The Segal Company Ltd.

Group Policy Number: G0030404

Plan A: All Eligible Active Employees of The Segal Company, Ltd.

Plan B: All Eligible Retirees Under 65 of The Segal Company, Ltd. and All Eligible Retirees Under 65 of Rogerscasey Canada, Inc.

Plan C: All Eligible Retirees 65 and Over of The Segal Company, Ltd. and All Eligible Retirees 65 and Over of Rogerscasey Canada, Inc.

Plan D: All Eligible Active Employees of Rogerscasey Canada, Inc

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Group Policy Effective Date: July 1, 2009

The Plan Description outlined in this booklet includes all the changes and/or additions to the plan up to and including October 1, 2023.

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 for the security they provide for you and your family, especially in case of unforeseen needs.

Your Plan Administrator can answer any questions you may have about your benefits, or how to submit a claim.

This booklet produced: September 20, 2023

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Benefit Summary

This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

Extended Health Care

Classifications Eligible for Plan Benefits

Members in Plans A, B, C and D

Dependents of Members in Plans A, B, C and D are also covered for this Benefit.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible

Individual $25 per calendar year
Family $50 per calendar year

Not applicable to:
- Hospital
- Vision Care
- Out of Province/Out of Canada

Benefit Percentage (Co-insurance)

50% for Psychoanalyst (Quebec residents only)

100% for all other Covered Expenses

Termination Age - upon your death

Survivor Extended Insurance Benefit

Included

Waiting Period

first of the month nearest the date you complete 6 weeks of continuous service

Hospital (Within Home Province)

Semi-private: unlimited

Rehabilitation Hospital (Within Home Province)

Semi-private for 180 days maximum stay for each period of disability

Prescription Drugs

Dispensing Fee Maximum: $10 per prescription or refill

Overall Drug Maximum: $15,000 per calendar year

Vision Care

- Eye exams: $50 per 24 months for persons age 18 and over (12 months for persons under age 18)
- Prescription Glasses, Contact Lenses or Laser Eye Surgery (combined): $100 per 24 months for persons age 18 and over (12 months for persons under age 18)

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: $500 per calendar year
- Osteopath: $500 per calendar year
- Podiatrist/Chiropodist (combined): $500 per calendar year
- Naturopath: $500 per calendar year
- Speech Therapist: $500 per calendar year
- Physiotherapist: $500 per calendar year
- Psychologist: $500 per calendar year
- Acupuncturist: $500 per calendar year
- Christian Science Practitioner: $500 per calendar year
- Psychoanalyst (Quebec residents only): $1,000 per calendar year
- Psychotherapist: $500 per calendar year

Medical Services and Supplies

Private Duty Nursing: $10,000 in any 36 month period

Orthopaedic Shoes and Custom Made Orthotics (combined): $100 per calendar year

Out-of-Province and Out-of-Canada (combined)

- Maximum: $1,000,000 per lifetime (Emergency and Referral combined)

- Emergency Hospital Room and Board Limit
  In Canada: semi-private
  Outside Canada: average semi-private

- Referral
  Benefit Duration: 60 days
  Hospital Room and Board Limit: $100 per day

Benefit Summary

Hearing Aids: $400 per 5-year period

Surgical Stockings: 4 pairs per calendar year

Surgical Brassieres: 4 per calendar year

Wigs and Hairpieces: reasonable and customary expenses

Contact Lenses or glasses following cataract surgery: 1 pair per lifetime

Dental Care

Classifications Eligible for Plan Benefits

Members in Plans A, B and D

Dependents of Members in Plans A, B and D are also covered for this Benefit.

The Benefit

Deductible

Individual	$25 per calendar year
Family	$50 per calendar year

Not applicable to Orthodontics (Level V).

Dental Fee Guide

Current Fee Guide for General Practitioners approved by the Provincial Dental Association in the Province in which the services are rendered, if rendered in Canada, and home province if rendered outside Canada.

Benefit Percentage (Co-insurance)

100% for Routine Care - Level I

100% for Routine Care - Level II

50% for Dentures - Level III

50% for Crowns and Bridgework - Level IV

50% for Orthodontics - Level V (applies to dependent children under 21 only)

Benefit Maximums

$2,000 per calendar year combined for Level I and Level II

$1,000 per calendar year combined for Level III and Level IV

$1,500 per lifetime for Level V - Orthodontics (applies to dependent children under age 21 only)

Termination

Active Employees - upon your death

Retired Employees - upon attainment of age 65

Survivor Extended Insurance Benefit

Included

Waiting Period

first of the month nearest the date you complete 6 weeks of continuous service

Designed with Your Needs in Mind

The Benefit 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;
- 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

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of The Segal Company, Ltd. or of Rogerscasey Canada, Inc. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (both available from your employer), the terms of the Group Policy will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are covered. The Group Policy must be in effect and you must satisfy all the requirements of the Policy.

You or any of your covered dependents have the right to request a copy of any or all of the following items:

- the sections of the Group Policy that apply to you and your dependents,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

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.

Actively at Work

at work for the Policyholder on a Full-time basis or Part-time basis of at least 60% of the employee's office's standard work hours (excluding Special Project Workers and Interns).

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Adherence

use of 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.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by Manulife Financial.

Calendar Year

means the 365-day period commencing on January 1st of each year.

Change in Life Event

a Change in Life Event occurs when:

a) an Employee acquires a Dependent;

b) an Employee has a change in marital status;

c) an Employee's Spouse's coverage ceases;

d) any Dependent ceases to qualify as a Dependent; or

e) any Dependent dies.

Coverage

the coverage under this Policy.

Covered Expenses

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

Deductible

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

Dentist

a doctor of dentistry, licensed to practice dentistry in the place where the services are provided.

Dependent

Your Spouse or Child, who is a resident of Canada and insured under the Provincial Plan.

Dependent shall not include:

a) a person divorced from you; or

b) a person cohabiting with you without public representation of married status.

- Spouse

Your legal Spouse, or the person who has, for at least 12 months, been continuously living with you in a role like that of a marriage partner.

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

- Child

your natural or adopted child, stepchild, or other child who is:

a) unmarried;

b) solely dependent on you for support;

c) not employed on a full-time basis;

d) not eligible for insurance as an employee under this or any other Group Policy; and

e) either under 21 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.

A newborn child shall be insured from the moment of birth.

A child insured under this Policy, who is incapacitated due to a mental or physical disability on the date he reaches the age when he would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this Policy.

A child is considered incapacitated if he is incapable of engaging in any substantially gainful activity and is dependent on you for support, maintenance and care, due to a mental or physical disability.

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

A stepchild must be living with you to be an eligible Dependent.

Disability or Disabled

the state of being Totally Disabled.

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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.

Drug Dispensing Fee

of the total prescription drug cost, that portion charged for the pharmacist's professional services for filling a prescription.

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.

Emergency

Means a sudden and unforeseen condition where there is an urgent or pressing need for immediate medical care.

Employee

a person who:

a) is directly employed by the Employer on a Full-time basis or Part-time basis of at least 60% of the employee's office's standard work hours (excluding Special Project Workers and Interns);

b) is compensated for services by the Employer;

c) is residing in Canada; and

d) insured under a Provincial Plan.

For the purposes of those Benefits which continue beyond retirement, the term Employee also means Retiree/Retired Employee.

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

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

Hospital

a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;

b) provides organized facilities for diagnosis, major surgery or rehabilitation;

c) provides 24-hour nursing service by registered nurses and has a Physician in regular attendance;

d) is not primarily operated as a nursing home or a place for rest or for the care and treatment of the aged, the blind or deaf; and

e) is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill, unless the institution is eligible to receive payments under a provincial hospital plan.

For the purpose of this Policy, the chronic beds of a Hospital are not considered to be part of that Hospital.

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.

Indefinite Lay-Off

a period during which the Employee is laid off work and for which there is no fixed recall date

Interchangeable Drug

includes but is not limited to:

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

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

Insured

a person who is an Employee, or the Spouse or Child of an Employee.

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

Licensed, Certified, Registered

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

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Life-Sustaining Drugs

non-prescription Drugs which are necessary to sustain life.

Lower Cost Alternative

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

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

For the purposes of this Policy, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and

b) the date the child is born.

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 Policy.

Parental Leave of Absence

the period of formal child care leave to which a Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Patient Assistance Program

a program that provides assistance to insured persons 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.

Physician

a doctor of medicine, licensed to practice medicine in the place where the services are provided.

Prior Authorization

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

Provincial Plan

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

Qualifying Period

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

Reasonable and Customary

within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Rehabilitation Hospital

a place that:

a) has a transfer arrangement with Hospitals;

b) provides inpatient nursing care (that meets minimum Provincial regulations) for the rehabilitation stage of an injury or illness; and

c) is approved as a rehabilitation hospital for payment of the Ward rate under the Provincial Health Plan.

Remarriage

either of the following arrangements that a surviving Spouse enters into subsequent to the Employee's death:

a) a legal marriage; or

b) a common-law marriage in which the surviving Spouse has been continuously living with another person in a role like that of a marriage partner.

Retiree/Retired Employee

an Employee who:

a) was an Employee immediately prior to retirement;

b) retired on or after age 55 with at least 10 years of service with the Company; and

c) was eligible to immediately begin collecting the retirement pension from the Company.

Stable

A condition as pertaining to the Out-of-Province or Out-of-Canada benefit, whereby an insured person:

a) has not in the 90 days before the departure date:

   i) been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination; or

   ii) experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the insured/covered person has been seen by a medical professional in relation to the symptoms; or

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iii) been prescribed or recommended a change in treatment or medication related to the medical condition by a Physician or other medical professional, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition; or

iv) been admitted to or treated at a hospital for the medical condition; or

b) did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

Temporary Lay-Off

a period during which the employee is laid off work and for which there is a fixed recall date.

Take Home Pay (Net Earnings)

your earnings, less deductions normally made for federal and provincial income tax.

Waiting Period

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

Ward

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

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 The Segal Company, Ltd., in partnership with The Manufacturers Life Insurance Company.

Your Plan Administrator

Your Plan Administrator 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 your Plan Administrator with the necessary information to perform such duties.

Your Plan Administrator is _____

Phone Number:

_____

Please record the name of your Plan Administrator and the contact number in the space provided.

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your Plan Administrator. Your Plan Administrator then forwards the application to Manulife Financial.

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 your Plan Administrator. Such changes could include:

- change in Dependent Coverage;
- applying for coverage previously waived; and
- change in Name.

To make such changes, you must complete the Application for Change Form available from your Plan Administrator.

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The Claims Process

How to Submit a Claim

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number and your Certificate number to avoid any unnecessary delays in the processing of your claim.

Your Plan Administrator can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

You may not commence legal action against Manulife Financial less than 30 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the Employer or the Administrator for the recovery of money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement 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, your Plan Administrator 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.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken 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 covered 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" (ie., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (ie., 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 covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

  In situations where you or your 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).
  - Where you and your spouse share joint custody of the 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.

- A claim for accidental injury to natural teeth will be determined under Extended 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 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.

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

Employee Eligibility

You are eligible for Group Benefits if you:

- are an active, regular Employee of an Employer insured under this Policy, working full-time or part-time for at least 60% of the employee's office's standard work hours (excluding Special Project Workers and Interns);
- are a Retired Employee, who retired on or after age 55 with at least 10 years of service with the Company and was eligible to immediately begin collecting the retirement pension from the Company;
- are insured under a Provincial Plan;
- are a resident in Canada;
- are a member of a Classification, which is eligible for insurance, as set out in the Benefit Schedule;
- are younger than the Termination Age shown in the Benefit Schedule; and
- have continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

Dependent Eligibility

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

Your dependents must be a resident in Canada and insured under a Provincial Plan in order to be covered under this Group Policy.

You must be covered in order for your dependents to be covered.

Note: Only those dependents who were insured under this plan when you retired may continue to be eligible for insurance.

Where used in this Benefit Booklet, the term Employee shall also mean Retiree.

Amount of Insurance

The amount of insurance for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

Evidence of Insurability

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

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Who Qualifies for Coverage?

Late Application

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

- apply for insurance more than 31 days after the date benefits terminated under your spouse's plan; or

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

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your Plan Administrator. Further medical evidence may be requested by Manulife Financial.

Effective Date of Coverage

Insurance for you and your dependents becomes effective as follows, if you are then Actively at Work:

- 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.

In no event will your insurance become effective on a date earlier than the Policy effective date.

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 medical evidence on the dependent is approved by Manulife Financial, whichever is later.

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

Increases in Insurance

An increase in insurance on you or your dependents will take effect as follows, if you are then Actively at Work:

a) if evidence of insurability is not required, on the Effective Date for Increases in Insurance shown in the Benefit Schedule; and

b) if evidence of insurability is required, on the date this evidence is approved by Manulife Financial.

If you are not Actively at Work when an increase in insurance would otherwise take effect, this increase in insurance will take effect on the next day on which he is again Actively at Work.

The Actively at Work requirement will be waived if you are receiving Workers' Compensation benefits and are covered under the Extension of Insurance provision.

Decreases in Insurance

A decrease in the amount for which any person is insured takes effect when the person is first eligible for the decreased amount.

Extension of Insurance

In provinces where worker's compensation or similar legislation requires that an Employer continue to cover an Employee who is receiving worker's compensation benefits, then such an Employee, under this Group Policy, will continue to be covered for a maximum period of one year from the date of injury, provided premiums are paid on his behalf. Insurance ceases on the earlier of the following dates:

a) one year following the date of injury; or

b) the date the Employee is no longer receiving workers' compensation or similarly legislated benefits.

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible employee;
- the date your employer terminates coverage;
- the date premium payments cease;
- the date the Group Policy terminates or coverage on the class to which you belong terminates;
- with respect to Dental Care Benefits for Retired Employees, on attainment of age 65;
- the date the you retire, unless you are eligible as a Retired Employee;
- the date you reach the Termination Age, as shown in the Benefit Summary;
- the date of your death; and
- the date your employment terminates or the date you ceases active work, except as noted under Exceptions to Termination of Employment not due to Retirement.

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

When Employment Terminates Due to Retirement

This Policy provides coverage for some benefits for Retirees. Retiree coverage is as indicated in the Benefit Summary pages. Insurance for those benefits which are not indicated in the Benefit Summary pages terminates when the Employee retires.

Exceptions to Termination of Employment not due to Retirement

If an Employee ceases to be Actively at Work, his insurance will normally terminate as specified under the Termination of Employee Insurance provision. However, Manulife Financial will waive this rule and continue insurance under the conditions set out below. An Employee's insurance can only be continued on a basis that does not discriminate against another Employee.

- Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all insurance coverage will continue, subject to premium payment, until the Policyholder terminates the coverage, but not beyond age 65 (or up to 12 months, if you are between the ages of 64 and 69 and eligible for insurance).

- Due to Maternity or Parental or other Mandated Leave of Absence

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If an Employee ceases to be Actively at Work due to Maternity or Parental other leave of absence that is mandated by legislation, all insurance coverage may continue, subject to premium payment, for the period of leave to which the Employee is entitled by legislation governing the Employer, but not beyond age 65 (or up to 12 months, if you are between the ages of 64 and 69 and eligible for insurance).

In jurisdictions where the continuation of insurance is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required premium contribution must also accompany the request for termination.

- **Due to Other Leave of Absence or Temporary Lay-Off**

If an Employee ceases to be Actively at Work due to a leave of absence other than Maternity or Parental leave, or due to Temporary Lay-off, all insurance coverage may continue, subject to premium payment, until the Policyholder terminates it, but in no event beyond the end of the policy month in which such absence began.

- **Legislated Benefit Extensions**

If legislation mandates that Employee benefits continue for a limited period after an Employee's employment terminates, Manulife Financial will extend each insurance benefit for the minimum period required by law, provided that:

a) the Policyholder continues to pay premiums for Employee and Dependent insurance; and

b) this Policy remains in force.

Extended Health Care

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

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

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

Covered 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
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- if they are associated with any Drug, supply or service that was subject to the Due Diligence process, the process has been completed with the result that expenses for that Drug, supply or service are eligible under the Plan as of the date of approval as determined by Manulife Financial and shared with the Plan Sponsor as required

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, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This plan will not automatically assume eligibility for all Drugs, services and supplies. New Drugs, existing Drugs with new indications, services and supplies are reviewed by Manulife 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, a person will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

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At Manulife Financial's discretion, medical information, test results or other documentation may 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 a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Advance Supply Limitation

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

Hospital Services In Canada

- Hospital Care (Within Home Province)

Charges, in excess of the charges for standard Ward accommodation, up to the Hospital maximum shown in the Benefit Summary, provided the person was confined to hospital on an in-patient basis.

- Rehabilitation Hospital (Within Home Province)

Daily charges in excess of the ward rate up to the Room and Board Limit shown in the Benefit Summary, to a maximum duration of 180 days per period of disability. Confinement must begin within 14 days of hospital discharge. A new period of disability will start if the insured person has not been confined in a rehabilitation hospital for at least 90 days.

- Expenses Not Covered

Charges for any portion of the cost of Ward accommodation, utilization or copayment fees (or similar charges).

Prescription Drugs

Charges for Drugs prescribed by a Physician or licensed Dentist or other professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or Physician legally authorized to dispense such drugs, that regardless of their legal status are not normally obtainable, except by prescription, up to the maximum for Covered Expenses shown in the Benefit Summary.

- Drugs and Medicines for Treatment of an Illness or Injury

Charges for the following expenses are covered:

a) injectable medications;

b) life sustaining drugs; and

c) prescription vitamins.

Charges for the following expenses are not covered:

a) the administration of serums, vaccines, or injectable drugs;

b) fertility drugs;

c) oral drugs to treat erectile dysfunction;

d) nicorettes or other aids to stop smoking;

e) anti-obesity Drugs;

f) Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for a patient's use at home;

g) non-prescription injectable vitamins; and

h) drugs determined to be ineligible as a result of Due Diligence.

- Hematinic Vitamins (Vitamins to treat blood disorders)

Charges for hematinic vitamins properly identified in the Compendium of Pharmaceuticals and Specialties.

- Preventative Drugs and Medicines

Charges for oral contraceptives, intrauterine devices and diaphragms are covered.

Charges for the following expenses are not covered:

a) preventive vaccines and medicines (oral or injected); and

b) dietary supplements, health foods, nutritional products and vitamins (except injectable and hematinic vitamins).

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- Diabetic Supplies

Charges for standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

- Direct Claims Payment

Manulife Financial will provide a Pay Direct Drug Card for each Employee covered for this Benefit. The Pay Direct Drug Card is honoured by participating Pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered Drug expenses the covered Employee must:

a) present the Pay Direct Drug Card to the Pharmacist; and

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

Reimbursement of covered Drug expenses will be payable directly to the Pharmacist. Prescriptions for covered drug expenses purchased without the Pay Direct Drug Card will be reimbursed directly to the Employee.

Vision Care

Charges for the following Vision Care expenses when prescribed by an ophthalmologist, optometrist, or oculist:

- eye exams, including refractions, when not covered by the Provincial Plan, up to the Eye Exams maximum shown in Benefit Summary;

- purchase and fitting of prescription glasses or elective contact lenses, or laser eye surgery, to a the Vision Care maximum shown in the Benefit Summary.

No amount will be paid for safety or sunglasses, anti-reflective coatings or tints other than No. 1 or No. 2.

Professional Services

Services of a licensed Chiropractor, Osteopath, Podiatrist/Chiropodist, Naturopath, Speech Therapist, Physiotherapist, Psychologist, Acupuncturist, Christian Science Practitioner, Psychoanalyst and Psychotherapist who is a licensed doctor (M.D.) (for Quebec residents only) up to the Professional Services maximum shown in the Benefit Schedule.

The recommendation of a Physician is not required for Professional Services.

No amount will be paid for any visit for which any amount is payable under the insured person's Provincial Plan, unless permitted by law. For Ontario residents, no amount will be paid for any visit for which any amount is payable under the insured person's Provincial Plan for podiatrists and chiropodists.

Medical Services and Supplies

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

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

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

when ordered by a Physician as medically necessary for a disability that requires the specialized training of an R.N. or R.N.A. (or equivalent designation).

Covered Expenses are subject to the Private Duty Nursing maximum shown in the Benefit Summary.

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

Charges for professional licensed ambulance service provided in the insured person's province of residence, including air or rail ambulance, to transfer the insured person:

- from the place of injury (or where illness struck) to the nearest hospital where adequate treatment is available;
- directly from the first hospital where treatment is given to the nearest hospital for medical specialized treatment not available at the first hospital;
- from a hospital to a rehabilitation hospital.

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Medical Equipment

The rental or, when approved by Manulife Financial, purchase of:

- Mobility Equipment: crutches, canes, walkers, and wheelchairs; and
- Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, kidney dialysis equipment, and other durable equipment usually found only in hospitals.

Non-Dental Prostheses, Supports and Hearing Aids

Charges for external prostheses.

Charges for contact lenses or glasses following cataract surgery, limited to one pair per lifetime.

Charges for surgical brassieres up to the maximum shown in the Benefit Summary.

Charges for surgical stockings up to the maximum shown in the Benefit Summary.

Charges for braces (other than foot braces), trusses, collars, leg orthosis, casts and splints.

Charges for hypodermic needles and catheters;

Charges up the Benefit Maximum shown in the Benefit Summary, for orthopedic shoes (including repairs) and orthotics, which have been specially designed and molded for the insured person and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- a description of the physical findings from the clinical examination;
- a brief description of the abnormal walking pattern associated with the diagnosis; and
- confirmation that the product has been custom-made.

Your orthopedic shoes and orthotics must be prescribed on an annual basis. For information on eligible prescribing and dispensing providers, please contact your Benefits Administrator for a copy of the plan member information sheet provided by Manulife Financial.

Charges for the cost, installation, repair, replacement and maintenance of a hearing aid or aids, (excluding charges for batteries) to a maximum of $500 per 5 calendar years.

Other Supplies and Services

The cost of ileostomy, colostomy and incontinence supplies.

The cost of medicated dressings and burn garments.

The cost of wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to the maximum shown in the Benefit Summary.

The cost of oxygen.

Diagnostic Procedures

Charges for microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec.

Dental Treatment

Charges for dental care by a licensed dentist for the prompt repair of sound natural teeth when required for a non-occupational accidental injury, external to the mouth, that occurred while the person was insured for this Benefit. The treatment must be received and approved for payment within 12 months of the accident. Injuries due to biting or chewing are not covered.

Out-of-Province/Out-of-Canada

Emergency

Charges incurred for the following medical treatment given outside the covered person's province of residence:

a) treatment required as a result of a Medical Emergency arising during the first 6 weeks while temporarily outside the province of residence provided that the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

   A Medical Emergency occurs when a covered person requires immediate medical attention while a covered person is travelling outside his province of residence due or related to:

   i) a sudden, unexpected injury which occurs or a new medical condition which begins while a covered person is travelling outside his province of residence; or

   ii) a previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his province of residence.

Such Medical Emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is able to return to his province of residence. No coverage is provided for any Medical Emergency related to a pregnancy for covered persons who are pregnant and travelling within 4 weeks of the due date.

Referral

Charges incurred for care unavailable in Canada, when referred by a physician and approved in advance by Manulife Financial, but not beyond the Benefit Duration shown in the Benefit Summary.

These charges are subject to the Out-of-Province/Out-of-Canada Maximum shown in the Benefit Summary.

For all treatment given Out-of-Canada, other than emergency medical treatment, Manulife Financial:

- requires that it be recommended as necessary by a Physician practicing in Canada; and
- suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

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Charges for the following are payable under this expense:

- physician's services;
- Hospital room and board in excess of the amount paid under the insured person's Provincial Plan. In such case, the amount payable under this expense is subject to the Hospital maximum shown in the Benefit Summary;
- the cost of special hospital services;
- hospital charges for out-patient treatment;
- with respect to medical treatment required as a result of a Medical Emergency, licensed ambulance services, including air and rail ambulance, to transfer the insured person back to a hospital within his home province, provided prior approval is obtained from Manulife Financial; and
- blood, blood products and their transfusion.

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

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

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 your Plan Administrator.

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

All claims must be submitted within 18 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 6 months 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.

Exclusions

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

- illness or injury which is occupational;
- for Out-of-Province or Out-of-Canada and Emergency Travel assistance only, self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered 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

Dental Care

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

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

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

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit;
- are incurred for services provided by a dentist, a dental hygienist working under the supervision of a dentist, or a denturist working within the scope of his license;

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- are reasonable as determined by Manulife Financial, taking all factors into account;
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide; and
- are for either an illness or injury that is non-occupational.

Level I - Routine Care

- complete oral exam, once per 2 calendar years;
- emergency exams;
- full-mouth x-rays, once per 2 calendar years;
- one unit of light scaling and one unit of polishing, limited to once every 6 months, when the service is performed outside Quebec, or prophylaxis (light scaling and polishing), limited to once every 6 months, when the service is performed in Quebec;
- recall exams (bitewing x-rays and fluoride treatments, once every 6 months);
- routine diagnostic and laboratory procedures;
- space maintainers for primary teeth (excluding appliances placed for orthodontic purposes);
- fillings, (amalgam, silicate, acrylic and composite). White fillings on molars are not covered. Retentive pins and pit and fissure sealants are covered where necessary for the maintenance of sound dental health;
- pre-fabricated full coverage restorations (metal and plastic) for primary teeth;
- minor surgical procedures, simple extractions and post surgical care;
- complicated extractions (including impacted and residual roots);
- anaesthesia and conscious sedation;
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture;
- injection of antibiotic drugs; and
- repair, resurfacing, recementing of crowns, inlays, onlays or bridges.

Level II - Routine Care

- surgical procedures not included in Level I (excluding implant surgery);
- occlusal guards in connection with periodontal treatment of bruxism;
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
  - scaling not covered under Level I, and root planing, up to a combined maximum of 10 units per calendar year;
  - provisional splinting;
- occlusal equilibration, up to a maximum of 8 units per calendar year; and
- endodontic services (which include root canals and therapy, root amputation, apexifications and periapical services). Root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime. Re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Work in Progress when Coverage under this Policy ends

If a person's insurance terminates under this Policy for reasons other than termination of this Policy or this Dental Care Benefit, and endodontic treatment had begun exposing a tooth, Manulife Financial will pay for expenses related to such treatment provided the expense is incurred within 31 days after the plan benefits terminate.

Level III - Dentures

- initial provision of full or partial removable dentures;
- replacement of removable dentures, provided the new dentures are necessary due to one of the following:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable;
  - the existing appliance is at least 60 months old and cannot be made serviceable; or
  - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures;
- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable.

Work in Progress when Coverage under this Policy ends

If a person's insurance terminates under this Policy for reasons other than termination of this Policy or this Dental Care Benefit, and an impression for a denture had been taken prior to the termination, Manulife Financial will pay for expenses related to the installation of the denture provided the expense is incurred within 90 days after the plan benefits terminate.

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Level IV - Crowns and Bridgework

- crowns and onlays (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay;
- inlays (covering at least 3 surfaces, provided the tooth cusp is missing);
- initial provision of fixed bridgework;
- replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.
- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Work in Progress when Coverage under this Policy ends

If a person's insurance terminates under this Policy for reasons other than termination of this Policy or this Dental Care Benefit, and an impression for a crown, onlay or bridgework had been taken prior to the termination, Manulife Financial will pay for expenses related to the installation of the crown, onlay or bridgework provided the expense is incurred within 90 days after the plan benefits terminate.

Level V - Orthodontics

- correction of malocclusion of the teeth;
- observation and adjustment;
- appliances for tooth guidance or uncomplicated tooth movement;
- appliances to control harmful habits;
- retention appliances; and
- fixed or cemented, unilateral and bilateral appliances.

Orthodontic Services are a Covered Expense for Dependent children only, provided treatment commences prior to reaching age 21.

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.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your Plan Administrator.

All claims must be submitted within 18 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 6 months from the termination date.

Exclusions

No benefit is payable for any expense which is directly or indirectly related to:

- illness or injury which is occupational;
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit;
- anti-snoring or sleep apnea devices;
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms;
- oral hygiene or nutritional counseling;
- consultations;
- space maintainers and prefabricated full coverage restorations for permanent teeth;
- a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Policy, or through a government plan or legally mandated program;
- services or supplies which are received from a medical or dental department maintained by an employer, association or trade union;
- services or supplies for which no charge would normally be made in the absence of insurance;
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction;
- replacement of removable dental appliances which have been lost, mislaid or stolen;
- laboratory fees which exceed reasonable and customary charges;
- white fillings on molars;
- 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;
- 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;
- implants, or any services rendered in conjunction with implants; or
- supplies which were first prescribed or recommended prior to the date the person became insured

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Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, Manulife Financial will continue the Extended Health Care and Dental Care benefits without payment of premium, until the earliest of:

- the date your spouse remarries (your dependent Children continue to be covered);
- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Common Insurance Terms);
- the date the dependent's insurance terminates for any reason;
- the date similar coverage is obtained elsewhere;
- the date which is 24 months from your death; or
- the date the Group Policy terminates.

Notes

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

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