

# Northwest Territories Power Corporation

Group Policy Number: G0090250

Class: C - Part-time Employees

## A message from your plan sponsor

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

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

After reviewing the coverage, if you have any questions, check in with our plan administrator.

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# What you need to know about your plan

## Who and what your plan covers

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

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

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

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

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

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

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

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

## Time Limit on Legal Action

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

**Your plan sponsor is Northwest Territories Power Corporation**

**This booklet produced: January 23, 2017**

**Your plan number is G0090250**  
This is the main number you should provide as a reference when contacting Manulife Financial. Be sure to record this number and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

**Your coverage class is C - Part-time Employees**

**The plan effective date is December 01, 1989**

This is the official day when all of the coverage and services your plan sponsor has arranged with us begins. Coverage starts once you have fulfilled any waiting period requirements set for your plan.

**Your plan may include a waiting period for some benefits.**

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

**Enhanced information is also available on the Internet**

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

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




**HOW LONG COULD IT TAKE TO HAVE MY CLAIM PROCESSED?**

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

<p><b>REGULAR</b> LETTERMAIL SUBMISSION</p>  <p>PAPER CHEQUE + PAPER CLAIM STATEMENT PAYMENT</p>	<p><b>FASTER</b> LETTERMAIL SUBMISSION</p>  <p>DIRECT DEPOSIT PAYMENT</p>	<p><b>FASTEST</b> ELECTRONIC SUBMISSION <small>VIA YOU OR YOUR SERVICE PROVIDER IF APPLICABLE</small></p>  <p>DIRECT DEPOSIT PAYMENT</p>
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**USE MORE THAN ONE PLAN TO GET MORE MONEY BACK**

Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works.

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

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

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

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## **Core Coverage and Services**

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

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## Dental

Benefit Details	Your Plan's Coverage
Waiting Period	6 months
Deductible	\$25 Individual, \$50 Family, per calendar year(s)
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.
Dental Fee Guide	Current Northwest Territories Fee Guide for General Practitioners
Coverage ends	At the earlier of age 70 or your retirement
Maximum applies to: Plan A - Basic Services	\$2,000 per calendar year
Maximum applies to: Plan C - Orthodontic Services	\$3,500 per lifetime
<p>Plan A - Basic Services</p> <p>Includes items such as:</p> <ul style="list-style-type: none"> <li>• one complete oral exam in any 24 consecutive months</li> <li>• full mouth x-rays during any 24 consecutive months</li> <li>• one unit of light scaling and one unit of polishing once every 5 months, when the service is performed outside Quebec, or prophylaxis once every 5 months, when the service is performed in Quebec</li> <li>• recall exams, bitewing x-rays, and fluoride treatments, once every 5 months</li> <li>• one visit for oral hygiene instruction</li> <li>• routine diagnostic and laboratory procedures</li> <li>• fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided: <ul style="list-style-type: none"> <li>- 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</li> <li>- the existing filling is amalgam and there is medical evidence indicating that the</li> </ul> </li> </ul>	100% to a maximum of \$2,000 per calendar year

<p>patient is allergic to amalgam</p> <ul style="list-style-type: none"> <li>• pre-fabricated full coverage restorations (stainless steel crowns), excluding crowns of porcelain fused to metal, acrylic, plastic, gold, porcelain and other substances</li> <li>• space maintainers (appliances placed for orthodontic purposes are not covered)</li> <li>• minor surgical procedures and post surgical care</li> <li>• extractions (including impacted and residual roots)</li> <li>• consultations, anaesthesia, and conscious sedation</li> <li>• periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including: <ul style="list-style-type: none"> <li>- scaling in excess of one unit, and root planing, up to a combined maximum of 16 units per calendar year(s) ;</li> <li>- provisional splinting; and</li> <li>- occlusal equilibration, up to a maximum of 8 units per calendar year(s)</li> </ul> </li> <li>• denture repairs, relines and rebases (relining and rebasing of dentures is limited to once every 36 consecutive months)</li> <li>• injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery</li> <li>• denture repairs, relines and rebases (relining and rebasing of dentures is limited to once every 36 months)</li> </ul>	
<p>Plan B - Supplementary Basic Services</p> <p>Includes items such as:</p> <ul style="list-style-type: none"> <li>• crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay</li> <li>• surgical procedures not included in Plan A</li> <li>• initial provision of fixed bridgework</li> <li>• replacement of bridgework, provided the new bridgework is required because: <ul style="list-style-type: none"> <li>- a natural tooth is extracted and the existing appliance cannot be made serviceable;</li> <li>- the existing appliance is at least 60 months old; or</li> <li>- the existing appliance is temporary and is replaced with the permanent bridge within</li> </ul> </li> </ul>	

<p>12 months of its installation</p> <ul style="list-style-type: none"> <li>• bridgework required solely to replace a natural tooth which was missing prior to becoming insured under this Plan is not covered</li> <li>• initial provision of full or partial removable dentures</li> <li>• replacement of removable dentures, provided the dentures are required because: <ul style="list-style-type: none"> <li>- a natural tooth is extracted and the existing appliance cannot be made serviceable;</li> <li>- the existing appliance is at least 60 months old; or</li> <li>- the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation (replacement of dentures within the first 12 months of becoming insured for this covered expense is not covered)</li> </ul> </li> </ul>	
<p>Plan C - Orthodontic Services</p> <p>Includes items such as:</p> <ul style="list-style-type: none"> <li>• orthodontic services (persons age 18 years and older are not covered)</li> </ul>	<p>50% to a maximum of \$3,500 per lifetime</p>
<p><u>Exclusions</u></p> <p><i>No Dental Care benefits will be payable for expenses resulting from:</i></p> <ul style="list-style-type: none"> <li>• <i>self-inflicted injuries</i></li> <li>• <i>war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion</i></li> <li>• <i>committing or attempting to commit an assault or criminal offence</i></li> <li>• <i>dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit</i></li> <li>• <i>anti-snoring or sleep apnea devices</i></li> <li>• <i>broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms</i></li> <li>• <i>services which are payable by any government plan</i></li> <li>• <i>services or supplies provided by an employer's medical or dental department</i></li> <li>• <i>services or supplies for which no charge would normally be made in the absence of insurance</i></li> <li>• <i>treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction</i></li> <li>• <i>replacement of removable dental appliances which have been lost, mislaid or stolen</i></li> <li>• <i>laboratory fees which exceed reasonable and customary charges</i></li> <li>• <i>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</i></li> </ul>	

- *implants, or any services rendered in conjunction with implants*
- *treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition*
- *services or supplies which are not specified as a covered expense under this benefit*

*If you anticipate charges for any treatment to exceed \$300, please submit a pre-treatment plan before receiving the service so you can understand what portion your plan may cover.*

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

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

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

## Extended Health Care Benefit

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

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

Benefit Details	Your Plan's Coverage
Waiting Period	none
Maximum	Unlimited
Deductible	Nil
Co-insurance	100% for Hospital Care, Medical Services & Supplies, Professional Services, Vision, Drugs
Coverage Ends	At the earlier of age 70 or your retirement

### Exclusions

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

(not applicable to Health Service Navigator®)

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature

- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *services or supplies which are provided while confined in a hospital on an in-patient basis*
- *services or supplies which are not specified as a covered expense under this benefit*
- *drugs determined to be ineligible as a result of due diligence*

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

EHC - Drugs	
100% Co-insurance	
Benefit Details	Your Plan's Coverage
<p>Prescribed Drugs with <b>Generic Substitution</b></p> <p>Includes the following drug classes:</p> <ul style="list-style-type: none"> <li>• oral contraceptives</li> <li>• preventive vaccines and medicines (oral or injected)</li> <li>• standard syringes, needles and diagnostic aids, required for the treatment of diabetes</li> <li>• vitamins properly identified in the Compendium of Pharmaceuticals and Specialties</li> </ul> <p>No coverage for / excludes:</p> <ul style="list-style-type: none"> <li>• sexual dysfunction drugs</li> <li>• dietary supplements, health foods and nutritional products</li> <li>• drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis</li> <li>• drugs determined to be ineligible as a result of due diligence</li> <li>• cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment used in the treatment of diabetes</li> <li>• charges to administer serums, vaccines &amp; injectable drugs</li> <li>• experimental or investigational drugs not approved as an effective, appropriate and essential treatment of an illness or injury</li> <li>• natural health products (products with a NPN)</li> </ul>	<p>Drug deductible 20% of the total cost of each prescription</p> <p>\$15,000 lifetime maximum on fertility drugs \$400 lifetime maximum on anti-smoking prescription drugs</p> <p><i>No Substitution Prescriptions - If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, then the full cost of the prescribed product is covered.</i></p> <p><i>There is a limitation on quantity of drugs that can be dispensed and claimed at one time, to the lesser of:</i></p> <p><i>a) the quantity prescribed by the Physician or Dentist; or</i></p> <p><i>b) a 34 day supply; or</i></p> <p><i>c) up to a 100 day supply may be payable in long term therapy where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.</i></p> <p><i>If you are a Quebec resident, your plan's coverage will coordinate with RAMQ.</i></p>

<b>EHC - Vision</b>	
100% Co-insurance	
Benefit Details	Your Plan's Coverage
Prescription Glasses, Contact Lenses, Laser Eye Surgery, Eye Exams	<p>\$300 per 24 consecutive months for prescription glasses, elective contact lenses , repairs and elective laser vision correction procedures</p> <p>if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable for all contact lense expenses will be \$350 during any 24 consecutive months</p> <p>Eye Exams - once per 24 consecutive months</p>
	<p><i>Find out about <b>discounts</b> available to you through Manulife Financial's relationship with Preferred Vision Services (PVS).</i></p>

## EHC - Health Care Professionals (Professional Services)

100% Co-insurance

Benefit Details	Your Plan's Coverage
<p>Services provided by the following licensed practitioners:</p> <p>Chiropractor, Osteopath, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Speech Therapist, Physiotherapist, Psychologist</p>	<p>\$300 per calendar year(s) for Chiropractor</p> <p>\$300 per calendar year(s) for Osteopath</p> <p>\$300 per calendar year(s) for Podiatrist/Chiropodist</p> <p>\$300 per calendar year(s) for Massage Therapist</p> <p>\$300 per calendar year(s) for Naturopath</p> <p>\$300 per calendar year(s) for Speech Therapist</p> <p>\$300 per calendar year(s) for Physiotherapist</p> <p>\$300 per calendar year(s) for Psychologist</p> <p>The maximum for each specialty includes no more than one x-ray per calendar year.</p> <p><i>Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses prior to reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this benefit program are payable after the Provincial Plan's maximum for the benefit year has been paid.</i></p> <p><i>Recommendation by a physician for Professional Services is not required.</i></p>

## EHC - Medical Supplies and Services

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

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

Benefit Details	Your Plan's Coverage
<p><b>Private Duty Nursing Services</b></p> <p>Provided by a registered nurse or registered nursing assistant who has completed an approved medications training program</p> <p>Excludes:</p> <ul style="list-style-type: none"> <li>• custodial care, homemaking duties or supervision</li> <li>• services performed by a nurse practitioner who is an immediate family member or who lives with the patient</li> <li>• services performed while confined to a hospital, nursing home or other similar institution</li> <li>• services that could be performed by a person with lesser qualifications, a relative, a friend or a member of the patient's household</li> </ul>	<p>\$10,000 per calendar year(s)</p> <p><i>Submit a detailed treatment plan estimate before Private Duty Nursing services begin so we can advise you of what benefit may be provided.</i></p>
<p><b>Hearing Aids</b></p>	<p>\$300 per 5 calendar year(s)</p> <p><i>Includes cost, installation, repair and maintenance of Hearing Aids (including charges for batteries)</i></p>
<p><b>Orthopaedic Shoes/Orthotics</b></p>	<p>Custom Made Shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of 1 pair per calendar year (must be constructed by a certified orthopaedic footwear specialist)</p> <p>\$150 per calendar year(s) for Custom Made Orthotic</p>

	<p>Foot Appliances</p> <p><i>Must be recommended by a physician or podiatrist.</i></p>
<p><b>Medical Equipment</b></p> <p>Includes items such as:</p> <ul style="list-style-type: none"> <li>• ambulance (licensed including air ambulance, provided in province of residence)</li> <li>• mobility equipment (crutches, canes, walkers, wheelchairs)</li> <li>• manual hospital beds</li> <li>• respiratory and oxygen equipment</li> <li>• other equipment usually found only in hospitals</li> <li>• non-dental external prostheses</li> <li>• braces (other than foot braces), trusses, collars, leg orthosis, casts and splints</li> <li>• ileostomy, colostomy and incontinence supplies</li> <li>• medicated dressings and burn garments</li> <li>• oxygen</li> <li>• charges for the treatment required as a result of an injury to natural teeth or jaw</li> <li>• surgical brassieres</li> <li>• surgical stockings</li> </ul>	<p><i>Medical equipment dispensed by a hospital is not an eligible expense.</i></p> <p><i>In the province of Quebec, microscopic and other similar diagnostic tests and services rendered in a licensed laboratory are included.</i></p> <p><i>Accidental dental treatment must be provided within 12 months of the accident. Injuries sustained while biting or chewing are not covered.</i></p>

<b>EHC - Hospital</b>	
100% Co-insurance	
<b>Benefit Details</b>	<b>Your Plan's Coverage</b>
General or Rehabilitation hospitals	<ul style="list-style-type: none"> <li>• in a Private Room</li> <li>• in excess of the hospital's public ward charge</li> </ul>
	<i>Manulife Financial will coordinate payment after any provincial plan coverage has first been applied.</i>

## EHC - Medical and Non-Medical Travel Emergencies

Benefit Details	Your Plan's Coverage
<p>Emergency medical coverage</p> <p>Conditions:</p> <ul style="list-style-type: none"> <li>Coverage is for immediate medical treatment required for: <ul style="list-style-type: none"> <li>a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or</li> <li>a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.</li> </ul> </li> <li>Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.</li> <li>Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependants.</li> </ul>	<p>100% with a maximum of \$5,000,000 per lifetime</p> <p>Stable means in the 90 days before departure, the insured person has not:</p> <ul style="list-style-type: none"> <li>been treated or tested for any new symptoms or conditions;</li> <li>had an increase or worsening of any existing symptoms;</li> <li>changed treatments or medications (other than normal adjustments for ongoing care);</li> <li>been admitted to the hospital for treatment of the condition.</li> </ul> <p>Coverage is not available if you (or your dependant) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.</p> <p>A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory.</p> <p><i>You are typically responsible for payment of medical expenses amounting to less than \$200 CDN. When you return from your trip, you can submit a claim to be reimbursed for those expenses through the normal claim submission process.</i></p> <p><i>For charges over \$200 CDN, contact the service partner shown on your benefits card as soon as possible to arrange for payment directly to the treating physician or facility.</i></p>
<p>Emergency Travel Assistance</p> <p>Including:</p> <ul style="list-style-type: none"> <li>24 hour access to multi-lingual service representatives</li> <li>referral to local medical care and</li> </ul>	<p>100% with all maximums below stated in Canadian Funds.</p> <p>\$1,000 for return of vehicle</p> <p>\$2,000 for meals and accommodations</p>

<p>treatment monitoring</p> <ul style="list-style-type: none"> <li>• payment of medical bills, medical transportation, return home of dependant children, visit by a family member, trip interruption/delay coverage, support through convalescence after hospital discharge, identification and/or return of a deceased traveller, meals and accommodation, vehicle return, pre-trip advice on passport, visa, vaccination and inoculation requirements for a destination, assistance in replacing lost documents and tickets, referral to legal assistance in your foreign destination, telephone interpretation service, emergency message service, and</li> <li>• after-hours medical advice phone support</li> </ul>	<p>\$5,000 for return of deceased</p> <hr/> <p><i>See <b>Emergency Travel Assistance</b> for additional information, a list of phone numbers for frequent Canadian travel destinations and for participating countries.</i></p>
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## Health for Life® - Resources to help you and your family maintain overall good health and wellness

Benefit Details	Your Plan's Coverage
<p>Your plan also includes access to services and information you and your family can use to live healthier lives. You can access these services on the Plan Member Secure Site.</p>	
<h3>Health eLinks® - Online resources for better health</h3>	
<p>Take the first step toward healthier living through online tools and resources such as:</p> <p>Health Risk Assessment</p> <p>Health Library, including:</p> <ul style="list-style-type: none"> <li>• Conditions database</li> <li>• Medications database</li> <li>• Tests and procedures database</li> <li>• Health features</li> <li>• Personal Health Improvement Program</li> </ul>	<p>Included and available on the Plan Member Secure Site</p>

## Health Service Navigator®

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

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

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

## Life Insurance

*You may also wish to consider supplementing this coverage by purchasing any available FollowMe, Optional or Personal Benefits coverage available for your plan.*

Benefit Details	Your Plan's Coverage
Waiting Period	none
Benefit Amount	3 times your annual earnings, to a maximum of \$250,000
Non-Evidence Limit	\$250,000
Reduction and Termination Age	Your benefit amount reduces by 50% at age 65 and terminates at age 70 or retirement, whichever is earlier
Qualifying Period for Waiver of Premium	6 months
Waiver of Premium	<p>If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium.</p> <p>Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:</p> <ul style="list-style-type: none"> <li>• your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period</li> <li>• any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above</li> </ul> <p>The availability of work will not be considered by Manulife Financial in assessing your disability.</p> <p>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.</p>
Conversion Privilege	If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without needing to provide medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of

	<p>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.</p> <p>See the <b>conversion option</b> details in the Individual plan options section.</p>
<p>Your beneficiary or estate must <b>submit a claim</b> within 90 days of the date of death. He or she can obtain the necessary paperwork from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.</p> <p>If you are terminally ill and not expected to live more than 24 months, and you require financial assistance, you may qualify for a Compassionate Assistance loan.</p> <p>You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.</p> <p>You should review your beneficiary designation to be sure that it reflects your current intent.</p>	

## Survivor Benefit

Benefit Details	Your Plan's Coverage
<p>If you die while your dependants are insured under the program, Manulife Financial will continue coverage for some benefits without payment of premium:</p> <ul style="list-style-type: none"><li>• Extended Health Care</li><li>• Dental Care</li></ul>	<p>Coverage will continue until the earliest of:</p> <ul style="list-style-type: none"><li>• the date your dependant is no longer a dependant</li><li>• the date similar coverage is obtained elsewhere</li><li>• the date which is 2 years from your death or</li><li>• the date your surviving spouse remarries</li></ul>

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

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

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## Conversion Option

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

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

## FollowMe™ Health

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

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

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

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

# Definitions

Explanation of some of the terms used in this document

## Co-insurance

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

## Co-payment

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

## Dependant

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

### *Child*

- your natural or adopted child, or stepchild, who is:
  - unmarried
  - under the age stated below:  
for Dental coverage - under age 21, or under age 25 if a full-time student;  
for Extended Health Care coverage - under age 21, or under age 25 if a full-time student
  - not employed on a full-time basis
  - not eligible for insurance as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when insurance would normally terminate will continue to be an eligible dependant. 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 dependant on the employee for support, maintenance and care, due to a mental or physical disability. Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary
- a stepchild must be living with you to be eligible

## Drugs

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

**RAMQ - Drug Benefit and Pharmacy Services for persons who reside in Quebec**

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

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

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

**a) Benefit Percentage**

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

- For any drug on the RAMQ List which is not otherwise covered under the terms of this benefit, the percentage payable is the percentage as set out by legislation.
- For any Legislated pharmacy services which are not otherwise covered under the terms of the Policy, the percentage is as set out by the then applicable Legislation.
- For any drug on the RAMQ List which is covered under the terms of this benefit, the percentage payable is the greater of:
  - the benefit percentage stated under the benefit; or
  - the percentage as set out by the then applicable legislation.

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

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

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

- deductible amounts, and
- the portion of covered drug expenses that is paid by an insured person, when the percentage of covered expenses payable under this benefit is less than 100%; and
- covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependant 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 dependant children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

**c) Deductible**

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

**d) Lifetime Maximums**

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

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

**e) Eligible Dependant Children**

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

- i) the age specified in this Benefit Booklet or
- ii) age 26.

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

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

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

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

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services related to a drug on the RAMQ List,
- iii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the legislation
- iv) the Annual Out-of-Pocket Maximum is as stipulated in the legislation

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

**Due Diligence**

A process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the plan. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized

clinical practice guidelines, or an advisory body.

### **Earnings**

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

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

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

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

### **Experimental or Investigational**

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

### **Lower Cost Alternative**

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

### **Medical and Non Medical Travel Emergencies**

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

### **Medically Necessary**

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

### **Non-Evidence Limit**

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

### **Out-Of-Pocket Maximum**

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

**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.

**Pyogenic Infection**

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

**Reasonable and Customary Charges**

The lowest of:

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