursing services begin so we can advise you of what benefit may be provided.*
Hearing Aids	$600 per 3 Plan Year(s) *Includes cost, installation, repair and maintenance of Hearing Aids (including charges for batteries)*
Orthopaedic Shoes/Orthotics	$150 per Plan Year(s) for Stock-item Orthopaedic Shoes Custom Made Shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of 1 pair per plan year (must be constructed by a certified

	orthopaedic footwear specialist) $400 per 3 Plan Year(s) for Custom Made Orthotic Foot Appliances *Must be recommended by a physician or podiatrist.*
Medical Equipment Includes items such as: • ambulance (licensed including air ambulance, provided in province of residence) • mobility equipment (crutches, canes, walkers, wheelchairs) • manual hospital beds • respiratory and oxygen equipment • other equipment usually found only in hospitals • non-dental external prostheses • braces (other than foot braces), trusses, collars, leg orthosis, casts and splints • ileostomy, colostomy and incontinence supplies • medicated dressings and burn garments • oxygen • charges for the treatment required as a result of an injury to natural teeth or jaw • surgical brassieres • wigs and hairpieces for temporary hair loss associated with medical treatment	4 per Plan Year for surgical brassieres $250 per lifetime for wigs and hairpieces *Medical equipment dispensed by a hospital is not an eligible expense.* *In the province of Quebec, microscopic and other similar diagnostic tests and services rendered in a licensed laboratory are included, up to a maximum of $1,000 per calendar year.* *Accidental dental treatment to the natural teeth or jaw must be provided within 12 months of the accident. Injuries sustained while biting or chewing are not covered.*
Surgical Stockings	4 pairs per Plan Year

EHC - Hospital	
100% **Co-insurance**	
Benefit Details	Your Plan's Coverage
General or Rehabilitation hospitals	• in a Semi-Private Room • in excess of the hospital's public ward charge
	Manulife Financial will coordinate payment after any provincial plan coverage has first been applied.

EHC - Medical and Non-Medical Travel Emergencies

Benefit Details	Your Plan's Coverage
Emergency medical coverage Conditions: • Coverage is for immediate medical treatment required for: - a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure. • Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date. • Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.	100% with a maximum of $5,000,000 per lifetime Stable means in the 90 days before departure, the insured person has not: • been treated or tested for any new symptoms or conditions; • had an increase or worsening of any existing symptoms; • changed treatments or medications (other than normal adjustments for ongoing care); • been admitted to the hospital for treatment of the condition. Coverage is not available if you (or your dependent) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition. A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory. *You are typically responsible for payment of medical expenses amounting to less than $200 CDN. When you return from your trip, you can submit a claim to be reimbursed for those expenses through the normal claim submission process.* *For charges over $200 CDN, contact the service partner shown on your benefits card as soon as possible to arrange for payment directly to the treating physician or facility.*
Non-Emergency medical coverage Conditions: • recommendation by a practicing physician in Canada is required • suggests that you submit a detailed treatment plan with cost estimates before	50% with a maximum of $3,000 every 3 Plan Year(s)

treatment begins. You will then be advised of any benefit that will be provided.	
Emergency Travel Assistance Including: • 24 hour access to multi-lingual service representatives • referral to local medical care and treatment monitoring • payment of medical bills, medical transportation, return home of dependent children, visit by a family member, trip interruption/delay coverage, support through convalescence after hospital discharge, identification and/or return of a deceased traveller, meals and accommodation, vehicle return, pre-trip advice on passport, visa, vaccination and inoculation requirements for a destination, assistance in replacing lost documents and tickets, referral to legal assistance in your foreign destination, telephone interpretation service, emergency message service, and • after-hours medical advice phone support	100% with all maximums below stated in Canadian Funds. $1,000 for return of vehicle $2,000 for meals and accommodations $7,500 for return of deceased *See **Emergency Travel Assistance** for additional information, a list of phone numbers for frequent Canadian travel destinations and for participating countries.*

Health Care Spending Account (HCSA)

Benefit Details	
Health Care Spending Account (HCSA) plan number *Be sure to use your HCSA number on all HCSA claims*	G0100533
Number of days you have to submit claims for your Health Care Spending Account funds after they are deposited	365 days
	You have 180 days after the deposit anniversary to submit claims to be paid from your HCSA funds for the previous deposit year.
You can find your HCSA balance on the Plan Member Secure Site. Full details about the types of things you can use your HCSA for are available from the Canada Revenue Agency website. You can find a list of eligible medical expenses, also referenced as line 330 from the deductions section of an individual tax return.	

Health for Life® - Resources to help you and your family maintain overall good health and wellness

Benefit Details	Your Plan's Coverage
Your plan also includes access to services and information you and your family can use to live healthier lives. You can access these services on the Plan Member Secure Site.	
Health eLinks® - Online resources for better health	
Take the first step toward healthier living through online tools and resources such as: Health Risk Assessment Health Library, including: • Conditions database • Medications database • Tests and procedures database • Health features • Personal Health Improvement Program	Included and available on the Plan Member Secure Site

Health Service Navigator®

Whether you or a family member have been diagnosed with a critical or chronic health condition, or you are simply curious about the services available in your area, Health Service Navigator® points you to agencies or resources that may be able to provide the information you need, including:

- tips and tools you can use to navigate through the Canadian health care landscape
- a national physician search database
- provincial health plan information
- health, medical condition, treatment plan options and medication information you can trust, and
- a second medical opinion service for times when you may want to double check a serious medical diagnosis you, your spouse or your child has received

With the exception of the second opinion service (which is available by phone only), Health Service Navigator tools are all available for you or your spouse or children any time on the Plan Member Secure Site.

Long-Term Disability

Benefit Details	Your Plan's Coverage
Waiting Period	none
Benefit Amount	66.7% of monthly basic earnings to a maximum of $5,000
Qualifying Period	90 working days
Definition of Disability	Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of: • your own occupation, during the Qualifying Period and the 5 years immediately following the Qualifying Period • any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 5 years specified above
	The availability of work will not be considered by Manulife Financial in assessing your disability. *If you must hold a government permit or license to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed, unless it is not renewed solely due to medical reasons. In this case, you will be considered Totally Disabled for up to 12 months after the end of the qualifying period.*
Maximum Benefit Period	to age 65 for Total Disability Benefits 5 years, but not beyond age 65, for Partial Disability Benefits
Non-Evidence Limit	$5,000
Termination	Age 65 less the Qualifying Period, or your retirement, whichever is earlier
Tax Status	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 any portion of the premium for this benefit, then any 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.
Waiver of Premium	The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.
Entitlement	To be entitled to disability benefits, you must meet the following criteria: • you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled • Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of: - your own occupation, during the Qualifying Period and the following 5 years, and - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 5 years specified above • you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.
Exclusions	*No benefits are payable for any disability related to:* • self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness • war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion • medical or surgical care which is not medically necessary • the committing of or the attempt to

	commit an assault or criminal offence • injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol • abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial • a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which drugs were prescribed, within 90 days prior to the effective date of your coverage
Periods for which you are not entitled to benefits *(Unless your employer is required to provide coverage because of legislation, regulation, or by law)*	When you are: • not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial • receiving EI (Employment Insurance) maternity or parental benefits • on lay off • on leave of absence • receiving benefits under an employer sponsored salary continuance plan • working in any occupation, except as provided for under the Partial Disability Benefit provision • incarcerated
Amount of Disability Benefit Payable	The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any amount you receive or are entitled to receive from the following sources for the same or related disability: • Workers' Compensation or similar coverage • Canada or Quebec Pension Plans • any government motor vehicle automobile insurance plan or policy, unless prohibited by law If necessary, the amount of your benefit will be further reduced so that your total amount from all sources does not exceed 100% of your pre-disability

	gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and: a) any amount you receive or are entitled to receive from: • any group, association (excluding the Ontario Medical Association Plan) or franchise plan • any retirement or pension plan • earnings or payments from any employer, including severance payments and vacation pay • self-employment • any government plan, excluding Employment Insurance Benefits b) any amount of Canada or Quebec Pension Plan benefits which another member of your family receives or is entitled to receive by reason of your disability Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.
Rules we use to calculate your benefit	Manulife Financial will apply the following rules in determining your disability benefit: • benefits payable from other sources which began before the commencement of your current Disability will not be taken into account • 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 • subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established • benefits payable under individual disability income insurance will not be taken into account • for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial • if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and

	assumed to be paid
Cost of Living Adjustments	Commencing with your January payment after benefits have been payable for 12 months and with each subsequent January payment, you are eligible for a cost of living adjustment in your disability benefit. The amount of the adjustment will be based on the average of the Consumer Price Index for each month in the 12 month period ending the last day of September of each year, to a maximum of 3%.
Subrogation	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 judgment 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.*
Termination of Payments	Your disability benefit payments will cease on the earliest of: • the date you cease to be Totally Disabled, as defined under this benefit, except as provided for under the Partial Disability Benefit • the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of: - your own occupation, during the Qualifying Period and the following 5 years, and - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 5 years specified above If you are receiving a partial disability benefit, benefits will cease on the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury limits you to

	returning to work in a reduced capacity, as defined under the Partial Disability Benefit. • the date you do not attend an examination by an examiner selected by Manulife Financial • the date on which benefits have been paid up to the Maximum Benefit Period for this benefit • the date of your death
Recurrent Disability	If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which 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 the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.
Partial Disability Benefit	If you become Partially Disabled after qualifying for Disability Benefits, Manulife Financial will pay a Partial Disability Benefit, as outlined below. *Definition of Partially Disabled* During a period of 5 years following the Qualifying Period, you will be considered Partially Disabled if you are able to work in your own occupation but, due to your disability, you can only do so in a reduced capacity such that your pre-disability earnings are reduced by 15% or more. After this period, you will be considered Partially Disabled if, due to your disability, you can only work in a reduced capacity in any occupation such that your pre-disability earnings are reduced by 15% or more.
Amount of Partial Disability Benefit Payable	The amount of the partial disability benefit payable to you is determined as follows: • your disability benefit (see Amount of

	Disability Benefit Payable) reduced by 50% of your employment income, if you return to work, or • 50% of your disability benefit, if you do not return to work If necessary, this amount will be reduced so that your total income from all sources does not exceed 100% of your pre-disability earnings. To account for inflation, each January your pre-disability earnings will be adjusted by the change in the Consumer Price Index for the preceding year.

***Submitting Claims**: Please contact your Plan Administrator 6 to 8 weeks prior to the end of your Qualifying Period. Manulife Financial will contact you to discuss details of your Long Term Disability coverage.*

***Payments**: Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.*

Vocational Rehabilitation Expense Benefit

If, while receiving disability benefits, you become involved in vocational rehabilitation approved by Manulife Financial, expenses reasonably associated with your rehabilitation will be payable by Manulife Financial, provided:

- the expenses have been pre-approved by Manulife Financial
- the charges are reasonable, and are not payable through any other source

Expenses which will be considered under this benefit are:

- rehabilitation assessment, including work capacity assessment and placement assistance
- vocational counselling, re-training or education, and non-medical rehabilitation devices

Life Insurance

You may also wish to consider supplementing this coverage by purchasing any available Optional or Personal Benefits coverage available for your plan.	
Benefit Details	Your Plan's Coverage
Waiting Period	none
Benefit Amount	$100,000
Non-Evidence Limit	$100,000
Reduction and Termination Age	Your benefit amount reduces to $94,000 if applicable at age 61 and further reduces to $86,000 if applicable at age 62 and further reduces to $80,000 if applicable at age 63 and further reduces to $74,000 if applicable at age 64 and further reduces to $66,000 if applicable at age 65 and terminates at age 70 or retirement, whichever is earlier
Qualifying Period for Waiver of Premium	90 working days
Waiver of Premium	If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium. Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of: • your own occupation, during the Qualifying Period and the 5 years immediately following the Qualifying Period • any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 5 years specified above The availability of work will not be considered by Manulife Financial in assessing your disability. If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed, unless it is not renewed solely due to medical reasons. In this case, you will be considered Totally Disabled for up to 12 months after the end of the qualifying period.

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

Your beneficiary or estate must **submit a claim** within 90 days of the date of death. He or she can obtain the necessary paperwork from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.

If you are terminally ill and not expected to live more than 24 months, and you require financial assistance, you may qualify for a Compassionate Assistance loan.

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

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

Survivor Benefit

Benefit Details	Your Plan's Coverage
If you die while your dependents are insured under the program, Manulife Financial will continue coverage for some benefits without payment of premium: • Extended Health Care • Dental Care	Coverage will continue until the earliest of: • the date your dependent is no longer a dependent • the date similar coverage is obtained elsewhere • the date which is 2 years from your death or • the date the Group Policy terminates

Individual plan options available to purchase if you are leaving the plan

When your group coverage ends, your relationship with Manulife doesn't have to stop there. You have the option to purchase your own personal plans.

Conversion Option

Some core coverage benefits (Life, Optional Life, Critical Illness, Optional Critical Illness) give you the option to purchase individual coverage when your group benefits terminate or reduce, without needing to provide medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your coverage. Other specific conditions for coverage may be noted in each benefit information section of this document.

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

FollowMe™ Health

The FollowMe Health plan is specially designed for those whose group health coverage has recently or will soon come to an end. FollowMe Health allows you to continue enjoying health and dental benefits without completion of a medical questionnaire, so there's no need to worry about interruption of coverage for you or your loved ones.

If you apply within 60 days of your loss of group health and dental benefits, you will qualify without having to complete a medical questionnaire.

With four different plans and levels of coverage to choose from, you're certain to find the FollowMe Health plan that meets your needs.

To find out more, request a brochure, get a quote, apply online or print an application, go to ***www.coverme.com*** *or call 1-877-COVER ME® (1-877-268-3763)*

Definitions

Explanation of some of the terms used in this document

Co-insurance

The way the cost of a service is shared between you and your plan. It exists in addition to any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your plan will cover up to 80% of the bill and you would pay the rest.

Co-payment

The fixed amount that you must pay towards the cost of a service each time you use your plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, you might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, you are required to pay $2.00.

Dependent

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

Spouse

- your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

Child

- your natural or adopted child, or stepchild, who is:
    - unmarried
    - under the age stated below:
      for Dental coverage - under age 22, or under age 25 if a full-time student;
      for Extended Health Care coverage - under age 22, or under age 25 if a full-time student
    - not employed on a full-time basis
    - not eligible for insurance as a member under this or any other Group Benefit Program

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

- a child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the member for support, maintenance and care, due to a mental or physical disability. Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary

- a stepchild must be living with you to be eligible

Drugs

- must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province permits them to write a prescription;
- must be dispensed by a licensed pharmacist;
- must have been approved for use by Health Canada and have a drug identification number (DIN).

RAMQ - Drug Benefit and Pharmacy Services for persons who reside in Quebec
If you and your dependents reside in Quebec, the following provisions apply to your drug benefit coverage:

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

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

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

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

ii) For any Legislated pharmacy services which are not otherwise covered under the terms of the Policy, the percentage is as set out by the then applicable Legislation.

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

- the benefit percentage stated under the benefit; or
- the percentage as set out by the then applicable legislation.

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

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

i) deductible amounts, and

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

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the legislation and includes

those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

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

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

d) Lifetime Maximums
Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and pharmacy service coverage provided after the lifetime maximum stated under this plan is reached is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered, and
ii) covered pharmacy services that are performed for drugs on the RAMQ List, and
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

e) Eligible Dependent Children
Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:
i) the age specified in this Benefit Booklet or
ii) age 26.

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

- only drugs that are on the RAMQ List are covered, and
- covered pharmacy services performed for a drug on the RAMQ List, and
- the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

f) Termination Age for Covered Drug and Pharmacy Service Expenses
Provided you are otherwise eligible for the drug benefit, the termination age (if any) for the drug benefit will not apply. Drug coverage provided after the termination age specified under The Benefit is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered,
ii) only covered pharmacy services related to a drug on the RAMQ List,
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the legislation
iv) the Annual Out-of-Pocket Maximum is as stipulated in the legislation

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

Due Diligence

A process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the plan. This process may use pharmacoeconomics, cost

effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Earnings

Earnings are your regular rate of pay from your employer (prior to deductions)

Earnings may include other income as agreed to in writing by your employer and Manulife Financial.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Experimental or Investigational

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

Lower Cost Alternative

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

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

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

Non-Evidence Limit

The amount of insurance benefits you can receive without needing to provide proof of good health. Anything over this figure means that Manulife must review medical evidence before you are approved for the higher amount.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Plan Year

A 12 month period starting each year on the Plan Year Start Date. If the month in the Group Policy Effective Date differs from the month in the Plan Year Start Date, then the first Plan Year will be the period between the Group Policy Effective Date and the Plan Year Start Date of the following year.

Prior Authorization

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

Plan Year

- A 12 month period starting each year on the Plan Year Start Date. If the month in the Plan Document Effective Date differs from the month in the Plan Year Start Date, then the first Plan Year will be the period between the Plan Document Effective Date and the Plan Year Start Date of the following year.

Pyogenic Infection

- A bacterial infection or inflammation that produces a generally viscous, yellowish-white fluid formed in infected tissue. The fluid consists of white blood cells, dead tissue and cellular debris.

Reasonable and Customary Charges

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