City of Surrey

Plan Document Number: G0086901A

Group Policy Number: G0038749A

Plan: A - Full-time Employees of CUPE Local 402

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: January 01, 2012

Group Policy Effective Date: January 01, 2012

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 redrafted: May 7, 2012

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0038749A.

Benefit Amount - 2 times your annual earnings, to a maximum of $150,000 and a minimum of $5,000

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Extended Health Care

Extended Health Care
Extended Health Care - The Benefit

The Benefit

Overall Benefit Maximum - $500,000 per lifetime

Deductible - $100 Individual, $100 Family, per calendar year
Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment

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

Benefit Percentage (Co-insurance)

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

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - last day of the month following the month in which you retire

Benefit Summary

Hospital Care

Extended Health Care - Hospital Care

charges, in excess of the hospital's public Ward charge, for semi-private or private accommodation, provided:

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

- the accommodation was specifically elected in writing by the patient

charges for convalescent care, for semi-private accommodation, up to a maximum of $20 per day for 180 days for all periods of treatment of an illness due to the same or related causes. The Plan Administrator will cover the cost of room and board for convalescent care if this care has been ordered by a doctor and as long as:

– confinement follows at least 5 consecutive days of in-patient hospitalization,

– confinement begins within 14 days of release from the hospital, and

– confinement is primarily for rehabilitation and not for custodial care.

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

Direct Drugs - Plan 3

Extended Health Care - Direct Drugs - Plan 3

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 an illness or injury, which by law or convention require the written prescription of a physician or dentist

oral contraceptives when prescribed for reasons other than contraception. When prescribed for the purpose of contraception, this Drug will be subject to the limit shown under Drug Maximums.

injectable medications

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

standard syringes, needles and diagnostic aids, required for the treatment of diabetes (excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment)

sclerotherapy, if medically necessary

Charges for the following are not covered:

the administration of injectable medications

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

fertility drugs unless when prescribed for reasons other than infertility

anti-smoking drugs

anti-obesity drugs unless with a prescription

drugs used in the treatment of a sexual dysfunction

intrauterine devices and diaphragms

- Drug Maximums

- Drug Maximums

Oral contraceptives when prescribed for the purpose of contraception - $200 per family per calendar year

All other covered drug expenses - Unlimited

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

In order to receive reimbursement after paying the full cost for a drug, you must submit the original receipt together with a fully completed Extended Health claim form.

Vision Care

Extended Health Care - Vision Care

eye exams including refractions, up to $100 per 2 calendar years

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $400 per 2 calendar years, including $375 per 2 calendar years for elective laser vision correction procedures. Charges for sunglasses or safety glasses are not covered.

Benefit Summary

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $200 per calendar year, including 1 x-ray per calendar year

Podiatrist/Chiropodist - Unlimited, including 1 x-ray per calendar year

Massage Therapist - Unlimited

Naturopath - $200 per calendar year

Speech Therapist - $250 per calendar year

Physiotherapist - Unlimited

Psychologist - $600 per calendar year

Acupuncturist - $400 per calendar year

Dental Care

Dental Care
Dental Care - The Benefit

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners and Specialists for your Province of Residence

If you reside in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by Manulife Financial.

Benefit Percentage (Co-insurance)

- 80% for Level I - Basic Services

- 80% for Level II - Supplementary Basic Services

- 60% for Level III - Dentures

- 60% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $3,000 per lifetime for Level V

Termination Age - last day of the month following the month in which you retire

Long Term Disability

The Long Term Disability Benefit is insured under Manulife Financial's Policy G0038749A.

Benefit Amount - 60% of monthly earnings, to a maximum of $4,500

Minimum Benefit - $100 or 10% of the Benefit Amount prior to CPP/QPP Integration, whichever is greater

Qualifying Period - 6 months

Maximum Benefit Period - to age 65. However, if benefit payment commences during the 12 months immediately preceding your 65th birthday, benefit payments will continue during the Disability until no later than the last day of the month in which benefits have been paid for 12 months.

Termination Age - age 65 less the Qualifying Period, or retirement, 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

This document provides a summary of the benefits you receive as an employee of City of Surrey. It does not contain all the details of the plan, those can be found in the Policy or Plan Document (both available from your employer). The Policy or Plan Document are subject to change from time to time. If there is a discrepancy between this document and the Policy or Plan Document, the terms of the Policy or 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 Group Policy and 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 Group Policy Number, 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 Group Policy Number, 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.

Consumer Price Index Factor

Consumer Price Index Factor

the ratio of:

the Consumer Price Index ("CPI") as of September of the year preceding the year for which the calculation is being made; to

the CPI as of September of the year the Employee became Totally Disabled.

The Consumer Price Index means the all-item Consumer Price Index for Canada (not seasonally adjusted) as published by Statistics Canada.

If Manulife Financial determines that there has been a change in the method of calculating the CPI, Manulife Financial reserves the right to use the CPI for the period preceding the change and an appropriate measure of inflation, as determined by Manulife Financial, will be used for the period after the change.

Convalescent Hospital

Convalescent Hospital

a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Covered Expenses

Covered Expenses

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

Deductible

Deductible

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

Dependent

Dependent

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

- Spouse

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

Your spouse must be a resident of Canada or the United States.

Explanation of Commonly Used Terms

- Child

natural or adopted child, legal ward, foster child, or stepchild, who is:

- unmarried

- under age 21, or 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

for Extended Health Care and Dental Care, a child of a female dependent of you or your spouse who is unmarried and under 21 years of age, or who is a full-time student at an accredited school, college or university, and is entirely dependent upon you for financial support, will also be considered to have satisfied the conditions of this definition.

your child must be a resident of Canada or the United States.

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

a newborn child shall become eligible from the moment of birth

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.

Hospital

Hospital

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

- is eligible to receive payments under a provincial hospital plan;
- provides organized facilities for diagnosis, major surgery, or rehabilitation;
- provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance;
- 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
- 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 Plan, the chronic beds of a Hospital are not considered to be part of that Hospital.

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

Explanation of Commonly Used Terms

Provincial Plan

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

Qualifying Period

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

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 agreed upon by Manulife Financial and the employer,

the amount shown in the applicable professional association fee guide, or

the maximum price established by law.

Retirement Date for Totally Disabled Employees

Retirement Date for Totally Disabled Employees — if you are totally disabled your retirement date is your 65th birthday, unless you have retired prior to this.

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

For many services, claims may be submitted online, or directly by the provider of the service. Where a paper claim submission is required, all claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number, Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

You can sign up for direct deposit by going to www.manulife.ca, My Profile, Banking Information and entering your banking information in the spaces provided.

Manulife Financial 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 can contact Manulife Financial's call centre at 1-855-9SURREY (1-855-978-7739).

Date Costs are Incurred

Date Costs are Incurred

The expense for a service or supply is deemed to have been incurred on the date the service was performed or the supply furnished. If a procedure involves multiple appointments, the expense is deemed to be incurred on the date the procedure is completed. For supplies that have to be ordered, the expense will be deemed to be incurred on the date the supplies were paid for. Proof of receipt of the supplies is required.

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.

For paper claim submissions, 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 Manulife Financial.

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

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.

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 for Group Benefits if you:

are a full-time employee of City of Surrey and work at least the Required Number of Hours,

are a member of an eligible class,

are younger than the Termination Age,

are residing in Canada, and

have completed the Waiting Period.

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. This does not apply to Optional Life.

Required Number of Hours

Required Number of Hours

Full-time employee - 35 hour(s) per week.

Job-sharing arrangement - scheduled an average of 17.5 hours per week over a 2 week period in accordance with the job sharing schedule.

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

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.

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.

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 Group Policy or 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 Group Policy or 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. If your coverage terminates due to your death, your dependents' coverage will be continued as specified under the Survivor Extended Benefit provision for Extended Health Care and Dental Care for a period of 12 months without requiring any contribution from you.

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0038749A.

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Employee Life - The Benefit

Benefit Amount - 2 times your annual earnings, to a maximum of $150,000 and a minimum of $5,000

Non-Evidence Limit - $150,000

Qualifying Period for Waiver of Premium - 6 months

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Waiting Period - 3 months of continuous employment

Submitting a Claim

Employee Life Insurance - Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your employer.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from your employer. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 180 days from the end of the qualifying period.

Waiver of Premium

Employee Life Insurance - Waiver of Premium

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

Definition of Totally Disabled

Employee Life Insurance - Totally Disabled

For Employees with 35 or more years of employment:

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed. However, if the permit or licence has been withdrawn or not renewed solely for medical reasons, you will be considered to be totally disabled for up to 12 months from the end of the qualifying period. You cannot be working other than in a rehabilitation program approved by Manulife Financial.

For All Other Employees:

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period

any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed. However, if the permit or licence has been withdrawn or not renewed solely for medical reasons, you will be considered to be totally disabled for up to 12 months from the end of the qualifying period. You cannot be working other than in a rehabilitation program approved by Manulife Financial.

Entitlement Criteria

Employee Life Insurance - Entitlement Criteria

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

you must be continuously Totally Disabled throughout the Qualifying Period for at least 30 days without interruption. If you cease to be Totally Disabled during the Qualifying Period and then become disabled again within 30 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled. However, the Qualifying Period cannot be extended by more than 6 months.

for Employees with 35 or more years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation

for All Other Employees, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 2 years, and
- any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above

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

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

Termination of Waiver of Premium

Employee Life Insurance - Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

the date you cease to be Totally Disabled, as defined under this benefit

for Employees with 35 or more years of employment, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation

for All Other Employees, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 2 years, and
- any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above

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

the date you do not attend an examination by an examiner selected by Manulife Financial

the date of your death

the date of your 65th birthday

Recurrent Disability

Employee Life Insurance - Recurrent Disability

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

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

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Conversion Privilege

Employee Life Insurance - Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

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

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by City of Surrey. 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.

Drug Benefit for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance legislation (An Act Respecting Prescription Drug Insurance And Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit For Persons Who Reside In Quebec, will apply to your drug benefit.

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - $500,000 per lifetime

Deductible - $100 Individual, $100 Family, per calendar year
Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment

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)

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

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - last day of the month following the month in which you retire

Waiting Period - 3 months of continuous employment

Covered Expenses

Extended Health Care - Covered Expenses

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

charges, in excess of the hospital's public Ward charge, for semi-private or private accommodation, provided:

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

- the accommodation was specifically elected in writing by the patient

charges for convalescent care, for semi-private accommodation, up to a maximum of $20 per day for 180 days for all periods of treatment of an illness due to the same or related causes. The Plan Administrator will cover the cost of room and board for convalescent care if this care has been ordered by a doctor and as long as:

- confinement follows at least 5 consecutive days of in-patient hospitalization,
- confinement begins within 14 days of release from the hospital, and
- confinement is primarily for rehabilitation and not for custodial care.

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

Direct Drugs - Plan 3

Extended Health Care - Direct Drugs - Plan 3

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 an illness or injury, which by law or convention require the written prescription of a physician or dentist

oral contraceptives when prescribed for reasons other than contraception. When prescribed for the purpose of contraception, this Drug will be subject to the limit shown under Drug Maximums.

injectable medications

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

standard syringes, needles and diagnostic aids, required for the treatment of diabetes (excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment)

Sclerotherapy, if medically necessary

Charges for the following are not covered:

the administration of injectable medications

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

fertility drugs unless when prescribed for reasons other than infertility

anti-smoking drugs

anti-obesity drugs unless with a prescription

drugs used in the treatment of a sexual dysfunction

intrauterine devices and diaphragms

- Drug Maximums

- Drug Maximums

Oral contraceptives when prescribed for the purpose of contraception - $200 per family per calendar year

All other covered drug expenses - Unlimited

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

In order to receive reimbursement after paying the full cost for a drug, you must submit the original receipt together with a fully completed Extended Health claim form.

Vision Care

Extended Health Care - Vision Care

eye exams including refractions, up to $100 per 2 calendar years

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum of $400 per 2 calendar years, including $375 per 2 calendar years for elective laser vision correction procedures. Charges for sunglasses or safety glasses are not covered.

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $200 per calendar year, including 1 x-ray per calendar year

Podiatrist/Chiropodist - Unlimited, including 1 x-ray per calendar year

Massage Therapist - Unlimited

Naturopath - $200 per calendar year

Speech Therapist - $250 per calendar year

Physiotherapist - Unlimited

Psychologist - $600 per calendar year

Acupuncturist - $400 per calendar year

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the calendar year has been paid.

Recommendation by a physician for Professional Services is not required , except for services of a massage therapist. A physician's recommendation for these services is required on an annual basis.

Medical Services and Supplies

Extended Health Care - 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

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the hospital by:

a registered nurse, or

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

Charges for the following services are not 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 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.

Your Group Benefits

- Ambulance

Ambulance

licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from 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, canes, 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. Charges for myoelectric appliances are not covered.

surgical stockings, up to a maximum of 2 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

modifications or adjustments to stock-item orthopaedic shoes or regular footwear and custom-made shoes (recommendation of either a physician or a podiatrist is required) 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

casted, custom-made orthotics, up to a maximum of 2 pairs per calendar year (recommendation of either a physician or a podiatrist is required).

cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $700 per 5 calendar years

- Other Supplies and Services

Other Supplies and Services

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $1,000 per 2 calendar years. Recommendation by a physician is not required.

oxygen

microscopic and other similar diagnostic tests and services rendered in a licensed laboratory

charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 6 months of the accident, excluding injuries due to biting or chewing. If your plan benefit coverage terminates under this plan, the employer will pay for expenses for the treatment of accidental injuries to the natural teeth, provided the accident is due to a force or blow external to the mouth and occurred while you were covered for this benefit. The treatment must be received and approved for payment within 6 months of the accident.

radiotherapy

coagulotherapy, plasma and blood transfusions

medical examinations, up to once every 22 months to a maximum of $100 per examination, if required by the employer for the purpose of obtaining a Class 1 or Class 3 Driver's License

stump socks, up to maximum of 10 per calendar year

glucometers, up to a maximum of $700 per lifetime

Synvisc

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 60 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.

An Emergency is an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

Emergency services are any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

expenses are included in the Overall Benefit Maximum

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 for semi-private accommodation in excess of Ward rates are payable, if hospital coverage is provided under this Benefit Program.

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

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

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 60 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

An Emergency is an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

Emergency services are any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

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.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will 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.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed drug; and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

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.

Proof that benefits are payable must be submitted within the earlier of:

March 31st following the year in which the claim was incurred; or

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

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

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, other than medical examinations required by the employer for the purpose of obtaining a Class 1 or Class 3 Driver's License

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 (except private duty nursing)

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

equipment used to treat seasonal affective disorder

Drug Benefit For Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and

drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

The following provisions apply only to the coverage of drugs that are on the RAMQ List, as legislated by An Act Respecting Prescription Drug Insurance (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage**

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

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

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

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

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

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

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

i) deductible amounts, and

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for your dependent children.

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

c) **Deductible**

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

d) **Lifetime Maximums**

Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

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

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

f) **Termination Age**

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

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation

iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation

iv) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

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

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

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by City of Surrey. 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 Fee Guide for General Practitioners and Specialists for your Province of Residence

If you reside in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by Manulife Financial.

Benefit Percentage (Co-insurance)

- 80% for Level I - Basic Services

- 80% for Level II - Supplementary Basic Services

- 60% for Level III - Dentures

- 60% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $3,000 per lifetime for Level V

Termination Age - last day of the month following the month in which you retire

Waiting Period - 3 months of continuous employment

Your Group Benefits

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 months

one unit of light scaling and one unit of polishing, once every 5 months to a maximum of twice per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing), once every 5 months to a maximum of twice per calendar year, when the service is performed in Quebec

recall exams, bitewing x-rays, and fluoride treatments, once every 5 months to a maximum of twice per calendar year

routine diagnostic and laboratory procedures

oral hygiene instruction, once every 5 months to a maximum of twice per calendar year

fillings, retentive pins and pit and fissure sealants. 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

pre-fabricated full coverage restorations (metal and plastic)

space maintainers (appliances placed for orthodontic purposes are not covered), for dependent children under age 18 only

appliances to control harmful habits

minor surgical procedures and post surgical care

extractions (including impacted and residual roots)

consultations, anaesthesia, and conscious sedation

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

- provisional splinting

endodontic services which include root canals and therapy, root amputation, apexifications and periapical services

onlays, one every 60 months

inlays, covering at least 3 surfaces, provided the tooth cusp is missing, one every 60 months

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 60 months 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. 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

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

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

crowns or veneers when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay

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 60 months old and cannot be made serviceable

- 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, or

- the existing appliance is less than 60 months old and is required to replace an existing appliance which has caused temporomandibular joint disturbances and which cannot economically be modified to correct the condition

Expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

Dental Care - Level V - Orthodontics

orthodontic services

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

If a person's plan benefit coverage terminates (for reasons other than termination of the Plan Document or the Dental Care Benefit) and endodontic treatment had begun exposing a tooth, or an impression for a denture, crown, onlay or bridgework had been taken prior to the termination, the employer will pay for expenses related to the endodontic treatment or installation of the crown, onlay or bridgework provided the expense is incurred within 31 days after the plan benefits terminate.

Dental Treatment after Coverage under this Plan ends

Dental Care - Dental Treatment after Coverage under this Plan ends

If your plan benefit coverage terminates under this plan, the employer will pay for expenses for the treatment of accidental injuries to the natural teeth, provided the accident is due to a force or blow external to the mouth and occurred while you were covered for this benefit. The treatment must be received and approved for payment within 6 months of the accident.

Submitting a Claim

Dental Care - Submitting a Claim

Your dental office will likely be able to provide you with a Dental Claim form and/or submit the claim electronically on your benefit. In the event that you are required to provide a Dental Claim form, you may obtain one from the Manulife Financial Plan Member website.

Proof that benefits are payable must be submitted within the earlier of:

March 31st following the year in which the claim was incurred; or

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

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

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

supplies usually intended for sport or home use, for example mouth guards, unless medically necessary

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. However, if an implant is the treatment of choice and the implant is part of a bridge, crown or denture, then only the cost of the bridge, crown or denture will be considered eligible.

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 without requiring any contribution from you, 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

Long Term Disability

Long Term Disability

The Long Term Disability Benefit is insured under Manulife Financial's Policy G0038749A.

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

Definition of Totally Disabled

Long Term Disability - Definition of Totally Disabled

For Employees with 35 or more years of employment:

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed. However, if the permit or licence has been withdrawn or not renewed solely for medical reasons, you will be considered to be totally disabled for up to 12 months from the end of the qualifying period. You cannot be working other than in a rehabilitation program approved by Manulife Financial.

For All Other Employees:

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period

any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed. However, if the permit or licence has been withdrawn or not renewed solely for medical reasons, you will be considered to be totally disabled for up to 12 months from the end of the qualifying period. You cannot be working other than in a rehabilitation program approved by Manulife Financial.

The Benefit

Long Term Disability - The Benefit

Benefit Amount - 60% of monthly earnings, to a maximum of $4,500

Minimum Benefit - $100 or 10% of the Benefit Amount prior to CPP/QPP Integration, whichever is greater

Non-Evidence Limit - $4,500

Qualifying Period - 6 months

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

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

Maximum Benefit Period - to age 65. However, if benefit payment commences during the 12 months immediately preceding your 65th birthday, benefit payments will continue during the Disability until no later than the last day of the month in which benefits have been paid for 12 months.

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period - 3 months of continuous employment

Entitlement Criteria

Long Term Disability - Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

you must be continuously Totally Disabled throughout the Qualifying Period for at least 30 days without interruption. If you cease to be Totally Disabled during the Qualifying Period and then become disabled again within 30 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled. However, the Qualifying Period cannot be extended by more than 6 months.

for Employees with 35 or more years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation

for All Other Employees, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 2 years, and

- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

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

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

Periods for Which You are Not Entitled to Benefits

Long Term Disability - Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

receiving Employment Insurance maternity or parental benefits

on lay-off, strike or lock-out during which you become Totally Disabled

on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law (in some provinces, Employers with a benefit plan are required to provide benefits to you during the health-related portion of a maternity leave of absence)

receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan

working in any occupation, except as provided for under the Rehabilitation Assistance provision

incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

absent from Canada, for any reason, for a period of more than 4 months. However, this restriction will be waived if Manulife Financial provides written agreement in advance to pay benefits during the period of absence.

Amount of Disability Benefit Payable

Long Term Disability - Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

Workers' Compensation or similar coverage

Canada or Quebec Pension Plans, excluding dependent benefits

Quebec Parental Insurance Plan

any Short Term Disability, loss of income or other salary continuation plan

any group plan provided by the employer for approved sick leave

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 80% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

any group, association or franchise plan

any retirement or pension plan of your employer payable as a result of disability or medical condition

earnings or payments from any employer, including severance payments and vacation pay (excluding severance payments from the City of Surrey)

self-employment

any government plan, excluding Employment Insurance Benefits

any government motor vehicle automobile insurance plan or policy, unless prohibited by law

Criminal Injuries Compensation Act

any Workers' Compensation Act or similar law for another disability excluding automatic cost-of-living increases that occur after benefits begin

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Benefit Calculation Rules

Long Term Disability - Benefit Calculation Rules

Manulife Financial will apply the following rules in determining your disability benefit:

benefits payable from other sources which began before the commencement of your current Disability will not be taken into account

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

subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established

benefits payable under individual disability income insurance will not be taken into account

for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial, and

if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid

Subrogation

Long Term Disability - Subrogation

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

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

Tax Status of Benefits

Long Term Disability - Tax Status

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

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

Payment of Disability Benefits

Long Term Disability - Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

Rehabilitation Assistance

Long Term Disability - Rehabilitation Assistance

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

In considering whether Rehabilitation Assistance is appropriate for you, Manulife Financial will take into account:

the nature, extent and expected duration of your disability

your level of education, training or experience

the nature, scope, objectives and cost of a Vocational Plan

- Vocational Plan

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife Financial will provide a structured Vocational Plan that will prepare you for a return to work, either:

with your employer

with an alternate employer

in a self-employed capacity

- Disability Benefits During Rehabilitation

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced by 50% of your rehabilitation income. Your disability benefit will be further reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your adjusted pre-disability gross earnings; net earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife Financial will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

- Adjusted Pre-Disability Earnings

- Adjusted Pre-Disability Earnings

If you are receiving disability benefits, each January, your pre-disability earnings will be adjusted using the Consumer Price Index Factor for the preceding year for the purposes of assessing your disability benefit while in a rehabilitation assistance program.

- Vocational Rehabilitation Expense Benefit

- Vocational Rehabilitation Expense Benefit

If, while receiving disability benefits, you become involved in vocational rehabilitation approved by Manulife Financial, expenses reasonably associated with your rehabilitation will be payable by Manulife Financial, provided:

the expenses have been pre-approved by Manulife Financial

the charges are reasonable, and are not payable through any other source

Expenses which will be considered under this benefit are:

rehabilitation assessment, including work capacity assessment and placement assistance

vocational counselling, re-training or education, and non-medical rehabilitation devices

Termination of Benefit Payments

Long Term Disability - Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

the date you cease to be Totally Disabled, as defined under this benefit

for Employees with 35 or more years of service, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of your own occupation

for All Other Employees, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 2 years, and

- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

the date you do not attend an examination by an examiner selected by Manulife Financial

the date on which benefits have been paid up to the Maximum Benefit Period for this benefit

the last day of the month of your death

the last day of the month you retire on pension with your employer or are eligible to retire with a full pension or full pension equivalent if you are disabled prior to age 64

Recurrent Disability

Long Term Disability - Recurrent Disability

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

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

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Interrupted Periods of Total Disability During the Qualifying Period

Long Term Disability - Interrupted Periods of Total Disability During the Qualifying Period

Interrupted periods of total disability occurring prior to the completion of the qualifying period will be considered to be one period of disability and will be accumulated to complete the qualifying period, provided each of the following conditions are met:

this Long Term Disability benefit is still in force

the initial period of total disability lasts for at least 30 days without interruption

after the initial period, there is no interruption of more than 30 days

each period of total disability is due to the same or related cause(s)

each period of total disability is completed within 12 months from the commencement of the qualifying period, or as approved by Manulife Financial in advance in cases where the qualifying period is 365 days or more

The difference between your normal number of scheduled hours and the number of hours actually worked will be credited towards the qualifying period. If this Long Term Disability benefit is terminated, any balance of the qualifying period must subsequently be satisfied by an uninterrupted period of total disability.

Waiver of Premium

Long Term Disability - Waiver of Premium

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

Survivor Benefit

Long Term Disability - Survivor Benefit

If you die while disability benefits are payable, Manulife Financial will pay a benefit to your surviving spouse or, if there is no surviving spouse, to the surviving dependent children. If there are no surviving dependents, the benefit is payable to your estate.

The amount of the Survivor Benefit payable is (3) times your last monthly benefit payment, less the amount of any outstanding benefit overpayments.

Submitting a Claim

Long Term Disability - Submitting a Claim

To submit a claim, you must complete the Long Term Disability claim form which is available from your employer. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Manulife Financial within 180 days from the end of the Qualifying Period.

Exclusions

Long Term Disability - Exclusions

No benefits are payable for any disability related to:

self-inflicted injuries or illnesses

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

medical or surgical care which is not medically necessary

the committing of or the attempt to commit an assault or criminal offence except for injuries sustained while operating a motor vehicle with a blood alcohol content over the permissible level stipulated in the Criminal Code at the time of injury

abuse of addictive substances, including drugs and alcohol, unless you:

– are actively participating and co-operating in a medical treatment program for substance abuse which has been approved by Manulife Financial, or

– has an organic disease which would cause total disability even if substance abuse ceased.

a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which drugs were prescribed, within 90 days prior to the effective date of your coverage.

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.