Westerkirk Capital Inc.

Group Policy Number: G0037843

Plans KR2: Unifor Local 673 Retirees of De Havilland Aircraft of Canada Limited

Note: The above are the main numbers you should provide as a reference when contacting Manulife. Be sure to record these numbers and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Group Policy Effective Date: December 1, 2007

This booklet produced: March 8, 2022

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Important information about your benefits:

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. Every effort has been made to describe the program accurately. However, should there be a question of interpretation, the terms outlined in the official plan documents will prevail.

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

a) the Group Policy;

b) your application for group benefits; and

c) any Evidence of Insurability you submitted as part of your application for benefits.

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

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

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

Explanation of Common Insurance Terms

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

Adherence

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

Advisory Body

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

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by Manulife.

Covered Expenses

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

Deductible

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

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.

Only one Spouse will be eligible for insurance, and will be as indicated by you on your application for coverage. Where this information is not contained on your application, the person who qualifies last under this Policy's definition of Spouse will be the eligible Spouse.

- Child

your natural or adopted Child, or stepchild, who is:

a) unmarried;

b) under age 21, or under age 25 if a full-time student;

c) not employed on a full-time basis; and

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

A newborn Child shall become eligible from the moment of birth.

A stepchild must be living with you to be eligible.

A Child who is incapacitated on the date he or she reaches the age when coverage 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 you for support, maintenance and care, due to a mental or physical handicap.

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

Disease Management Programs

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

Drug

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

Due Diligence

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

Exclusive Distribution

Manulife-approved vendors.

Experimental or Investigational

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

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.

Interchangeable Drug

includes but is not limited to:

a) a generic equivalent to the brand name Drug deemed to be interchangeable by law where the drug is dispensed; or

b) a Drug that contains the same active ingredient that has not been deemed interchangeable in the province where the Drug is dispensed; but has been identified as interchangeable by Manulife.

Explanation of Common Insurance Terms

Licensed, Certified, Registered

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

Life-Sustaining Drugs

non-prescription Drugs which are necessary to sustain life.

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.

Manulife Managed Formulary

The Manulife Managed Formulary is a listing of all drugs which qualify for reimbursement under your Group Benefits Program.

Medically Necessary

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

Non-Evidence Limit

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

Nursing Home

a health care facility licensed to provide skilled nursing care and medical supervision for up to 2½ hours each day, together with 24 hour personal care service.

Patient Assistance Program

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

Pharmacoeconomics

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

Prior Authorization

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

Provincial Plan

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

Reasonable and Customary

the lowest of:

a) 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;

b) the amount shown in the applicable professional association fee guide; or

c) the maximum price established by law.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Who Qualifies for Coverage?

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits, as long as you:

a) are a retired employee of Westerkirk Capital Inc.; and

b) are younger than the Termination Age; and

c) are residing in Canada.

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 insurance for yourself in order for your Dependents to be eligible.

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

Evidence of Insurability

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

In all cases, medical evidence can be submitted by completing the Evidence of Insurability form, available from your plan administrator, or at www.manulife.com/groupbenefits. Further medical evidence may be requested by Manulife*.*

Late Application

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:

a) apply for insurance more than 31 days after the date benefits terminated under your Spouse's plan; or

b) apply for benefits, and benefits under your spouse's plan have not terminated.

Effective Date of Coverage

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

If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife, whichever is later.

Your Dependent's insurance becomes effective on the date the Dependent becomes eligible, or the date any required medical evidence on the Dependent is approved by Manulife, whichever is later.

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

For any changes in coverage (Dependent coverage, beneficiary information, name, applying for coverage that was previously waived), complete the Application for Change form, available at www.manulife.com/groupbenefits, or from your plan administrator.

Submitting a Claim

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

Submit Online (if applicable)

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

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

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

By Mail

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

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

Submission Requirements

Claims must be submitted within the following timeframes:

a) 90 days from the date of the loss, for claims for Life benefits; and

b) 12 months from the date the expense was incurred, for claims for Extended Health Care benefits, while insurance under the plan is in force. Upon termination of a person's insurance under this plan, proof that Extended Health Care benefits are payable must be submitted within the earlier of:

   i) 12 months from the date the expense was incurred; or

   ii) 90 days from the date of termination of coverage.

For Life claims, complete the Life Claim form.

For Extended Health Care, complete the Extended Health Care form. Visit the forms section at www.manulife.com/groupbenefits to determine which claimed expenses can be submitted via the website.

For Out-of-Province or Out-of-Canada expenses, complete the Out of Province claim form. Expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife, along with the explanation of payment from the Provincial Plan.

The Claims Process

Co-ordination of Extended Health Care Benefits

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 (briefly) here's how it works:

If you have a claim for yourself: then submit to Manulife first. For any unpaid balances, send a copy of your Manulife claim statement and the other insurance carrier's claim form to the other insurance company for processing.

If you have a claim for your Spouse: then submit the claim to your 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.

If you have a claim for a dependent Child: then send the claim to the insurance carrier of the parent whose birthdate falls earliest in the calendar year first. Submit any unpaid balance to the other insurance company.

For complete details, please go to www.manulife.com/groupbenefits.

Naming a Beneficiary

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

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

Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against Manulife less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitation of Actions Act (NB)
Civil Code of Quebec (QC)

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

a) the date your employer terminates coverage;

b) the date you enter the armed forces of any country on a full-time basis;

c) the date the Group Policy terminates or coverage on the class to which you belong terminates;

d) the date you reach the Termination Age; or

e) the date of your death.

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

Life Insurance Benefit

Benefit Details

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.

Benefit Amount - $4,000 less CPP/QPP death benefit (minimum benefit $3,000)

Non-Evidence Limit - $4,000

Termination Age – employee's death

Naming a Beneficiary

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

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

Extended Health Care

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

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

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

The Benefit

Overall Benefit Maximum - $35,000 lifetime.

Overall lifetime maximum is not applicable to Hospital Care (other than nursing home), Drugs, Vision, Professional Services (other than services of a Physiotherapist, Psychologist and Psychotherapist) and Medical Services and Supplies (Cancer antigen (CA 125) and Prostate-specific antigen (PSA) tests, Ambulance and Hearing Aids).

Deductible - $35 Individual, $60 Family, per calendar year(s)

Not applicable to:

Hospital Care (other than nursing home)
Drugs
Vision
Professional Services (other than services of a Physiotherapist, Psychologist and Psychotherapist)
Medical Services and Supplies (Cancer antigen (CA 125) and Prostate-specific antigen (PSA) tests, Ambulance and Hearing Aids only)
Out-of-Province/Canada Emergency Medical Treatment
Out-of-Canada – Referrals

- Deductible Carry-Forward

Covered Expenses used to satisfy the Deductible in the last 3 months of the calendar year may also be used to satisfy the Deductible in the following calendar year.

Drug Deductible - $5.00 per prescription

Drug Dispensing Fee Maximum - $9.00 per prescription

Benefit Percentage (Co-insurance)

100% for
Hospital Care (other than Nursing Home)
Drugs
Vision
Professional Services (other than services of a Physiotherapist Psychologist and Psychotherapist)
Medical Services and Supplies (Hearing Aids)

80% for
Hospital Care (Nursing Home)
Professional Services (Physiotherapist, Psychologist and Psychotherapist)
Medical Services and Supplies (other than Hearing Aids)

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's death

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary, as determined by Manulife, provided they are:

a) Medically Necessary for the treatment of an illness or injury and recommended by a physician;

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

d) not covered under the Provincial Plan or any other government-sponsored program;

e) legally insurable;

f) used as prescribed or recommended by a physician; and

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

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

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

Manulife maintains a list of Drugs, services and supplies that require Prior Authorization. Prior Authorization is applied to ensure that the therapy prescribed is Medically Necessary. Where there are Lower Cost Alternative treatments or prescribing guidelines recommend alternative Drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.
At Manulife's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the Drug, service or supply.

Manulife has the right to ensure you or your Dependents access Manulife's Exclusive Distribution channels where applicable when purchasing a drug, service or supply. Manulife may decline a Drug, service or supply purchased from a provider outside the Exclusive Distribution channel.

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

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

Advance Supply Limitation

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

- Drug Expenses

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

a) the quantity prescribed by your physician or dentist, or

b) a 34-day supply.

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

Hospital Care

a) charges, in excess of the hospital's public Ward charge, for semi-private accommodation up to $215 per day, provided:

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

   ii) the accommodation was specifically elected in writing by the patient

b) confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of $3 per day for 120 days per disability

c) charges for room, board and normal nursing care provided in a licensed nursing home (for convalescent or chronic care, excluding custodial care)

d) charges for room, board and normal care provided in a hospice for up to 30 days, to a lifetime maximum of $7,500 per person.

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

Drug Benefit and Pharmacy Services for Quebec Residents

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

Manulife Managed Formulary

Charges for any Drug which is eligible for reimbursement under the current Manulife Managed Formulary (5094G) when prescribed by a Physician or Dentist and dispensed by a licensed pharmacist.

The Formulary, compiled and managed by Manulife Financial, includes all Drugs eligible for reimbursement, available strengths and dosage forms and the drug identification numbers. The Formulary is dynamic and subject to change, Drugs may be removed when a less costly Drug that has been deemed to be equally safe and effective is listed on the Manulife Managed Formulary.

To be considered eligible for reimbursement under the Policy, the insured person may be required by Manulife Financial to try alternative, less expensive drug therapies before being eligible for a more expensive drug therapy.

Charges for oral contraceptives, preventive vaccines and medicines (oral or injected), intrauterine devices and diaphragms are considered eligible for reimbursement under this Policy.

Charges for the following expenses are **not** covered:

a) the administration of injectable Drugs;

b) fertility Drugs;

c) anti-smoking Drugs;

d) Drugs, biologics and related preparations which are administered in Hospital or an in-patient or out-patient basis; and

e) Drugs determined to be ineligible as a result of Due Diligence.

- Diabetic Supplies

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

- Drug Maximums

Over the Counter life-sustaining Drugs - $300 per calendar year

Drugs used in the treatment of a sexual dysfunction - $1,000 per calendar year

All other covered Drug expenses – Unlimited

- Payment of Covered Expenses

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

Covered Expenses for any prescribed Drug will not exceed the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

Manulife can limit the covered expense for any Drug to that of a lower cost Interchangeable Drug at the time the Drug is purchased.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed Drug is not to be substituted with another product, the maximum amount covered is the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

Reimbursement at the cost of a prescribed Drug, where a Lower Cost Alternative Drug is available, will only be considered if medical evidence is provided by the treating physician to support why the Lower Cost Alternative Drug cannot be tolerated or is ineffective.

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

Direct Claims Payment

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

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

Vision Care

a) eye exams, up to $75 per 12 consecutive months for persons under age 14 and up to $75 per 24 consecutive months for persons age 14 and over;

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures. The following expenses are covered every 12 months for persons under age 14, and every 24 months for persons age 14 and over:

- contact lenses – up to a maximum of $235 per person
- single lenses – up to a maximum of $275 per person
- bifocals – up to a maximum of $295 per person
- trifocals – up to a maximum of $315 per person
- laser vision correction procedures – up to a maximum of $270 per lifetime

c) contact lenses if prescribed as medically necessary or required to improve vision to at least a 20/70 level in the better eye or because keratoconus, irregular astigmatism, irregular corneal curvature, or physical deformity resulting in an inability to wear normal lenses

Professional Services

Services provided by the following licensed practitioners:

a) Chiropractor - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

b) Naturopath - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

c) Homeopath - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

d) Massage Therapist - $500 per calendar year

e) Speech Therapist - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

f) Osteopath - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

g) Physiotherapist - $160 for the initial visit, $100 for subsequent visits to a maximum of 24 visits per calendar year

h) Mental Health Practitioners* - reasonable and customary, up to a maximum of 24 visits per calendar year

i) Podiatrist/Chiropodist - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

j) Acupuncturist - $650 per calendar year combined for services of a chiropractor, naturopath, homeopath, speech therapist, osteopath, podiatrist/chiropodist and acupuncturist

*Mental Health Practitioners include Psychologists and Psychotherapists only

Recommendation by a physician for Professional Services is not required, except for services of a massage therapist, physiotherapist, psychologist and psychotherapists once every 12 months.

Expenses for services of a podiatrist/chiropodist 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.

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

Medical Services and Supplies

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

Private Duty Nursing

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

a) a registered nurse; or

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

Covered Expenses are subject to a maximum of $25,000 per calendar year.

Charges for the following services are **not** covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

c) service performed while the patient is confined in a hospital, nursing home, or similar institution; or

d) service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

Pre-Determination of Benefits

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

Ambulance

Charges for a licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available.

Medical Equipment

Rental or, when approved by Manulife, 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, Supports and Hearing Aids

a) external prostheses; breast prostheses, up to a maximum of $1,000 every 3 calendar years.

b) surgical stockings, up to 4 pairs per calendar year (recommendation by a physician is required);

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

d) braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;

e) stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and 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 (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of $400 per 18 months combined with custom-made orthotics;

f) casted, custom-made orthotics, up to a maximum of $400 per 18 months combined with stock-item orthopaedic shoes and custom-made shoes (recommendation of either a physician or a podiatrist is required);

g) cost, installation, repair and maintenance of hearing aids, (excluding charges for batteries), one per 24 months. Ear moulds for dependent children aged 14 years and under, up to a maximum of $400 per calendar year.

Other Supplies and Services

a) ileostomy, colostomy and incontinence supplies;

b) medicated dressings and burn garments;

c) wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $600 per lifetime;

d) oxygen;

e) diagnostic x-ray, laboratory and other diagnostic procedures, up to a maximum of $1,250 per calendar year and including optical coherence tomography tests;

f) charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, unless a longer period is required by legislation, excluding injuries due to biting or chewing; and

g) viscosupplementation, up to a maximum of $720 per calendar year.

Out-of-Province/Out-of-Canada

a) treatment required as a result of a medical emergency which occurs during the first 180 days while temporarily outside the province of residence, provided the insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to the Extended Health Care overall benefit maximum.

   A Medical Emergency is:

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

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

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

   i) been treated or tested for any new symptoms or conditions

   ii) had an increase or worsening of any existing symptoms

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

   iv) been admitted to the hospital for treatment of the condition

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

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

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

b) referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar years

   If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are included in the above maximum.

   For all non-emergency medical treatment out of Canada:

   i) the treatment must be recommended by a physician practicing in Canada, and

   ii) it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

Charges for the following are payable under this expense:

a) physician's services;

b) hospital room and board at standard Ward rates. Charges in excess of Ward rates are payable, if hospital coverage is provided under this Benefit Program;

c) the cost of special hospital services;

d) hospital charges for out-patient treatment;

e) licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available; and

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

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

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

Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your Dependents while you are temporarily outside your province of residence and is offered for the same period as specified under the Out-of-Province/Out-of-Canada benefit. The assistance services are delivered through an international organization, specializing in travel assistance.

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

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

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

Medical Emergency Assistance

A Medical Emergency is:

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

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

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

a) been treated or tested for any new symptoms or conditions;

b) had an increase or worsening of any existing symptoms;

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

d) been admitted to the hospital for treatment of the condition.

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

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

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

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of insurance coverage, is provided.

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

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

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

f) **Return of Dependent Children**

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

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

g) **Trip Interruption/Delay**

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

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

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

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

h) **After Hospital Convalescence**

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

i) **Visit of Family Member**

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

j) **Vehicle Return**

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

k) **Identification of Deceased**

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

l) **Meals and Accommodation**

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

Non-Medical Assistance

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

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

b) **Lost Document and Ticket Replacement**

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

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Health Advice and Assistance

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

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

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

b) **Medical Advice**

Medical advice will be provided on:

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

ii) the type of side effect to expect from a prescribed drug, and

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

c) **Link to 911**

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

d) **Follow-Up Call**

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

Exceptions

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

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

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

Your Emergency Travel Assistance card lists the toll-free numbers to call in case of an emergency, while travelling outside your province. The toll-free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your I.D. number and plan document number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have an Emergency Travel Assistance Card, please contact your plan administrator.

Subrogation (Third Party Liability)

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

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

Exclusions

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

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

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

c) committing or attempting to commit an assault or criminal offence;

d) injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol;

e) an illness or injury for which benefits are payable under any government plan or workers' compensation;

f) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

g) services or supplies provided by an employer's medical or dental department;

h) services or supplies for which no charge would normally be made in the absence of insurance;

i) services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance;

j) services or supplies which are not permitted by law to be paid;

k) services or supplies which are required for recreation or sports;

l) services or supplies which would have been payable by the Provincial Plan if proper application had been made;

m) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

n) medical or surgical care which is cosmetic;

o) 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;

p) services or supplies which are provided while confined in a hospital on an in-patient basis; or

q) services or supplies which are not specified as a covered expense under this benefit.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

a) Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List, provided such Drugs are on the list at the time the expense is incurred; and

b) covered pharmacy services that are to be paid when the drug is on the Quebec Basic Prescription Drug Insurance Plan List; and

c) Drugs that are listed as a Covered Expense in this Benefit Booklet, but are not on the Quebec Basic Prescription Drug Insurance Plan List.

Coverage for Drugs on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services published for private plans

The following provisions apply to the coverage of Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act. Coverage for all other Drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered Drug expenses payable will be:

i) for any Drugs on the Quebec Basic Prescription Drug Insurance Plan List which are not otherwise covered under the terms of the plan, the percentage as set out by the then applicable Legislation.

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

iii) for any Drug on the Quebec Basic Prescription Drug Insurance Plan List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage stated under The Benefit, or

- the percentage as set out by the then applicable Legislation.

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

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

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

i) Deductible amounts, and

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

iii) covered pharmacy services that are performed by pharmacists for Drugs on the Quebec Basic Prescription Drug Insurance Plan List.

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 Quebec Basic Prescription Drug Insurance Plan List 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 Quebec Basic Prescription Drug Insurance Plan List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services that are performed for Drugs on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by Manulife for Covered Expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services performed for a Drug on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by Manulife for Covered Expenses is the percentage as set out by the then applicable Legislation.

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

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

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered,

ii) only covered pharmacy services related to a drug on the Quebec Basic Prescription Drug Insurance Plan List are covered,

iii) the percentage payable by Manulife for Covered Expenses is the percentage as set out by the then applicable Legislation,

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

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

Coverage for Drugs that are listed as a covered expense in this Benefit Booklet but are not on the Quebec Basic Prescription Drug Insurance Plan List

Coverage for Drugs that are listed as a covered expense under this Benefit but not on the Quebec Basic Prescription Drug Insurance Plan List will be subject to all the standard provisions included in this Benefit Booklet.

Health Service Navigator Services

Your Extended Health Care benefit includes Health Service Navigator, a service designed to provide credible health information and resources to assist you in better understanding your health concerns and health services available within Canada and your local community. It includes provincial guides that summarize the coverage available to you through your provincial health plan coverage, a national physician search database and tips on how to navigate and leverage the myriad of health resources available to you within the Canadian health care system. Health Service Navigator also provides access to a second opinion service delivered through a premiere second opinion service coordinator with a consortium of highly ranked U.S. based hospitals that support the service. Second opinions are available for a broad range of specific medical conditions.

Limitations

Any medical conditions that are a direct result of either of the following events are excluded from coverage for Health Service Navigator:

- Radioactive Contamination that is not associated with one's occupation; or
- War or warlike operations (whether war is declared or not), invasion, act of foreign enemy, hostilities, mutiny, riot, civil commotion, civil war, rebellion, revolution, insurrections, conspiracy, military or usurped power, martial law or state of siege, or any events or causes which determine the proclamation or maintenance of martial law or state of siege.

Furthermore, Manulife Financial shall not be liable for any expense incurred by you or your eligible dependent which is not specifically described and covered under this Health Service Navigator benefit or your Group Benefits Policy, including but not limited to the cost of treatment**,** travel costs, fees, medical expenses, appointment cancellation charges and other expenses.

Right of Refusal

In some cases, the medical information submitted by the patient may be determined by the physicians of the consortium hospitals to be insufficient, or not of an adequate quality to render a second opinion. In such cases, the second opinion service coordinator will inform the patient within 24 hours, of the reasons for the inability to deliver a report. The patient will then have the opportunity to deliver additional or alternative material to the second opinion service coordinator, for consideration by the physicians of the consortium hospital rendering the opinion. If such information is still insufficient, then the physicians of such consortium hospital have the right to refuse to render a second opinion, and neither they nor the second opinion service coordinator nor Manulife shall have any further obligation in relation to such second opinion request.

Summary Only

Please note that the provisions in this section of the booklet are only intended as a brief summary of the services available under Health Service Navigator. Your plan member brochure has additional information concerning the services. Your Plan Administrator or Manulife Financial can answer any questions you may have about this benefit.

Survivor Extended Benefit

If you die prior to age 55 while your dependents are covered under this Group Benefit Program, Manulife will continue the Extended Health Care benefits without payment of premium. Coverage continues based on years of service, up to a minimum period of 3 months and maximum period of 9 months following your death.

If you die on or after age 55 while your dependents are covered under this Group Benefit Program, Manulife will continue the Extended Health Care benefits without payment of premium. Coverage continues until your spouse dies, remarries or enters into a common-law relationship.

Coverage on any dependent ceases on the earliest of:

a) the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Common Insurance Terms);

b) the date similar coverage is obtained elsewhere; or

c) the date the Group Policy terminates.

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.