# Laurentian University

**Divisional Description:** Division 21 - Laurentian University Staff Union

**Group Policy Numbers:** GH 8820, GH 83293 and GH 83294

**Employee Name:** _____

**Certificate Number:** _____

## Welcome to Your Group Benefits Program

**Group Policy Effective Dates:**

Major Medical: October 1, 1960

Dental: January 1, 1976

Long Term Disability: October 1, 1962

As a valued employee of Laurentian University, the Sudbury Neutrino Observatory, the Centre of Excellence in Mining Innovation (CEMI) and the Mining, Innovation, Rehabilitation and Applied Research Corp (MIRARCO), you are entitled to the medical and financial security of your Group Benefit Program, provided by Laurentian University in partnership with Manulife Financial.

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but also for the security they provide for you and your family, especially in case of unforeseen needs.

Human Resources can answer any questions you may have about your benefits, or how to submit a claim.

Please note: Laurentian University benefits are based on a benefit year of July 1st to June 30th, except for some expenses, under vision care, which are based on any 24 consecutive months.

**You may contact Manulife Financial at 1 (800) 268-6195 for enquiries. Please have your Group Numbers and Certificate Number available.**

This booklet produced: November 3, 2022

# Table of Contents

***Designed with Your Needs in Mind***

This booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- an Explanation of Common Insurance Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits, and
- information you need, and simple instructions, on how to submit a claim.

***Important Note***

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

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of Laurentian University, the Sudbury Neutrino Observatory, the Centre of Excellence in Mining Innovation (CEMI) and the Mining, Innovation, Rehabilitation and Applied Research Corp (MIRARCO). The information in this booklet is a summary of the provisions of the Group Policy. The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of Laurentian University and Manulife Financial are governed by the Group Policy (available from Human Resources). In the event of a discrepancy between this booklet and the Group Policy, the terms of the Group Policy will apply. No alteration of this booklet is permitted by any person, except by an authorized representative of Manulife Financial.

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

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

- the Group 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 Group Policy.

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

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

# Explanation of Common Insurance Terms

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

***Adherence***

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

***Advisory Body***

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

***Child(ren)***

- your unmarried children (including adopted, foster and step-children) who are less than 21 years of age. For Major Medical and Dental, unmarried children, who are full-time students and dependent upon you for support, will be eligible until age 25. Children are insured from birth for Major Medical and Dental Benefits.

- any mentally or physically handicapped child may remain insured past the maximum age. The child, upon reaching maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

***Deductible***

the amount of eligible expenses for which you are responsible prior to consideration of payment of benefits.

***Dependent***

- a spouse who, with respect to Major Medical and Dental coverage, is a resident of the same country in which you reside, or

- a child who is a resident of the same country in which you reside or who is in regular full-time attendance at an accredited institute of learning outside Canada. The child must remain a Canadian citizen and O.H.I.P must be continued for Major Medical and Dental coverage to be continued.

***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 Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the policy. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

***Earnings***

your gross earnings excluding bonus, commissions, overtime, stipends and overload.

***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.

***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 Financial as effective, appropriate and essential treatment 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 covered under the Group Policy.

***Patient Assistance Program***

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

***Pharmacoeconomics***

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

***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.

***Reasonable and Customary***

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,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

## Explanation of Common Insurance Terms

***Spouse***

a person who either:

- is married to you through an ecclesiastical or civil ceremony, or
- although not legally married to you, continuously cohabits with you in a conjugal relationship, which is recognized as such in the community in which you reside, at the time a claim is incurred. The term conjugal relationship shall be deemed to include a conjugal relationship between partners of the same sex.

***Totally disabled***

for Long Term Disability, you are unable to work and earn an income due to sickness or bodily injury that leaves you wholly and continuously disabled.

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

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

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

Your Group Benefit Program is provided by Laurentian University, in partnership with The Manufacturers Life Insurance Company.

## *Payroll and Benefits Centre*

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

As a member of this Group Benefit Program, it is up to you to provide the Payroll and Benefits Centre with the necessary information to perform such duties.

## *Human Resources*

For all other issues, please contact the Plan Administrator in Human Resources.

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| Your HR Plan Administrator is Julie Richer<br><br>Phone Number: (705) 675-1151 extension 3029 |

## *Applying for Group Benefits*

To apply for Group Benefits, you must submit a completed Application for Group Insurance form, available from the Payroll and Benefits Centre.

## *Making Changes*

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

- change in Dependent Coverage
- change in Name
- applying for coverage previously waived

To make such changes, you must complete the Request for Benefit Changes, available from the Payroll and Benefits Centre.

## *Manulife Financial Website*

You can access claim forms at the Manulife Financial website (www.manulife.ca/groupbenefits).

# The Claims Process

## *How to Submit a Claim*

All claim forms, available from the Payroll and Benefits Centre, must be correctly completed. Remember, always provide your Group Policy Number and your Certificate Number to avoid any unnecessary delays in the processing of your claim.

The Payroll and Benefits Centre can assist you in properly completing the forms, and Human Resources will answer any questions you may have about the claims process and your Group Benefits Program.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined under Submitting a Claim. 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.

### *Payment of Major Medical and Dental Claims*

Once the claim has been processed, Manulife Financial will send an Explanation of Benefits to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, the Plan Administrator in Human Resources will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact your Plan Administrator in Human Resources.

### *Co-ordination of Major Medical and Dental Benefits*

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

***Order of Benefit Payment***

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

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

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

  - For Claims incurred by you or your Dependent Spouse:

    The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

    In situations where you or your Dependent Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

    - The Plan where the person is covered as an active full-time employee, then
    - The Plan where the person is covered as an active part-time employee, then
    - The Plan where the person is covered as a retiree.

  - For Claims incurred by your Dependent Child:

    The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

    However, if you and your Spouse are separated or divorced, the following order applies:

    - The Plan of the parent with custody of the child, then
    - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
    - The Plan of the parent not having custody of the child, then
    - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

- A claim for accidental injury to natural teeth will be determined under health care plans with accidental dental coverage before it is considered under dental Plans.

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

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

# The Claims Process

***Submitting a Claim for Co-ordination of Benefits***

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

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

## *Eligibility*

You are eligible for Group Benefits if you:

- are a full-time or contract* employee and work at least 20.25 hours per week, and
- are one of the following:
  - a salaried non-union employee, or
  - a contract employee, or
  - a salaried employee who is a member of Laurentian University Staff Union,
  - an hourly-rated employee who is a member of the Laurentian University Staff Union,
  - an hourly-rated employee who is a member of C.A.W./T.C.A Canada “University of Sudbury”,

  **You are a contract employee if you are employed for a specified and finite period of time, your employment terms are outlined in a contract between yourself and Laurentian University and such contract specifies that you are eligible for benefits coverage.*
- are younger than the Termination Age,
- are residing in Canada, or you have been hired by the policyholder but have not yet taken residence in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please see the section entitled Your Group Benefits.

Your dependents are eligible for insurance on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for insurance for yourself in order for your dependents to be eligible.

## *Evidence of Insurability*

Medical evidence is required for all benefits, except Extended Heath Care for yourself and Dental insurance for all persons, when you make a Late Application for insurance on any person.

Medical evidence can be submitted by completing the Evidence of Insurability form available from the Payroll and Benefits Centre. Further medical evidence may be requested by Manulife Financial.

## *Late Application*

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 31 days; or
- apply for insurance on any person which had earlier been cancelled.

## Who Qualifies for Coverage?

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

- apply for insurance more than 31 days after the date benefits terminated under your spouse's plan; or
- apply for insurance and benefits under your spouse's plan have not terminated.

### *Late Dental Application*

If you apply for coverage for Dental insurance for yourself or your dependents late, the amount payable under Basic, Major and Orthodontic Services will be limited to $100 for each insured person for the first 12 months of coverage.

### *Effective Date of Coverage*

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

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

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

Your dependent's insurance becomes effective on the date the dependent becomes eligible, or the date any required evidence of insurability on the dependent is approved by Manulife Financial, whichever is later.

If one of your dependents (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Once you are insured for dependent coverage, additional dependents will be insured from the date eligible, regardless of hospital confinement.

### *Termination of Insurance*

Your Group Insurance will terminate on the earliest of the following events:

- the date you cease to be an eligible employee.
- the date you became employed and receive remuneration from another employer while on leave of absence, for the Long Term Disability benefit.
- for Long Term Disability, on the 1st of the month coincident with or immediately following the date you reach age 65 less the qualifying period (64 years 6 months).
- If you elect early retirement pursuant to the Special Voluntary Early Retirement Plan (SVERP) for faculty members or the Early Leaving Assistance Plan (ELAP) for staff, Major Medical (including ManuScript Prescribed Drug Plan) and Dental benefits may be continued until the 1st of July coincident with or immediately following the date you reach 65. If you elect retirement outside the scope of the SVERP or the ELAP, you will not be allowed to continue participation in these benefits.
- the date you enter the armed forces of any country on a full-time basis.

- the date the Group Policy terminates.
- the date you reach the Termination Age.
- the date you retire.
- the date any required contribution is due but not paid.

If you continue to be employed beyond the July 1st coincident with or immediately following your 65th birthday, you will be entitled to Major Medical (including ManuScript Prescribed Drug Plan) and Dental benefits.

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

# Major Medical

*(If your salary is paid from a grant, you are insured through a past employer, you are covered by your spouse's plan, or you previously declined coverage prior to July 1, 1975, you are not required to elect this benefit. If your salary is paid from a grant, you may apply for the benefits at a later date subject to certain restrictions.)*

If you or one of your dependents incurs charges for any of the Eligible Expenses specified, your Major Medical benefit can provide financial assistance.

***The Benefit***

**Overall Benefit Maximum** - Expenses incurred in Canada are subject to a maximum of $50,000 per person every 3 consecutive benefit years (not applicable to Drugs).

Expenses incurred outside Canada are subject to a lifetime maximum of $5,000,000 per person.

**Deductible** - Drugs: $0.35 per item, and nil for all other expenses

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

**Termination Age** - If you elect early retirement pursuant to the Special Voluntary Early Retirement Plan (SVERP) for faculty members or the Early Leaving Assistance Plan (ELAP) for staff, coverage may be continued until the 1st of July coincident with or immediately following the date you reach 65. If you elect retirement outside the scope of the SVERP or the ELAP, your coverage will terminate upon retirement.

**Waiting Period** - until the 1st day of the month coincident with or immediately following the date of employment

***Eligible Expenses***

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician (except for Emergency Travel Assistance expenses, and paramedical practitioners under Professional Services)
- incurred for the care of a person while insured under this Group Benefit Program
- not covered under the Provincial Plan or any other government-sponsored program
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the policy as of the date of approval as determined by Manulife Financial and shared with your employer as required.

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

This policy will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife 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.

Manulife Financial 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 Financial'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 Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial 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 Financial 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 Financial reserves the right to reduce the amount of an eligible 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 Financial.

***ManuScript Prescribed Drug Plan***

- Drugs, sera and injectables when prescribed* by a physician or dentist and dispensed by a pharmacist, dentist or a physician, subject to a maximum dispensing fee of $8. Anti-smoking drugs are subject to a lifetime maximum of $400 per person. Fertility drugs are subject to a lifetime maximum of $15,000 per person. Drugs used in the treatment of a sexual dysfunction are subject to a maximum of $1,200 per person per calendar year. Drugs determined to be ineligible as a result of due diligence are not eligible.

  ** All prescribed drugs, including those available "over the counter", whether or not they legally require a written prescription by a physician.*

- Drugs and supplies of a non-prescription nature required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease.

- Charges for oral contraceptives, intrauterine devices and diaphragms.

**Payment of Drug Claims**

Your ManuScript Prescribed Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. When you present your ManuScript Prescribed 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 ManuScript Prescribed 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 ManuScript Prescribed Drug Card to the pharmacist at the time of purchase, and

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

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

- you cannot locate a participating pay direct Drug pharmacy,
- you do not have your ManuScript Prescribed Drug Card with you at that time, or
- the prescription is not payable through the ManuScript Prescribed Drug Card system.

For details on how to receive reimbursement after paying the full cost of the prescription, please contact the Payroll and Benefits Centre for an Extended Health Care Claim form.

***Health Care Facilities***

- Hospital room and board charges, in excess of ward accommodation, for semi-private accommodation. If confined in a private room, payment will be made up to the hospital's charge for semi-private accommodation. Charges for any portion of the cost of ward accommodation, utilization or copayment fees (or similar charges) are not eligible.
- Hospital charges incurred as an out-patient for necessary medical or surgical treatment (excluding physicians' fees, and special nurses' fees).
- Room, board and normal nursing care provided in a licensed nursing home (for convalescent or chronic care, but excluding custodial care), up to $20 per day.

***Medical Transportation Services***

- Transportation by a licensed ground ambulance to and from the nearest medical facility for immediate treatment.

  If medically necessary, transportation by any form of licensed ambulance (including air-ambulance) or by any vehicle normally used for public transportation, for:

  - transfer to the nearest appropriate medical facility or hospital for necessary treatment, and/or
  - medical evacuation for admission to hospital in the province where the patient normally resides.

  Ground transportation to and from the hospital and airport at the point of departure and arrival is also eligible.

***Medical Supplies and Services***

- Diagnostic procedures, radiology, blood transfusions and oxygen (including the equipment necessary for its administration).
- Purchase of trusses, braces, crutches and artificial limbs or eyes.
- Elastic support stockings, up to $25 per benefit year.
- Purchase of casted, custom-made orthotics which are recommended by a physician or podiatrist, to a maximum of one pair per person, limited to 3 years from the last date of purchase, subject to expenses of not more than $400 per pair ($375 per pair in Quebec).
- Orthopaedic shoes which are attached to and form part of a brace. If the shoes do not form part of a brace, 2 pairs are eligible per benefit year, up to 50% of the cost of the shoes or the cost of the adjustment, whichever is greater.
- Rental, or, at Manulife Financial's option, purchase of a wheelchair, hospital bed or respirator/ventilator.

***Dental Services***

- Dental treatment for the repair of damage resulting directly from an accidental injury to natural teeth. The treatment must be rendered within 365 days following the accident, and your coverage, as well as the policy, must still be in force. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result.

***Professional Services***

- Professional services of a physician (where this coverage is permitted by law). In Ontario, insurance carriers are not permitted to consider expenses in excess of the provincial medical plan (OHIP).
- Private duty nursing services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

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

  Charges for the following services are not eligible:

  - service provided for custodial care, homemaking duties or supervision.
  - service performed by a nursing practitioner who is an immediate family member or lives with the patient.
  - services performed while the patient is confined in a hospital, nursing home or similar institution.
  - service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

  Manulife Financial suggests that a detailed treatment plan be submitted with cost estimates before nursing services begin. Manulife Financial will then advise you of any benefit that will be provided.

- Professional services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields) up to the levels specified below.

  - Physiotherapist and Athletic Therapist - unlimited maximum

  - Psychologist, Psychotherapist, Registered Social Worker, Speech Therapist, Podiatrist, Chiropractor, Osteopath, Naturopath and Massage Therapist - up to a total payment of $2,000 per person per benefit year for all practitioners combined. Registered Social Worker limited to expenses of not more than $150 per visit

  *The Paramedical Services Reasonable and Customary Charges Brochure can be found by logging into the Manulife Plan Member website at www.manulife.ca/groupbenefits.*

  *Please note that not all of the practitioners which are listed on the Reasonable and Customary Fees listing are covered under this Plan. Only those practitioners listed above are covered under this Plan.*

  *Under some circumstances, benefits may not be payable until the government plan concerned has paid its yearly maximum. Check with your Plan Administrator if you require further details.*

***Hearing Aids***

- Hearing aids, up to $350 per person in any 2 consecutive benefit years.

***Vision Care***

- Purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, up to an overall maximum of $300 per person in any 24 consecutive months.

- Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, provided vision can be improved to at least the 20/40 level by contact lenses (but cannot be improved to that level by regular glasses). Payment will be made up to $200 per person in any 24 consecutive months.

- Services for visual training or remedial exercises.

- Ocular examinations (including refraction) - one per benefit year for dependent children, and one in any 2 consecutive benefit years for you and your spouse.

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

***Referral Treatment***

- Hospital and physicians' charges (as described under Outside Canada Coverage) shall also include medically necessary treatment, on the referral of a physician located in Canada, provided such treatment is not available in Canada, and provided the government plan of insurance pays a portion of the charges. A specialized or customized treatment shall not be considered an eligible expense where a general treatment is available in Canada.

***Outside Canada Coverage***

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

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

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

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

In the event of a medical emergency which occurs while a claimant is travelling, vacationing or otherwise temporarily residing outside Canada, the following items will be considered as eligible expenses:

- In-patient hospital charges for the following:
  - the difference between the room and board benefit payable by the provincial hospital plan and the actual cost of ward accommodation, and
  - medically necessary hospital services and supplies furnished during hospital confinement.
- Hospital charges for medical and surgical treatment incurred by a person on an out-patient basis.
- Physicians' charges for professional services.

In addition, expenses incurred outside Canada (for both emergency and non-emergency treatment) will be considered for reimbursement in the same manner as those incurred in Canada as described under Eligible Expenses for the following items:

- Drugs
- Health Care Facilities
- Medical Transportation Services
- Medical Supplies and Services
- Dental Services

- Professional Services (other than physicians' services)
- Hearing Aids
- Vision Care
- Referral Treatment

***Emergency Travel Assistance***

Emergency Travel Assistance is a travel assistance program available for you and your covered dependents. The assistance is delivered through an international organization, specializing in travel assistance.

The following assistance services are provided, when required as a result of a medical emergency which occurs while travelling outside your normal province of residence. The services are available during the period that the covered person is covered for the Outside Canada Coverage expense, provided under this benefit.

***Medical Emergency Assistance***

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

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

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

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

a) **24 - Hour Access:**

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

b) **Medical Referral:**

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

c) **Claims Payment Service:**

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

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

d) **Medical Care Monitoring:**

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

e) **Medical Transportation:**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's normal province of residence. Expenses incurred for the medical transportation will be paid, as described under Eligible Expenses - Medical Transportation Services.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip economy transportation will also be paid.

f) **Return of Dependent Children:**

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

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

g) **Trip Interruption/Delay:**

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

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

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

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 Manulife Financial.

j) **Vehicle Return:**

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

k) **Identification of Deceased:**

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

l) **Meals and Accommodation:**

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

**Non-Medical Assistance**

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

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

b) **Lost Documentation and Ticket Replacement:**

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

c) **Legal Referral:**

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

d) **Interpretation Service:**

Telephone interpretation service in most major languages is provided.

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**

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

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

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

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

Your Emergency Travel Assistance card also lists your certificate number and group policy 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 the Payroll and Benefits Centre.

***Submitting a Claim***

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from the Payroll and Benefits Centre, or online at www.manulife.ca/groupbenefits.

Submit the claim to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it.

To submit a Hospital Claim, have the hospital complete their section of the claim form and give it to you for completion. When completed, submit the form to Manulife Financial.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

***Expenses not Covered***

No payment will be made for expenses resulting from:

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

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot, except if you sustain an injury while attempting to prevent a riot in the performance of your occupation.

- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.

- Examinations required for the use of a third party.
- Travel for health reasons.
- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of insurance.
  - which are performed or provided by an immediate family member or a person who lives with the patient.
  - which are provided while confined in a hospital on an in-patient basis.
  - which are not specified as an Eligible Expense under this plan.
- Expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (Major Medical Eligible Expenses - Referral Treatment and Outside Canada Coverage). Such expenses incurred outside Canada on an elective basis are not payable.
- Drugs, sera, injectables and supplies which are not approved by Health and Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.
- Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.
- Vitamins (other than injectables) and dietary supplements whether or not such prescription is given for a medical reason, except where federal or provincial law requires a prescription for their sale.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.

***Extension of Benefits***

If you are totally disabled when your Major Medical benefit terminates, benefits for such disability will be payable, as long as you remain disabled, up to a maximum period of 365 days after termination for Major Medical benefits and up to a maximum period of 90 days after termination for hospital benefits. However, coverage will terminate if you become eligible for insurance under another group plan.

If one of your covered dependents is hospitalized when your insurance terminates, then benefits will be payable in the same manner as your own or until your dependent is discharged from the hospital, whichever is earlier.

Extension of the Major Medical benefit will cease if the Policy should terminate.

***Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec***

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

***Covered Expenses***

The following expenses are covered:

- 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 in this Benefit Booklet, but are not on the RAMQ List.

***Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List) and pharmacy services published for private plans***

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 this Benefit Booklet:

a) **Benefit Percentage**

Prior to the Annual Out-Of-Pocket Maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

i) for any drugs on the RAMQ List which are not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation.

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

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

- the benefit percentage stated under The Benefit; or
- the percentage as set out by the then applicable Legislation.

After the Annual Out-Of-Pocket Maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

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

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

i) deductible amounts, and

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

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

The Annual Out-Of-Pocket Maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

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

c) **Deductible**

Deductible amounts (if any) for the drug benefit will apply, until the Annual Out-Of Pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

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

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

iii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

- only drugs that are on the RAMQ List are covered, and

- only covered pharmacy services performed for a drug on the RAMQ List are covered, and

- the percentage payable by Manulife Financial for covered expenses is the percentage as set out by the then applicable Legislation.

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

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age 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 are covered,

iii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by the then applicable Legislation,

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

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

***Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List***

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.

# Dental Care

If you or your dependents require any of the dental services specified under Eligible Expenses, your Dental Care benefit can provide financial assistance.

***The Benefit***

**Dental Fee Guide** - current General Practitioners Dental Fee Guide or the minimum fee specified in the current Denturist Fee Guide of the Province of Ontario.

**Benefit Percentage (Co-insurance)**

100% for Basic

80% for Major

50% for Orthodontics

**Benefit Maximums**

$2,500 per person per benefit year for Basic and Major expenses combined and $2,500 lifetime per person for Orthodontic expenses.

**Termination Age** - If you elect early retirement pursuant to the Special Voluntary Early Retirement Plan (SVERP) for faculty members or the Early Leaving Assistance Plan (ELAP) for staff, coverage may be continued until the 1st of July coincident with or immediately following the date you reach 65. If you elect retirement outside the scope of the SVERP or the ELAP, your coverage will terminate upon retirement.

**Waiting Period** - until the 1st day of the month coincident with or immediately following the date of employment

***Eligible Expenses***

Eligible expenses are those which are recommended as necessary by a physician or dentist and are not in excess of the Dental Fee Guide.

Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of his license.

There are several dental procedures which are covered by Provincial Health Plans up to certain maximums. If the dentist or dental surgeon chooses to charge more than the amount payable by the Provincial Plan, legislation in some provinces does not permit the excess charges to be eligible under this Plan.

***Basic Services***

- The following services will be eligible for payment once every 6 months:
  - Oral examinations.
  - One unit of scaling and one unit of polishing (or prophylaxis {light scaling and polishing} when the service is performed in Quebec).
  - Topical fluoride treatment.
  - Preventive recall packages.
  - Bite-wing x-rays.
- Full mouth series of x-rays, once every 24 months.
- Consultation required by the attending dentist.
- Provision of space maintainers for missing primary teeth, and provision of habit breaking appliances.
- Amalgam, silicate, acrylic and composite fillings.
- Endodontic Treatment (i.e. The treatment of diseases of the dental pulp including root canal therapy.)
- Periodontic Treatment of diseases of the gums and other supporting tissue of the teeth including:
  - scaling not covered under Preventive Services, and root planing;
  - provisional splinting; and
  - occlusal equilibration.

  However, procedures for guided tissue regeneration are considered eligible only if performed in conjunction with the following periodontal surgical procedures: Flap approach or Osseous grafts – autografts or allografts, provided natural teeth are involved.
- Diagnostic x-ray and laboratory procedures required in relation to dental surgery.
- General anaesthetic or conscious sedation required in relation to dental surgery.

- Surgical extractions, including extractions of impacted teeth.
- Simple alveolectomy (incision into tooth socket) at time of tooth extraction.
- Surgical removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess.

***Major Services***

- Crowns, including gold and porcelain, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative materials. When crowns are rendered on molar teeth, only the cost of metal material will be considered.
- Onlays when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using Basic Services.
- Inlays when 3 or more surfaces are involved and the tooth cannot be restored using basic restorative materials.

  If only 1 or 2 tooth surfaces are involved, the inlay will be considered for reimbursement under Basic Services and payment will be determined based on the cost of a comparable amalgam or composite restoration.
- Relining, rebasing or the repair of an existing denture or existing bridge.
- The creation of an initial bridge or initial denture.
- The replacement of an existing bridge or denture, under one of the following circumstances:
  - If necessitated by the extraction of additional natural teeth while insured under the group dental plan.
  - If the existing bridge or denture is at least 3 years old and cannot be made serviceable.
  - If the existing bridge or denture is temporary and is replaced with a permanent bridge or denture within 12 months of the installation of the temporary appliance.
- Other necessary oral surgical procedures not specifically listed under Basic Services.
- Injection of antibiotic drugs when prescribed by a Dentist.

***Orthodontic Services***

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

***Alternate Treatment***

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

***Late Entrant Limitation***

If you or your dependents become insured for dental benefits more than 31 days after you first become eligible to apply, the amount payable under Basic, Major and Orthodontic Services will be limited to $100 for each insured person for the first 12 months of coverage.

***Pre-Determination of Benefits***

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

***Extension of Benefits***

Eligible expenses incurred after the date coverage ceased will not be reimbursed, regardless of whether or not a treatment plan has been filed with Manulife Financial, unless the expenses are the result of either of the following situations:

- An impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date coverage ceased and the denture, bridge, crown, inlay or onlay is installed within 30 days after the coverage ceased.

- Coverage ceased due to your death, and, within 90 days following the death, your dependent has dental work done which is part of a series of planned dental treatment which had begun, or for which definite dental appointments had been made, while you were living.

***Submitting a Claim***

To submit a claim, you and your dentist must complete a Dental Claim form, which is available from the Payroll and Benefits Centre, or online at www.manulife.ca/groupbenefits.

Submit the claim to Manulife Financial. All applicable receipts must be attached to the completed claim form when submitting it.

All claims must be submitted by the end of the calendar year following the year in which the expense was incurred. However, upon termination of your insurance for any reason, all claims must be submitted no later than 90 days from the termination date.

***Expenses not Covered***

No payment will be made for expenses resulting from:

- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot, except if you sustain an injury while attempting to prevent a riot in the performance of your occupation.

- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.

- Examinations required for the use of a third party.

- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.

- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.

- Any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of insurance.
  - which are performed or provided by an immediate family member or a person who lives with the patient.
  - which are not specified as an Eligible Expense under this plan.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
- The replacement of an existing dental appliance which has been lost, mislaid or stolen.
- Dental services and supplies rendered for full-mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction.
- Treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.
- Implants, or any services rendered in conjunction with implants.

# Long Term Disability

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Manulife Financial will pay a disability benefit.

***Definition of Totally Disabled***

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

- for which you are, or may become fitted, by education, training and/or experience, and
- for which the current monthly earnings are 75% or more of the current monthly earnings for your normal occupation.

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

***The Benefit***

**Benefit Amount**

- Annual earnings less than $25,000 - 70% of your monthly earnings as of the date your disability commenced, up to a maximum of $5,000 per month
- Annual earnings of $25,000 but less than $40,000 - 66 2/3% of your monthly earnings as of the date your disability commenced, up to a maximum of $5,000 per month

- Annual earnings greater than $40,000 - 60% of your monthly earnings as of the date your disability commenced, up to a maximum of $5,000 per month

**Qualifying Period** - 6 months

- Benefits are payable from the end of the Qualifying Period. Benefits are not payable during the Qualifying Period.

- You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

**Maximum Benefit Period** - the June 30th coincident with or following the attainment of age 65

**Termination Age** - the first of the month coincident with or immediately following the date you attain age 65 less the Qualifying Period, or retirement, whichever is earlier

If you are on leave of absence without pay and work for another employer during your leave, you may still maintain your benefits. However, if you become disabled while working for another employer and you have maintained your Long Term Disability benefits with Laurentian University, Manulife Financial will decline a Long Term Disability claim.

**Waiting Period** - until the 1st day of the month coincident with or immediately following the date of employment

**Entitlement Criteria**

To be entitled to Long Term Disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period,

- you must be under the continuing care of a physician, and

- you must reside in Canada for the duration of your disability in order to receive benefit payments.

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

***Amount of Disability Benefits Payable***

The Benefit Amount will be reduced by any benefits or payments you receive or are entitled to receive from the following sources for the same or related disability, including public pension plan disability benefits paid to you on behalf of your dependents:

- Disability benefits payable under the Canada/Quebec Pension Plan.

- Earnings or payments from any employer.

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

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

- Benefits payable under any workers' compensation act.

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

- Income replacement indemnity payable under any plan of automobile insurance.

- Earnings recovered through a legally enforceable cause of action against some other person or corporation (in accordance with provisions under Third Party Liability).

The benefit, as calculated, will be further reduced by any amount by which such benefit, plus the income from all sources just outlined, exceeds 85% of your net pre-disability earnings.

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

***Public Pension Plans***

The Benefit Amount will not be affected by changes in your Canada or Quebec Pension Plan benefit unless the changes result from:

- A correction due to an error made when your award was originally determined.

- A change of 10% or more in the benefit formula under the government plan.

- A change in dependent status (where applicable).

The Benefit Amount will not be reduced by disability benefits payable under a public pension plan (CPP/QPP) until actual determination of the award has been made, if, at the time you submit your claim, you sign an agreement to reimburse Manulife Financial.

Otherwise, CPP/QPP benefits which have not been determined by the time your benefit is payable will be estimated and deducted from your monthly benefit. Adjustments to correct such payments will be made after the award has been determined.

***Cost of Living Adjustment***

After one full calendar year of total disability, and annually thereafter, you are eligible for a Cost Of Living Adjustment. Increases will commence with your January payment. Your initial Benefit Amount will be increased by the ratio between:

- the average of the Consumer Price Indices for the 12 months ending June 30 of the first calendar year of disablement, and

- the average of the Consumer Price Indices for the 12 months ending June 30 of the current calendar year,

to a maximum of 3% per year, compounded annually with a cumulative carry-over.

The adjustment used to determine the cost of living benefit in any particular year will be the higher of the adjustment reached in the current year or that reached in any previous year. Should the Consumer Price Index decrease, your monthly benefit will remain at its present level.

***Third Party Liability***

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

### *Tax Status of Benefits*

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

### *Rehabilitation*

Once Manulife Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In order to participate in a Rehabilitation program not developed by Manulife Financial, Manulife Financial must approve the program.

Although most income reduces your benefit payment, for up to 24 months only half of your income from a Rehabilitation program will be used to reduce your payments.

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

### *Cessation of Benefit Payments*

Your monthly payments will cease on the earliest of the following events:

- The date you are no longer totally disabled.
- The July 1st coincident with or next following the date you reach age 65. However, should you complete the qualifying period after your 64th birthday but prior to your 65th birthday, the monthly income payments will continue beyond age 65 as long as you are totally disabled, subject to a maximum of 12 monthly payments.
- The date you fail to undergo, when requested by Manulife Financial, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by Manulife Financial.
- The date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program or alcoholism, drug addiction or substance abuse treatment program when recommended by Manulife Financial.
- The date you are incarcerated in a prison or mental institution by authority of a criminal court.
- The date you refuse to complete and return a Reimbursement Agreement/Direction form or comply with the terms of a signed Reimbursement Agreement/Direction form, when requested, in accordance with the provisions under Third Party Liability.
- The date you die.

***Recurrent Disabilities***

If you become Totally Disabled again from the same or related causes within 6 months of full-time active employment from the end of the period for which Long Term Disability benefits were paid, Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy any applicable Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

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

***Waiver of Premium***

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

***Extension of Benefits***

Long Term Disability benefits will extend beyond your termination date provided you became disabled while you were still insured. Benefits will continue to be paid according to the contract provisions regardless of the subsequent termination of the Group Policy.

Manulife Financial reserves the right to request proof of the continuance of total disability, and to require you to submit to an examination by Manulife Financial's medical advisors when requested.

***Submitting a Claim***

To submit a claim, you must complete a Claimant's Statement form, which is available from Human Resources. Your physician must also complete an Initial Attending Physician Statement.

The completed claim forms must be submitted to Manulife Financial within 6 months from the end of the Qualifying Period.

***Exceptions and Limitations***

Disability Income is not payable for the following:

- A disability caused by self-inflicted injuries or illness, unless medical evidence establishes that the injuries are related to a mental health illness.

- A disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot, except if you sustain an injury while attempting to prevent a riot in the performance of your occupation.

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for benefits at any time when you are on pregnancy leave of absence or could be placed on such leave by your employer in accordance with relevant government legislation or the leave agreed upon by you and your employer.