The Corporation of the Township of Langley

Plan Document Number: G0148388 - Extended Health Care, Dental Care

Group Policy Number: G0148389 - Life Insurance

Plan D: CUPE Employees

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.

Plan Document Effective Date: March 1, 2025

Group Policy Effective Date: March 1, 2025

This booklet produced: May 15, 2025

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Explanation of Commonly Used 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.

Administrator

Manulife.

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 your employer.

Birth

the complete live delivery of a child from its mother.

Covered Expenses

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

Deductible

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

Dependent

your Spouse or Child who is covered under the Provincial/Territorial 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 coverage, 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 Plan'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 a full-time student;

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

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

Explanation of Commonly Used Terms

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

A stepchild must be living with you to be eligible.

A foster child is not considered an eligible Dependent.

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 covered 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.

Your employer 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 Plan Document. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial/Territorial formularies, recognized clinical practice guidelines, or an Advisory Body.

Earnings

your regular rate of pay from your employer (prior to deductions), including regular bonuses and regular overtime pay and excluding regular commissions.

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

a) the amount reported on your claim form; or

b) the amount reported by your employer to Manulife and for which premiums have been paid.

Essential Duties

the physical and cognitive functions or tasks, recognized by Manulife to be, fundamental to the occupation and are performed at a regular frequency and duration or are infrequent, seldom or rare, but if not performed, would not fulfil the requirements of the occupation.

These functions or tasks, if omitted, modified or changed, would leave the requirements of the occupation unfulfilled.

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/territory where the Drug is dispensed; but has been identified as interchangeable by Manulife.

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.

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 Plan Document.

Non-Evidence Limit

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

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.

Personalized Medicine Test

a pharmacogenomic test that provides information on a person’s response to medication.

Explanation of Commonly Used Terms

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/Territorial Plan

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

Qualifying Period

a period of continuous Total Disability, starting with the first day of Total Disability, which you must complete in order to qualify for disability benefits.

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.

Total Disability or Totally Disabled

a restriction or lack of ability due to an illness or injury which prevents you from performing the Essential Duties of:

a) your own occupation, during the Qualifying Period and the 24 months immediately following the Qualifying Period; and

b) any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 24 months specified above.

The availability of work will not be considered by Manulife 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.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

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

Eligibility

You are eligible for Group Benefits as of the first day of the month coincident with or next following:

a) 1 month of service, for Employee Life Insurance Benefits;

b) 3 months of service for Extended Heath Care Benefits; and

c) 6 months of service for Dental Care Benefits;

as long as you:

a) are an active full-time employee of The Corporation of the Township of Langley and work at least 35 hours per week; or

b) are an active part-time employee of The Corporation of the Township of Langley and work at least 20 hours per week;

c) are younger than the Termination Age; and

d) 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 coverage for yourself in order for your Dependents to be eligible.

Medical Evidence

Medical evidence is required when you apply for insurance in excess of the Non-Evidence Limit.

Medical evidence is also required for all benefits, except Dental, when you make a Late Application for coverage 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.ca/groupbenefits. Further medical evidence may be requested by Manulife*.*

Late Application

An application is considered late when you:

a) apply for coverage on any person after having been eligible for more than 31 days; or

b) re-apply for coverage on any person whose insurance had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your Spouse's plan, your application is considered late when you:

a) apply for coverage 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.

Who Qualifies for Coverage?

Effective Date of Coverage

If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.

If medical evidence 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.

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

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

Your Dependent's coverage will not be effective prior to the date your coverage 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.ca/groupbenefits, or from your plan administrator.

Submitting a Claim

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

Submit Online or you can download the Manulife app from Google Play or the Apple Store

Sign up to use Manulife's Plan Member Secure Site at www.manulife.ca/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.ca/groupbenefits, or from your employer.

Submission Requirements

Claims must be submitted within the following timeframes:

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

b) 12 months from the date the expense was incurred, for claims for Extended Health Care and Dental Care benefits, while coverage under the plan is in force. Upon termination of a person's coverage under this plan, proof that Extended Health Care and Dental 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.ca/groupbenefits to determine which claimed expenses can be submitted via the website.

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

For Dental Care, claims can be submitted either electronically by your dentist, or by paper, using a standard dental claim form.

The Claims Process

Co-ordination of Extended Health Care and Dental 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.ca/groupbenefits.

Naming a Beneficiary

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit 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 Coverage

Your Group Benefit coverage will terminate on the earliest of:

a) the date you cease to be an eligible employee;

b) the date you cease to be actively at work, unless the Group Policy or Plan Document allows for your coverage to be extended beyond this date;

c) the date your employer terminates coverage;

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

e) the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates;

f) the date you reach the Termination Age; or

g) the date of your death.

Your Dependents' coverage terminates on the date your coverage 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 - 1.5 times your annual Earnings, to a maximum of $250,000 and a minimum of $15,000

Non-Evidence Limit - $250,000

Termination Age - your benefit terminates on attainment of age 70 or immediately at retirement, whichever is earlier

Qualifying Period for Waiver of Premium - 180 days

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.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

a) 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;

b) Manulife must receive medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms; and

c) you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife.

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

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

a) the date you cease to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

b) the date you do not supply Manulife with appropriate medical evidence documenting how your illness or injury causes you to be Totally Disabled, as defined under the Explanation of Commonly Used Terms;

c) the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife;

d) the date you do not attend an examination by an examiner selected by Manulife;

e) the date of your death; or

f) the date of your 65th birthday.

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, 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.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife 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.

For more information on the conversion privilege, please see your plan administrator. Provincial/Territorial differences may exist.

Extended Health Care

Your Extended Health Care Benefit is provided directly by The Corporation of the Township of Langley. Manulife has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

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.

Your Group Benefits

The Benefit

Overall Benefit Maximum - $1,000,000 per lifetime

Not applicable to:
Personalized Medicine Program
Out-of-Province/Territory or Out-of-Canada Emergency Medical Treatment
Out-of-Canada – Referrals
Emergency Travel Assistance.

Deductible - $100 Individual, $100 Family, per calendar year

Not applicable to:
Personalized Medicine Program
Out-of-Province/Territory or Out-of-Canada Emergency Medical Treatment
Out-of-Canada – Referrals

Note: *The deductible is not applicable to Emergency Travel Assistance.*

- 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 Dispensing Fee Maximum - $12.00 per prescription

Benefit Percentage (Co-insurance)

100% for
Personalized Medicine Program

90% of the first $1,000 of eligible expenses for family coverage and 100% thereafter for
Drugs (purchased through a preferred provider*)

80% of the first $1,000 of eligible expenses for family coverage and 100% thereafter for
Hospital Care
Vision
Professional Services
Medical Services and Supplies

70% of the first $1,000 of eligible expenses for family coverage and 100% thereafter for
Drugs (purchased through a pharmacy other than a preferred provider*)

Note:
The Benefit Percentage for Out-of-Province/Territory or Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 80%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

*Preferred Providers:
Bayshore
Shoppers Drug Mart
Loblaws
No Frills
Real Canadian Superstore
Costco
Save on Foods
London Drugs

Termination Age – your benefit terminates on the last day of the month in which your employment terminates or the last day of the month following the month in which you retire, whichever is earlier

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary, as determined by Manulife or your employer, 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/Territorial 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 Plan as of the date of approval as determined by the Administrator and shared with your employer as required.

In the event that a provincial/territorial 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 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.

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 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.

Personalized Medicine Program

Personalized medicine testing and counseling under Manulife's personalized medicine program provided you have satisfied the medical conditions and criteria established by Manulife. Manulife will use the expertise of an approved vendor to provide the testing and counseling.

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

a) Drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist;

b) oral contraceptives, intrauterine devices and diaphragms;

c) injectable medications;

d) Life-Sustaining Drugs;

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

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

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

b) charges made by a practitioner or physician to administer injectable medications;

c) Drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis;

d) Drugs determined to be ineligible as a result of Due Diligence;

e) fertility Drugs;

f) anti-smoking Drugs;

g) anti-obesity Drugs;

h) Drugs used in the treatment of a sexual dysfunction; or

f) preventive vaccines and medicines (oral or injected)

- Drug Maximums

All 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/Territorial 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 and the Drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

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

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.

- Payment of Drug Claims

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

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

To fill a prescription for covered Drug expenses:

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

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

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

a) you cannot locate a participating Pay Direct Drug pharmacy;

b) you do not have your Pay Direct Drug Card with you at that time; or

c) the prescription is not payable through the Pay Direct Drug Card system.

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

Vision Care

a) eye exams, $100 every 2 year Block Period;

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $500 every 2 year Block Period;

c) elective laser vision correction procedures, to a maximum of $1,000 per lifetime

Note: 2 year Block Period = January 1, 2025 to December 31, 2026

Professional Services

Services provided by the following licensed practitioners:

a) Acupuncturist - $250 per calendar year

b) Chiropractor - $800 per calendar year combined for services of a chiropractor and naturopath. Charges for x-rays are not eligible.

c) Massage Therapist - $1,250 per calendar year combined for services of a massage therapist and physiotherapist

d) Naturopath - $800 per calendar year combined for services of a chiropractor and naturopath

e) Physiotherapist - $1,250 per calendar year combined for services of a massage therapist and physiotherapist

f) Podiatrist/Chiropodist - $300 per calendar year. Charges for x-rays are not eligible.

g) Speech Therapist - $250 per calendar year

Recommendation by a physician for Professional Services is not required.

Expenses for some of these Professional Services may be payable in part by Provincial/Territorial Plans. Coverage for the balance of such expenses prior to reaching the Provincial/Territorial Plan maximum may be prohibited by provincial/territorial legislation. In those provinces/territories, expenses under this Benefit Program are payable after the Provincial/Territorial 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.

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

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

Charges for a licensed ambulance service provided in the patient's province/territory 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 or your employer, 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. Cochlear Implant Speech Processors/Transmitter are included up to a maximum of 1 per 5 years.

Non-Dental Prostheses, Supports and Hearing Aids

a) external prostheses, myoelectric/microprocessor limbs will be paid up to the equivalent of a standard prosthesis;

b) surgical stockings, up to a maximum of 2 pairs per calendar year;

c) surgical brassieres, up to a maximum of $1,250 per 2 calendar years combined for surgical brassieres and wigs and hairpieces;

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

e) 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 $250 per calendar year for Dependent children and $500 per calendar year for any other person combined for orthopaedic shoes and custom-made orthotics;

f) casted, custom-made orthotics, up to a maximum of $250 per calendar year for Dependent children and $500 per calendar year for any other person combined for orthopaedic shoes and custom-made orthotics; (recommendation of either a physician or a podiatrist is required); and

g) cost, installation, repair and maintenance of hearing aids, (excluding charges for batteries and recharging devices) to a maximum of $937.50 per 5 calendar years;

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, injury, alopecia areata, alopecia universalis or alopecia totalis, up to a maximum of $1,250 per 2 calendar years combined for surgical brassieres and wigs and hairpieces;

d) stump socks, up to a maximum of $250 per calendar year;

c) oxygen;

d) viscosupplementation for knee pain caused by osteoarthritis;

e) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain;

f) transcutaneous electric muscle stimulators (TEMS) if required due to an injury or illness and all muscle tone has been lost;

g) microscopic and other similar diagnostic tests and services, including medical heart and cardiac screeners, rendered in a licensed laboratory in any province. Prostate Specific Antigen (PSA testing is also included for persons age 45 and over up to a maximum of $43.75 per calendar year; and

h) charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing.

Gender Affirmation Treatment

Charges for the following feminization or masculinization procedures provided in Canada, subject to a maximum of $15,000 per lifetime when medical criteria are satisfied.

a) Transition-related genital and chest/breast surgeries that are not covered by the Provincial/Territorial Plan

b) Facial feminization/masculinization surgeries

c) Body feminization/masculinization surgeries

d) Vocal cord surgery

e) Electrolysis or laser hair removal

f) Body hair or skin graft

Expenses related to the reversal of gender affirmation treatments are not covered.

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

- In-Canada Medical Travel

Charges for the following expenses, when referred by a Physician to a hospital, medical treatment centre or medical specialist because, in the Physician's opinion, adequate medical treatment is not available within 1,000 kilometers round trip of the covered person's province/territory of residence, up to a maximum of $1,000 every 24 months:

a) transportation for:

i) round trip economy class travel tickets via a commercial airline, rail, bus or ferry for the covered person and companion; or

ii) mileage for other land transportation (e.g. automobile or taxi) calculated according to the Canada Automobile allowance rate for the year the expense was incurred. Excludes amenities and rental fare other than fuel.

b) accommodation in a hotel or other commercial facility combined for the covered person and, if required, the covered person's companion, during the treatment and one day before and after the treatment, up to a maximum of $75 per day

c) meals combined for the covered person and, if required, the covered person's companion, during the treatment and one day before and after the treatment, up to a maximum of $50 per day

Transportation must take place within 2 months of the Physician's referral.

The covered person requires a medical recommendation by a Physician stating that the covered person requires medical assistance from a companion for the companion to be a Covered Expense under this benefit.

Out-of-Province/Territory or Out-of-Canada and Emergency Travel Assistance

IMPORTANT NOTICE

Your Plan Document includes travel coverage – what's next? We want you to understand (and it is in your best interests to know) what your Plan Document includes, what it excludes, and what is limited (payable but with limits). Please take time to read through this benefits booklet before you travel.

- This benefit covers claims arising from sudden and unforeseen situations (example: accidents and emergencies) and typically not follow-up or recurrent care.
- To qualify for this benefit, you and your dependents must meet all of the eligibility requirements (example: covered by your provincial/territorial health insurance plan for the duration of your trip).
- This benefit contains limitations and exclusions. Examples may include: Medical Conditions that are not Stable, Medical Emergencies related to pregnancy or delivery within 4 weeks of the expected date of delivery.
- This benefit may not cover claims related to pre-existing Medical Conditions, whether diagnosed or not at the time of departure.
- In the event of a claim your prior medical history may be reviewed.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. IF YOU HAVE QUESTIONS, PLEASE CONTACT THE MANULIFE CUSTOMER SERVICE CENTRE AT 1-800-268-6195 OR ONLINE AT MANULIFE.CA

Special definitions

The following terms apply for the purposes of medical Treatment provided outside of the Employee or Dependent's province/territory of residence.

Hospital

a Hospital is an institution that is licensed as an accredited hospital that is staffed and operated for the care and Treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment.

a Hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the older adults or health spa.

Medical Condition

any disease, illness or injury (including symptoms of undiagnosed conditions).

Medical Emergency

a sudden and unforeseen Medical Condition that requires immediate Treatment. A Medical Emergency no longer exists when the evidence reviewed by Manulife indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment.

Physician

a Physician is a person licensed in the jurisdiction where the services are provided, to prescribe and administer medical Treatment.

Reasonable and Customary Charges

charges incurred for drugs, services and supplies that are comparable to what other providers charge for similar drugs, services and supplies in the same geographical area.

the lowest of:

a) The prevailing amount charged in the absence of coverage for the same or comparable drug, services or supply in the same geographical area in which the charge is incurred, as determined by Manulife; or

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

c) the maximum price established by law; or

d) the amount as determined by Manulife as reasonable to be charged for the drug, service, or supply.

Stable

a Medical Condition is considered Stable when in the 90 days prior to departure **all** of the following statements are true:

a) there has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment, and

b) there has not been any change to any existing prescribed drug, or any recommendation or starting of a new prescription drug, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, and

c) the Medical Condition has not become worse, and

d) there have not been any new, more frequent or more severe symptoms, and

e) there has been no hospitalization or referral to a specialist, and

f) there have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

g) there is no planned or pending treatment.

All of the above conditions must be met for a Medical Condition to be considered Stable.

Treatment, Treat

a procedure prescribed, performed or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing and surgery.

Out-of-Province/Territory or Out-of-Canada

Coverage Information

a) Treatment required as a result of a Medical Emergency which occurs during the first 90 days while temporarily outside the province/territory of residence, provided the covered person who receives the Treatment is also covered by the Provincial/Territorial Plan during the absence from the province/territory of residence, up to a maximum of $5,000,000 per lifetime.

b) referral outside of Canada for medical Treatment which is available in Canada to a maximum of $3,000 per 3 calendar year(s)

   If, while outside Canada on referral for medical Treatment, the covered 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/territory 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/Territorial Plan.

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

Emergency Travel Assistance

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

Please call the travel assistance organization before obtaining Treatment, so we may:

a) confirm coverage

b) provide referrals

c) provide assistance

d) authorize Treatment

If it is medically impossible for you to call prior to obtaining Treatment, we ask you to call or have someone call on your behalf as soon as possible.

Your Emergency Travel Assistance card lists the toll-free numbers to call in case of an emergency, while travelling outside your province/territory. 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.

Emergency Travel Assistance is a travel assistance program available for you and your covered Dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a Medical Emergency while travelling outside your province/territory of residence, for the same period as specified under the Out-of-Province/Territory or Out-of-Canada benefit.

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

Medical Emergency Assistance

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 coverage, is provided.

c) **Claims Payment Service**

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

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

If Medically Necessary for a qualified medical attendant to accompany the covered 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 a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

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

g) **Trip Interruption/Delay**

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

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

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

h) **After Hospital Convalescence**

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

i) **Visit of Family Member**

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

j) **Vehicle Return**

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

k) **Identification of Deceased**

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

l) **Meals and Accommodation**

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

Non-Medical Assistance

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

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to their province/territory 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 a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Exceptions

The Administrator, and the company contracted by the Administrator to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical Treatment, or the failure of a covered person to obtain medical Treatment or emergency assistance services for any reason.

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

Exclusions

No Out-of-Province/Territory or Out-of-Canada Medical Emergency or Emergency Travel Assistance benefits are payable for expenses directly or indirectly related to:

a) any Medical Condition which is not Stable in the 90 days before the scheduled date of departure from the province/territory of residence;

b) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

c) further related medical Treatment if the Administrator determines that you should transfer to another facility or return to your home province/territory of residence for treatment;

d) tests, Treatment or surgery for which you could have returned home, after your Medical Emergency Treatment has started. This includes but is not limited to invasive or investigative testing, MRI, CT, surgery, cardiac catheterization, other cardiac procedures, transplant, and follow up appointments;

e) non-Emergency or elective Treatment (e.g. cosmetic surgery, chronic care, rehabilitation, or any Treatment not immediately medically required, including any expenses for directly or indirectly related complications);

f) any claim, if you or your Dependent are not covered under the Government Health Insurance Plan (GHIP) of your province or territory of residence for the entire duration of the trip. It is your responsibility to check that you do have this coverage;

g) any charges incurred relating to a trip made for the purpose of obtaining a diagnosis, Treatment, surgery, investigation, palliative care, or any alternative therapy, as well as any related complication;

h) any Medical Condition or symptoms for which it is reasonable to believe or expect that Treatment will be required during your trip;

i) the continued Treatment, recurrence or complication of a Medical Condition or related condition, following Emergency Treatment during your trip, if the Administrator determines that your Emergency has ended and you are able to return to your province/territory of residence for further Treatment;

j) a Medical Condition that is the result of you or your covered Dependent not following Treatment as prescribed, including prescribed prescription or over-the-counter medication;

k) any Medical Emergency related to a to pregnancy, delivery, or complications of either, for covered persons who are pregnant and travelling within 4 weeks of the expected date of delivery;

l) a Medical Condition arising during your trip from, or in any way related to, the operation of a motor vehicle or watercraft of any kind by you or your covered Dependent while impaired by a drug or any intoxicant or having a blood alcohol level of more than 80 mg of alcohol per 100 ml of blood.

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, your employer 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 your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

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

a) war, whether declared or undeclared, insurrection, the hostile actions of any armed forces, willing participation in a riot or civil commotion or any service in the armed forces of any country;

b) your involvement in the commission or attempted commission of an assault, criminal offence, or illegal act;

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

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

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

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

g) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

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

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

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

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

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

m) medical or surgical care which is cosmetic;

n) services or supplies which are performed or provided by the covered person, an Immediate Family Member or a person who lives with the covered person;

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

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

Dental Care Benefit

Your Dental Care Benefit is provided directly by The Corporation of the Township of Langley. Manulife has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your Dependents require any of the dental services specified under Covered Expenses below, your Dental 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 below.

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

Deductible - Nil

Dental Fee Guide - Current British Columbia Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

90% for Level I - Basic Services

90% for Level II - Supplementary Basic Services

60% for Level III - Dentures

60% for Level IV - Major Restorative Services

60% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I, Level II, Level III and Level IV

$4,500 per lifetime for Level V

Termination Age - your benefit terminates on the last day of the month in which your employment terminates or the last day of the month following the month in which you retire, whichever is earlier

Covered Expenses

The following expenses are covered if they:

a) are incurred for the necessary dental care of a covered person while covered under this benefit;

b) are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license;

c) are reasonable as determined by your employer or Manulife, taking all factors into account; and

d) do not exceed the fees recommended in the Dental Fee Guide, or Reasonable and Customary charges as determined by your employer or Manulife, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, your employer will pay benefits as if the least expensive course of treatment were used. Your Administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant. This provision does not apply to bonded fillings.

Level I - Basic Services

a) complete oral exam, once every 3 calendar years;

b) full-mouth x-rays, once every 36 months;

c) panoramic x-rays, once every 24 months;

d) one unit of light scaling twice per calendar year and two units of polishing, once per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing), once per calendar year, when the service is performed in Quebec;

e) recall exams, bitewing x-rays, and fluoride treatments, two per calendar year;

f) routine diagnostic and laboratory procedures;

g) preventive restorative resin and pit and fissure sealants, combined limit of one per tooth per 2 years;

h) fillings, limited to one per 2 years. Replacement fillings are covered provided:

   i) 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

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam;

i) pre-fabricated full coverage restorations (metal and plastic);

j) space maintainers (appliances placed for orthodontic purposes are not covered);

k) minor surgical procedures and post-surgical care;

l) extractions (including impacted and residual roots);

m) consultations, anaesthesia, and conscious sedation;

n) 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;

o) injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery;

p) gold foil; and

q) inlays (covering at least 3 surfaces, provided the tooth cusp is missing)

Level II - Supplementary Basic Services

a) surgical procedures not included in Level I (excluding implant surgery);

b) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

   i) scaling not covered under Level I, and root planing,

   ii) provisional splinting,

   iii) occlusal equilibration, up to a maximum of 8 units per calendar year;

c) endodontic services which include root canals and therapy, root amputation, apexifications and periapical services. Root canals are limited to one per 5 years per tooth. Re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment:

   i) root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime.

   ii) re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Level III - Dentures

a) initial provision of full or partial removable dentures;

b) replacement of removable dentures, provided the dentures are required because:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 5 years old and cannot be made serviceable, or

   iii) the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation.

Level IV - Major Restorative Services

a) crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay (stainless steel crowns limited to one per 24 months);

b) chairside or laboratory veneers, one per 5 years per tooth;

c) initial provision of fixed bridgework;

d) replacement of bridgework, provided the new bridgework is required because:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 5 years old and cannot be made serviceable, or

   iii) the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation.

Level V - Orthodontics

Orthodontic services

Late Entrant Limitation

If you or your Dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $250 for each covered person.

Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Covered Expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, your employer 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 your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

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

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

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

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

d) dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit;

e) anti-snoring or sleep apnea devices;

f) broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms;

g) services which are payable by any government plan;

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

i) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

j) treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction;

k) replacement of removable dental appliances which have been lost, mislaid or stolen;

l) laboratory fees which exceed Reasonable and Customary charges;

m) services or supplies which are performed or provided by the covered person, an Immediate Family Member or a person who lives with the covered person;

n) implants, or any services rendered in conjunction with implants;

o) treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition; or

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

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Extended Health Care and Dental Care benefits without requiring any contribution from you. The coverage continued on a Dependent will be the same as that which was in effect on the date of your death and is subject to any age reduction or termination shown in the Plan Document at that time.

Coverage will continue until the earliest of:

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

b) the date similar coverage is obtained elsewhere;

c) the date which is 6 months from your death; or

d) the date the Plan Document terminates.

Medical Second Opinion

Medical Second Opinion (“MSO”) is a service available to you or your eligible dependents.

The Medical Second Opinion (“MSO”) service provides a complete review and advice that can be considered by both you and your physician(s) after you or your eligible Dependents have received a diagnosis or treatment plan for a covered condition as determined by Manulife. The MSO service includes access to a specifically trained nurse assigned as the primary contact and assists in navigation throughout the process.

Medical second opinions are conducted by a team of physicians with specialties that are specific to the covered condition and are selected based on their experience with similar cases and their research knowledge.

Any medical conditions that are a direct result of either of the following events are not eligible for MSO service:

a) attempted suicide and/or self-inflicted injuries or injuries caused by a third person with the employee's consent

b) radioactive contamination

c) war or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law of state of siege

d) poisoning or poisonous gas inhalation

e) epidemics/pandemics/natural disasters

For more information about the list of covered conditions and the Medical Second Opinion service, please visit Manulife.ca/MSO.

Important Information about your Benefits

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 and/or Plan Document has the right to request a copy of any or all of the following items:

a) the Group Policy and/or Plan Document;

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 and/or Plan Document.

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.

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.