Kingston General Hospital

Plan Document Number: G0088519

Class: 020: CUPE - Active (Plan C)

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: October 1, 2010

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

Table of Contents

Benefit Summary

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

This version of the Benefit Summary provided electronically: November 13, 2014

Extended Health Care

The Benefit

Extended Health Care
Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $22.50 Individual, $35 Family, per calendar year(s)

Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

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

Benefit Percentage (Co-insurance)

Options 1 and 3

100% for
- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Not Available in Canada is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 2

100% for
- Hospital Care

Termination Age

For Employee: the end of the month in which the employee attains age 70. Upon retirement, coverage may continue under Class 080.

For Spouse: the end of the month in which the employee attains age 70 or spouse's age 70, whichever is earlier

Benefit Summary

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

Not covered for Option 2

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

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

oral contraceptives, intrauterine devices and diaphragms

injectable medications including vitamins (charges made by a practitioner or physician to administer injectable medications are not covered)

allergy serums

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

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)

Charges for the following expenses are not covered:

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

drugs used in the treatment of a sexual dysfunction

- Drug Maximums

- Drug Maximums

Fertility drugs - $2,500 per calendar year to a maximum of $5,000 per lifetime

Anti-smoking drugs - $500 per 5 consecutive calendar years

Injectable vitamins - 80 injections per 5 consecutive calendar years

Intrauterine devices - one per 60 consecutive months

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered. Appropriate supporting documentation for adverse reaction is required.

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

you cannot locate a participating Pay Direct Drug pharmacy

you do not have your Pay Direct Drug Card with you at that time

the prescription is not payable through the Pay Direct Drug Card system

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

Benefit Summary

Vision Care

Extended Health Care - Vision Care

Not covered for Option 2

eye exams, once per 24 consecutive months

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $300 per 24 consecutive months

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 24 consecutive months

visual training, to a maximum of $150 per lifetime

Professional Services

Extended Health Care - Professional Services

Not covered for Option 2

Services provided by the following licensed practitioners:

Chiropractor - $375 per calendar year

Massage Therapist - $200 per calendar year

Speech Therapist - $200 per calendar year

Physiotherapist - $350 per calendar year. Effective September 29, 2015, $375 per calendar year.

Psychologist - $200 per calendar year

Dental Care

Dental Care

Dental Care - The Benefit

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services

- 100% for Level II - Supplementary Basic Services

- 50% for Level III - Dentures

- 50% for Level IV - Major Restorative Services

Benefit Maximums

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

- $1,000 per calendar year for Level III

- $1,000 per calendar year for Level IV

Termination Age

For Employee: the end of the month in which the employee attains age 70. Upon retirement, coverage may continue under Class 080.

For Spouse: the end of the month in which the employee attains age 70 or spouse's age 71, whichever is earlier

How to Use Your Benefit Booklet

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:

Your Benefit Booklet includes...

a detailed Table of Contents, allowing quick access to the information you are searching for,

Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,

a clear, concise explanation of your Group Benefits,

information you need, and simple instructions, on how to submit a claim.

Important Note

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of Kingston General Hospital. The information in this booklet is a summary of the provisions of the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Plan Document (both available from your employer), the terms of the Plan Document 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 Plan Document must be in effect and you must satisfy all the requirements of the Plan.

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

Your Group Benefit Card

Your Group Benefit Card

Your Group Benefit Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Plan Document Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Plan Document Number and your Certificate Number are also necessary for ALL correspondence with Manulife Financial. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

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

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by your employer.

Change in Life Event

a Change in Life Event occurs when: ***Change in Life Event***

you acquire a dependent;

you have a change in marital status;

your Spouse's coverage ceases;

any dependent ceases to qualify as a dependent; or

any dependent dies.

Continuous Service

a period of unbroken employment with any Participating Employer including vacation days and holidays granted, approved leaves of absence, temporary lay-offs and interruptions of service approved by Manulife Financial. ***Continuous Service***

Covered Expenses

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

Deductible

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

Dependent

your Spouse or Child who is covered under the Provincial Plan. ***Dependent***

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

for the purposes of this definition, the term spouse may also include the employee's separated spouse. Coverage for a separated spouse may be continued provided the employee has agreed to the coverage. Agreement of coverage may be determined by a signed claim form which indicates that the employee and spouse are separated, but that the employee wishes to continue the coverage for that spouse.

The above definition will not include a divorced spouse, as, once the divorce decree is granted, the marriage is no longer considered legal.

An employee bound by family law to continue group benefits for a divorced spouse must purchase individual coverage elsewhere for the spouse.

only one spouse will be eligible for benefits under this plan, and will be as indicated by the employee on his application for benefits under this plan, or by indication on the claim form. Where this information is not contained on the employee's application, the person who qualifies last under this plan's definition of spouse will be the eligible spouse.

- Child

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

- unmarried

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

- not employed on a full-time basis, and

- not eligible for coverage as an employee under this or any other Group Benefit Program

a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

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

Your employer may require written proof of the child's condition as often as may reasonably be necessary.

a stepchild must be living with you to be eligible

Drug

Drug

a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number.

Earnings

Earnings

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

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

the amount reported on your claim form, or

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

Explanation of Commonly Used Terms

Experimental or Investigational

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

HOODIP

Hospitals of Ontario Disability Income Plan.

HOODIP

HOOPP

Healthcare of Ontario Pension Plan.

HOOPP

Immediate Family Member

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.

Licensed, Certified, Registered

Licensed, Certified, Registered

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

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Life-Sustaining Drugs

Medically Necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Medically Necessary

Non-Evidence Limit

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

Non-Evidence Limit

Participating Employer

an employer that is a member of the Ontario Hospital Association (OHA) and participates in any OHA-sponsored plan.

Participating Employer

Provincial Plan

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

Provincial Plan

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.

Qualifying Period

Explanation of Commonly Used Terms

Reasonable and Customary

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.

Take Home Pay (Net Earnings)

Take Home Pay (Net Earnings)

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

Waiting Period

Waiting Period

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

Ward

Ward

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

Why Group Benefits?

Why Group Benefits?

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 Employer's Representative

Your Employer's Representative

Your employer is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by 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 employer with the necessary information to perform such duties.

Your Employer's Representative is _____

Phone Number: (_____)_____-_____

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

Applying for Group Benefits

Applying for Group Benefits

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

Making Changes

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 employer. Such changes could include:

change in Dependent Coverage

change in Beneficiary

applying for coverage previously waived

change in Name

The Claims Process

How to Submit a Claim

How to Submit a Claim

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

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

Payment of Extended Health Care and Dental Claims

Claim Payment

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 employer 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 employer.

Submission of Proof upon Benefit Termination

Submission of Proof

Upon termination of a person's plan benefits under this Plan, proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

12 months from the date the expense was incurred; or

90 days from the date of termination of plan benefit coverage.

Co-ordination of Extended Health Care and Dental Care Benefits

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

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.

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible to enroll for Group Benefits if you:

are a permanent full-time employee actively working at least 30 hours per week,

are a part-time employee working less than 30 hours per week or participating in a job-sharing arrangement working an average of 18.75 hours per week,

have completed the Waiting Period shown under each benefit in the section entitled Your Group Benefits,

are younger than the Termination Age, and

are residing in Canada.

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

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

Required Number of Hours

Required Number of Hours

Full-time employee - 30 hour(s) per week, or pro-rata full-time equivalency as determined by the employer

Job-Sharing Employee - normal work schedule of at least 18.75 hour(s) per week

Contract employee - 15 hour(s) per week

Medical Evidence

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

Late Application

An application is considered late when you:

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

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

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

apply for benefits 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 employer. Further medical evidence may be requested by Manulife Financial.

Who Qualifies for Coverage?

Late Dental Application

Late Dental Application

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to $125 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

Effective Date of Coverage

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

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

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

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

Your dependent's coverage will not be effective prior to the date your coverage becomes effective. This does not apply to Dependent Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.

Termination of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

the date you cease to be an eligible employee

the date you cease to be actively at work, unless the Plan Document allows for your coverage to be extended beyond this date

the date your employer terminates coverage

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

the date the Plan Document terminates or coverage on the class to which you belong terminates

the date you reach the Termination Age

the date of your death

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

Your Group Benefits

Extended Health Care

Extended Health Care

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

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

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

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $22.50 Individual, $35 Family, per calendar year(s)

Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

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

- Deductible Carry-Forward

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

Benefit Percentage (Co-insurance)

Options 1 and 3

100% for
- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Not Available in Canada is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Option 2

100% for
- Hospital Care

Termination Age

For Employee: the end of the month in which the employee attains age 70. Upon retirement, coverage may continue under Class 080.

For Spouse: the end of the month in which the employee attains age 70 or spouse's age 70, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Covered Expenses

Extended Health Care - Covered Expenses

Unless otherwise stated, the expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial or your employer, provided they are:

- medically necessary for the treatment of sickness 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

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.

Advance Supply Limitation

Extended Health Care - Advance Supply Limitation

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

- Drug Expenses

- Drug Expenses

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

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

b) a 34 day supply.

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

Hospital Care

Extended Health Care - Hospital Care

Option 1 - charges, in excess of the hospital's public ward charge, for private accommodation

Option 2 - charges, in excess of the hospital's public ward charge, for semi-private accommodation

Option 3 - charges, in excess of the hospital's semi-private room, for private accommodation

For Options 1, 2 and 3, the following will apply:

- the person must be confined to hospital on an in-patient basis, and

- the accommodation must be specifically elected in writing by the patient

for Options 1, 2 and 3, confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of $3 per day for up to 120 days per calendar year

for Options 1, 2 and 3, confinement in a convalescent care facility, up to a maximum of $10 per day for up to 120 days per calendar year

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

Not covered for Option 2

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

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

oral contraceptives, intrauterine devices and diaphragms

injectable medications including vitamins (charges made by a practitioner or physician to administer injectable medications are not covered)

allergy serums

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

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)

Charges for the following expenses are not covered:

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

drugs used in the treatment of a sexual dysfunction

- Drug Maximums

- Drug Maximums

Fertility drugs - $2,500 per calendar year to a maximum of $5,000 per lifetime

Anti-smoking drugs - $500 per 5 consecutive calendar years

Injectable vitamins - 80 injections per 5 consecutive calendar years

Intrauterine devices - one per 60 consecutive months

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered. Appropriate supporting documentation for adverse reaction is required.

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

you cannot locate a participating Pay Direct Drug pharmacy

you do not have your Pay Direct Drug Card with you at that time

the prescription is not payable through the Pay Direct Drug Card system

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

Vision Care

Extended Health Care - Vision Care

Not covered for Option 2

eye exams, once per 24 consecutive months

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $300 per 24 consecutive months

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 24 consecutive months

visual training, to a maximum of $150 per lifetime

Professional Services

Extended Health Care - Professional Services

Not covered for Option 2

Services provided by the following licensed practitioners:

Chiropractor - $375 per calendar year

Massage Therapist - $200 per calendar year

Speech Therapist - $200 per calendar year

Physiotherapist - $350 per calendar year. Effective September 29, 2015, $375 per calendar year.

Psychologist - $200 per calendar year

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required.

Professional Services are not limited to reasonable and customary charges.

Medical Services and Supplies

Extended Health Care - Medical Services and Supplies

Not covered for Option 2

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

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

Covered Expenses are subject to a maximum of $10,000 per lifetime.

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

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

Pre-Determination of Benefits

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

- Ambulance

Ambulance

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

- Medical Equipment

Medical Equipment

rental or, when approved by Manulife Financial or your employer, purchase of:

- Mobility Equipment: crutches (limited to one pair per lifetime), canes (limited to one per lifetime), walkers, and wheelchairs

- Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- Non-Dental Prostheses, Supports and Hearing Aids

external prostheses, limited to one appliance per limb per lifetime. Breast prostheses are limited to one left and one right prosthesis every 2 calendar years.

surgical stockings, up to a maximum of 4 pairs per calendar year

surgical brassieres, up to a maximum of 2 per calendar year

braces (other than foot braces), trusses, collars, leg orthosis, casts and splints. Trusses are limited to one per 5 calendar years. Cervical collars are limited to one per calendar year. Braces are limited to one per lifetime.

stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of 2 pairs per calendar year. Orthopaedic shoes are not limited to reasonable and customary charges.

casted, custom-made orthotics, up to a maximum of 1 pair per calendar year (recommendation of either a physician or a podiatrist is required). Orthotics are not limited to reasonable and customary charges.

cost, installation, repair and maintenance of hearing aids (including charges for batteries), to a maximum of 1 per ear per 36 consecutive months

Other Supplies and Services

- Other Supplies and Services

ileostomy, colostomy and incontinence supplies

medicated dressings

burn pressure garments, to a maximum of $500 per calendar year

wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of 1 per lifetime

oxygen

lenses and frames following cataract surgery, or when the covered person lacks an organic lens, to a maximum of one per eye

speech aids, to a maximum of $500 per lifetime

viscosupplementation, provided services are prescribed by a physician in the covered person's province of residence

a TENS unit, to a maximum of $1,000 per lifetime

tracheotomy supplies

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

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

Out-of-Province/Out-of-Canada

- Out-of-Province/Out-of-Canada

treatment required as a result of a medical emergency which occurs during the first 90 days while temporarily outside the province of residence, provided 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 is

- a sudden, unexpected injury or a new medical condition which occurs while a covered 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 covered 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.

expenses are payable up to a maximum of $5,000,000 per lifetime

referral outside Canada for treatment which is available in Canada to a maximum of $500,000 per lifetime

If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $500,000 per lifetime.

For all non-emergency medical treatment out of Canada:

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

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

Charges for the following are payable under this expense:

physician's services

hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program. Hospital charges are limited to a maximum of 31 days per period of confinement.

the cost of special hospital services

hospital charges for out-patient treatment

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

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

Charges resulting from pre-existing conditions are payable provided the pre-existing condition is stable prior to travel and medical attention is not anticipated during the period of travel. Individuals will be considered clinically stable when, during the 3 months prior to departure:

they have not been under treatment or evaluation for new symptom(s) or examination finding(s) that are present; or

they have not been experiencing a worsening severity or increased frequency of existing symptom(s) or examination finding(s) related to known diagnosed or undiagnosed disease(s), condition(s) or illness(es);

a physician (or other medical professional) has not prescribed or recommended a change in treatment or medication;

there has been no admission to a hospital; and

no future investigation(s) or new treatment is planned.

Individuals will not be considered stable if they have been diagnosed with a terminal condition, have a disease(s), illness(es), condition or condition(s) of a nature or severity that requires fluctuating levels of consultation, attendance or treatment by a physician or other health care professional(s).

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

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

Emergency Travel Assistance

Extended Health Care - Emergency Travel Assistance

Not covered for Option 2

Emergency Travel Assistance is a travel assistance program available for you and your covered dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a medical emergency during the first 90 days while travelling outside your province of residence.

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

Medical Emergency Assistance

A Medical Emergency is:

a sudden, unexpected injury or a new medical condition which occurs while a covered 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 covered 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 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 benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

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

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

f) **Return of Dependent Children**

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

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

g) **Trip Interruption/Delay**

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

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

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

h) **After Hospital Convalescence**

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

i) **Visit of Family Member**

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

j) **Vehicle Return**

If a covered person is unable to operate 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 province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

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

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Exceptions

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

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

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

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

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

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

Submitting a Claim

Extended Health Care - 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 employer.

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

All claims must be submitted within 12 months after the date the expense was incurred.

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.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Extended Health Care - Exclusions

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

self-inflicted injuries

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

committing or attempting to commit an assault or criminal offence

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

Dental Care

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

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

The Benefit

Dental Care - The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services

- 100% for Level II - Supplementary Basic Services

- 50% for Level III - Dentures

- 50% for Level IV - Major Restorative Services

Benefit Maximums

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

- $1,000 per calendar year for Level III

- $1,000 per calendar year for Level IV

Termination Age

For Employee: the end of the month in which the employee attains age 70. Upon retirement, coverage may continue under Class 080.

For Spouse: the end of the month in which the employee attains age 70 or spouse's age 71, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Covered Expenses

Dental Care - 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 within the scope of his license, or a denturist working within the scope of his license

are reasonable as determined by your employer or 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 your employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Dental Care - Alternate Treatment

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

Level I - Basic Services

Dental Care - Level I - Basic Services

complete oral exam, one per 2 calendar years

full-mouth x-rays, one per 36 consecutive months and limited to covered persons age 12 and over

occlusal and extraoral radiographs, one per calendar year (limited to dependent children age 18 and under for Orthodontic purposes)

cephalometric x-rays, five per 2 consecutive calendar years

one unit of light scaling and one unit of polishing, once every 9 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 9 months, when the service is performed in Quebec

recall exams, bitewing x-rays, and fluoride treatments, once every 9 months

routine diagnostic and laboratory procedures

oral hygiene instruction, once every 6 months

fillings (amalgam, silicate, acrylic and composite) and retentive pins. Replacement fillings are covered provided:

– the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or

– the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

pit and fissure sealants for permanent molars, limited to one initial sealant or one replacement sealant per tooth per lifetime and limited to dependent children under age 18

mouth guards, one per calendar year

periodontal appliances, limited to one upper and one lower appliance per 2 consecutive calendar years

pre-fabricated full-coverage restorations (metal and plastic). Stainless steel crowns are limited to one per tooth per lifetime and are limited to dependent children under age 18.

space maintainers (excluding appliances placed for orthodontic purposes), limited to one per tooth per lifetime and limited to dependent children under age 17

space maintainer appliances, maintenance and repairs, limited to dependent children under age 17

minor surgical procedures and post surgical care

extractions (including impacted and residual roots)

consultations, anaesthesia, and conscious sedation

denture repairs, relines, rebases and remakes, only if the expense is incurred later than 3 months after the date of the initial placement of the denture and limited to one upper and one lower denture reline, repair, rebase or remake per 2 calendar years

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

Level II - Supplementary Basic Services

Dental Care - Level II - Supplementary Basic Services

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

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 12 units per calendar year

- provisional splinting

- occlusal equilibration, up to a maximum of 8 units per calendar year

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

Level III - Dentures

Dental Care - Level III - Dentures

initial provision of full or partial removable dentures

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

- a natural tooth is extracted and the existing appliance cannot be made serviceable

- the existing appliance is at least 3 years old and cannot be made serviceable, or

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

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay, limited to one occurrence per tooth in 12 consecutive months. Crowns and onlays performed in conjunction with bridgework are not eligible.

inlays, covering at least 3 surfaces, provided the tooth cusp is missing, limited to one occurrence per tooth in 12 consecutive months. Inlays performed in conjunction with bridgework are not eligible.

initial provision of fixed bridgework

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

- a natural tooth is extracted and the existing appliance cannot be made serviceable

- the existing appliance is at least 3 years 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

Late Entrant Limitation

Dental Care - Late Entrant Limitation

If you or your dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $125 for each covered person.

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

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

All claims must be submitted within 12 months after the date the expense was incurred.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Dental Care - Exclusions

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

self-inflicted injuries

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

committing or attempting to commit an assault or criminal offence

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

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

services which are payable by any government plan

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

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

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

implants, or any services rendered in conjunction with implants

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

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

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Extended Health Care and Dental Care benefits, provided your dependents continue to pay premiums, until the earliest of:

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

the date similar coverage is obtained elsewhere

the date which is 12 months from your death, or

the date the Plan Document 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.