City of Hamilton

Plan Document Number: G0085801M1

Group Policy Number: G0038901M1

Plan: C51 – Members of CUPE 5167

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: September 1, 2004

Group Policy Effective Date: September 1, 2004

The Plan described is up to date as at: July 21, 2019

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.

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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:

- 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

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of the City of Hamilton. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance and the Plan Document for the Extended Health Care, Dental Care and Long Term Disability. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from your employer), 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 is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Plan Contract Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Plan Contract 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.

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 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

To apply for Group Benefits, you must submit a completed Benefits Enrolment/Change form, available from your employer.

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
- change in Name

How to Submit a Claim

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Plan Contract Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim. For details refer to **"Submitting a Claim"** under the applicable benefits section of this booklet.

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

Payment of Extended Health Care and Dental Claims

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, please contact the Manulife Plan Member Call Centre at 1-800-268-6195.

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

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact the Manulife Plan Member Call Centre at 1-800-268-6195.

All claims processed under this policy will be subject to reasonable and customary charges which are considered the lowest of:

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

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.

The Claims Process

Order of Benefit Payment

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

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

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

  - For Claims incurred by you or your Dependent Spouse:

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

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

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

  - For Claims incurred by your Dependent Child:

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

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

  - The Plan of the parent with custody of the child, then
  - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
  - The Plan of the parent not having custody of the child, then
  - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).
  - Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

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

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

Submitting a Claim for Co-ordination of Benefits

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

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

- Submit all necessary claim forms and original receipts to the Primary Carrier.

- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a full-time employee,
- are a member of an eligible class,
- are eligible based on the terms of the CUPE 5167 Collective Bargaining Agreement with the City of Hamilton,
- 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. A person who becomes eligible after you become covered is eligible on the date that person becomes a dependent under the Group Plan.

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

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
- the date of your retirement*

* Employee Life Insurance, Extended Health Care and Dental Care will be available under the retiree group to any employee meeting the following criteria;

A former employee who:

- retired from the Employer under the OMERS 90 factor, or was enrolled in Extended Health Care, Dental Care and Life Insurance coverage immediately preceding retirement, and,
- retired from the Employer on an early OMERS pension, is between the ages of 55 and 65, and is in receipt of an OMERS pension or Workers Compensation Disabilty Pension and at the date of retirement had twenty continuous years of employment with the Employer, or
- was terminated after April 1, 1996 for non-disciplinary reasons, while in receipt of LTD benefits.

This coverage shall be available to eligible retirees until the earlier of:

- the date of death
- the last day of the month in which the retiree attains age 65
- the date similar coverage is obtained elsewhere (applicable to Extended Health Care and Dental Care only)
- for employees in receipt of LTD benefits, the date the LTD benefit payments cease

Your dependents' coverage terminates on the earliest of:

- the date your coverage terminates
- the date the dependent ceases to be an eligible dependent

It is your responsibility to advise your Plan Administrator when your dependents no longer meet the definition of an eligible dependent (refer to Explanation of Commonly Used Terms for definition).

Extension of Extended Health Care and Dental Care Benefits For Disability

In the event of termination of employment while you or your dependent are totally disabled, benefits for that individual shall continue until the earliest of:

- the date the Plan Document terminates
- the date total disability ceases
- the 90th day following termination of coverage
- the date you and your dependents become eligible for coverage under any other group plan

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0038904B.

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

The Benefit

Benefit Amount - 2 x your annual earnings (base salary/wage rate), rounded to the nearest $1,000, if not already a multiple thereof

Non-Evidence Limit - $600,000. Amounts above this amount require satisfactory Evidence of Insurability

Termination Age - coverage terminates when the employee attains age 65, or retirement, whichever is earlier

Waiting Period

120 working days or accumulated 6 months aggregate service

Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 1 year from the date of the loss.

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 Plan Administrator.

Extended Health Care

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

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

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

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

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Dispensing Fee Maximum - $7.00 per prescription

Benefit Percentage (Co-insurance)

100% coverage up to the applicable maximums per benefit. See benefit details.

Termination Age – retirement

Waiting Period

120 working days or accumulated 6 months aggregate service

Covered Expenses

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

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable and customary as determined by Manulife Financial, 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.

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- smoking cessation aids and drugs (prescribed and over the counter)
- anti-obesity drugs
- fertility drugs
- oral contraceptives
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

- life-sustaining drugs
- preventive vaccines (including flu vaccine) and medicines (oral or injected)
- standard syringes, needles and test tapes, required for the treatment of diabetes

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- intrauterine devices and diaphragms
- prescription vitamins
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Smoking Cessation Drugs and Aids: $300 per calendar year

All other covered drug expenses: Unlimited

- Payment of Covered Expenses

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

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

If there is no lower cost interchangeable product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

Where a prescription contains a written direction from the Physician or Dentist that the prescribed Drug is not to be substituted with another product, the maximum amount covered is the price of the lowest cost Interchangeable Drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no lower cost Interchangeable Drug for the prescribed Drug, the amount covered is the cost of the prescribed Drug.

- Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see Submitting a Claim or contact the Manulife Plan Member Call Centre at 1-800-268-6195.

Hospital Care

- Public Hospital Coverage: ward accommodation only, as provided by the provincial plan. No additional coverage is provided under this group benefits plan.
- Private Hospital Coverage: confinement in any eligible Private Hospital for private coverage
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Vision Care

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

- one eye exam, purchase and fitting of prescription glasses/elective contact lenses, as well as repairs, or elective laser vision correction procedures to a combined maximum of $350 per 24 consecutive months
- when contact lenses are the only means available to restore the visual acuity of the better eye to at least 20/40, a maximum of $250 will be eligible for such contact lenses per lifetime, in addition to the regular vision care benefit outlined above.

Charges for the following expenses are not covered:

- non-prescription sunglasses
- prescription or non-prescription safety glasses

Paramedical Services

Services provided by the following licensed practitioners:

- Chiropractor: $300 per calendar year
- Massage Therapist: $30 per visit to a maximum of 12 visits per calendar year
- Speech Pathologist: $200 per calendar year
- Physiotherapist: $1,500 per calendar year, initial assessments are not covered

- Clinical Psychologist: up to 2 visits per month to a maximum of $1,000 per calendar year combined for services of a clinical psychologist, psychiatrist, psychotherapist and social worker

- Psychiatrist: up to 2 visits per month to a maximum of $1,000 per calendar year combined for services of a clinical psychologist, psychiatrist, psychotherapist and social worker

- Psychotherapist: up to 2 visits per month to a maximum of $1,000 per calendar year combined for services of a clinical psychologist, psychiatrist, psychotherapist and social worker

- Social Worker: up to 2 visits per month to a maximum of $1,000 per calendar year combined for services of a clinical psychologist, psychiatrist, psychotherapist and social worker

Expenses for Paramedical 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 benefit year has been paid.

Recommendation by a physician for Paramedical Services is not required, except for services of a massage therapist or speech pathologist.

Medical Services and Supplies

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

Private Duty Nursing

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

- a registered nurse; or

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

Nursing services must be certified medically necessary by the attending physician.

If treatment extends beyond thirty days Manulife Financial requires updated authorization from a medical doctor on a monthly basis in order to continue coverage.

Charges will be subject to a maximum of $25,000 per calendar year to a lifetime maximum of $100,000.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision

- service performed by a nursing practitioner who is an immediate family member or who lives with the patient

- service performed while the patient is confined in a hospital, nursing home, or similar institution

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

- agency fees, commissions and overtime charges, or any amount in excess of the fee level set by the largest nursing registry in the Province of Ontario.

Pre-Determination of Benefits

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

Ambulance

- licensed professional 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

- rental or, when approved by Manulife Financial, purchase of the following charges which are reasonable and customary when incurred on the written authorization of a physician and when required for therapeutic use only:

  - Mobility Equipment: crutches, canes, walkers, hospital bed and hospital bed repairs, wheelchair and wheelchair repairs

  - Durable Medical Equipment: apnea monitor, aerochambers, compressors, nebulizers, CPAP machines, respirators (refer to Explanation of Commonly Used Terms for definition) and equipment necessary for the administration of oxygen.

  - Diabetic Equipment: pen injectors, kidney checking devices, bloodletting devices, insulin infusion set, insulin infusion pump and blood glucose monitoring machines.

Non-Dental Prostheses, Supports and Hearing Aids

Purchase of the following when incurred on the written authorization of a physician:

- external prostheses, artificial limbs (in the case of myoelectric or sport prostheses, payment shall be limited to the amount that would otherwise be paid for standard type artificial limbs), standard eyes, stump socks and repairs to prosthetic appliances

- corrective prosthetic lenses and frames, provided once only following cataract surgery or when the person lacks an organic lens

- surgical stockings, to a maximum of $400 per calendar year

- surgical brassieres

- braces (excluding any brace used to correct a dental defect, deficiency or injury), trusses, casts (including fiberglass), cervical collars and splints

- custom-made shoes (must be constructed by a certified orthopaedic footwear specialist), modifications and adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist/chiropodist is required), or casted, custom-made orthotics (recommendation of either a physician or a podiatrist/chiropodist is required), to a combined maximum of $500 per calendar year for employees and a combined maximum of $750 per 2 calendar years per spouse and dependent child

- cost and repair of hearing aids (including charges for batteries, but excluding ear examinations and tests) on the written prescription of a licensed, certified or registered audiologist, otolaryngologist, otologist or physician, to a maximum of $350 in any 36 consecutive months

- lymphedema sleeves/compression sleeves with a mean compression factor of 20mmHG, up to a maximum of 2 sleeves per body part or limb per calendar year

Other Supplies and Services

Purchase of the following when incurred on the written authorization of a physician:

- incontinence supplies, urinary kits and ostomy supplies (where a surgical stoma exists)
- surgical bandages and dressings
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $1,500 per lifetime
- oxygen
- charges by a hospital for diagnostic services while an inpatient, out-patient or for emergency care or services which are not covered by the Provincial Health Insurance Plan
- PSA (prostatic specific antigen) test, one test per employee and spouse per 24 consecutive months
- charges for the treatment of accidental injuries to natural teeth necessitated by a direct accidental blow to the mouth, to a maximum of $500 per accident for replacement, no limit for repair, excluding injuries due to biting or chewing. Before the services begin, it is advisable that you submit a detailed treatment plan, available from your dentist, with cost estimates. You will then be advised of any benefit that will be provided. Payment will be made up to the fees set out in the Ontario Dental Association fee guide for General Practitioners in effect on the date of treatment. The accident and treatment must occur while coverage is in force. Treatment must begin within 90 days of the accident, and must be completed within 3 years of the accident.
- cystistat kit up to a maximum of 1 course of treatment. Purchase will be eligible when a pre-authorization is completed by the attending physician, outlining the diagnosis and recommended course of treatment. The patient will be re-evaluated after the 8th treatment and additional pre-authorization must be obtained if further treatment is required.
- tracheotomy supplies
- radium therapy and radioactive isotope treatments

Out-of-Province/Canada

- treatment required as a result of a medical emergency which occurs during the first 60 days while traveling or living temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

  A medical emergency is a sudden, unexpected injury which occurs or a foreseen or unforeseen illness which begins while a covered person is travelling or living temporarily outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is stable enough to return to his province of residence.

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.

- the cost of special hospital services
- hospital charges for out-patient treatment

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

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 on the Group Benefits Secure Site – www.manulife.ca/groupbenefits.

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

Claims for Out-of-Province/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.

All claims must be submitted within 12 months following the end of the calendar year in which the expense was incurred.

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

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

- an illness or injury for which benefits are payable under any government plan or workers' compensation
- 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
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms or other documentation and transfer of medical files
- 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 provided by an employer's medical or dental department

- 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
- drugs, 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
- drugs, services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit
- medical or surgical care which is cosmetic
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- services or supplies provide while confined in a nursing home or home for the aged
- charges for care, services or supplies which are not medically necessary, as determined by Manulife Financial
- charges for or in connection with dental care or services, except as otherwise provided in this Plan
- charges for services provided in a health spa, chronic care or psychiatric hospital or chronic care unit of a general hospital, except as otherwise provided in this Plan
- charges for vaporizers
- for additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear or as the result of a pathological change, subject to prior written approval by Manulife Financial
- charges for benefits or that part of benefits which cease to be payable under any government program
- rest cures
- charges for service agreements
- charges which involve willful concealment or misrepresentation of any material fact or circumstance concerning this coverage, either before or after the incurrence of an expense. In the event that any claim(s) submitted by the covered person is (are) found to be inappropriate after due investigation, then the covered person shall indemnify Manulife Financial from all costs related to the investigation. (Waiver of Manulife Financial of its rights to indemnification in any particular instance will not preclude Manulife Financial from exercising its rights in any other situations that may arise.)

Dental Care

Your Dental Care Benefit is provided directly by City of Hamilton. 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

Deductible - Nil

Dental Fee Guide – Current Ontario Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

100% for Basic Services - Level I

100% for Supplementary Basic Services - Level II

50% for Dentures - Level III

50% for Major Restorative Services - Level IV

50% for Orthodontics - Level V

Benefit Maximums

Unlimited for Level I and Level II

$1,500 per calendar year combined for Level III and Level IV

$2,500 per lifetime for Level V

Termination Age – retirement

Waiting Period

120 working days or accumulated 6 months aggregate service

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 and customary as determined by Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit (for crowns, bridges and dentures only) 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

- complete oral exam, once every 6 months for persons under age 13 and once every 9 months for persons age 13 and over
- full-mouth x-rays, once per 24 months
- panoramic x-rays, once every 9 months
- one unit of light scaling and one unit of polishing, once every 6 months for persons under age 13 and once every 9 months for persons age 13 and over, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months for persons under age 13 and once every 9 months for persons age 13 and over, when the service is performed in Quebec
- recall exams, bitewing x-rays and fluoride treatments, once every 6 months for persons under age 13 and once every 9 months for persons age 13 and over
- routine diagnostic and laboratory procedures
- oral hygiene instruction/reinstruction, once every 9 months
- 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
- veneer applications - chairside
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered) for dependent children only
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultation, anaesthesia, and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- cephalometric films and tracing of cephalometric films
- microbiological tests for determination of pathologic agents

- bacteriological tests for determination of dental caries susceptibility
- sinus examinations
- unscheduled office or institutional visits
- laboratory services related to Level I procedures

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
  - occlusal equilibration, up to a maximum of 8 units per 12 months
  - gingival curettage
  - nervous and muscular disorders
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
  - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
  - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment
- management of temporomandibular joint (TMJ) dislocation
- treatment of fractures
- laboratory services related to Level II procedures

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 48 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
- laboratory services related to Level III procedures

Level IV – Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- 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, or
  - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation
- splinting
- laboratory services related to Level IV procedures

Level V - Orthodontics

- orthodontic services, for dependent children under 18 years of age
- laboratory services related to Level V procedures

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $300, you should 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

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 30 days for Level II services and 90 days for Level III and Level IV services after your benefit terminates.

Submitting a Claim

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

All claims must be submitted within 12 months following the end of the calendar year in which the expense was incurred.

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

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

- services which are payable by any government plan
- 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
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms or other documentation and transfer of medical files
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies provided by an employer's medical or dental department
- 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 not specified as a covered expense under this benefit
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction, except for management of temporomandibular joint dislocation
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- implants, or any services rendered in conjunction with implants
- anti-snoring or sleep apnea devices
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- charges which are in excess of the fee stated in the suggested fee guide applicable to this benefit
- charges for any expenses which were incurred prior to the date on which the covered person becomes covered under this benefit

Long Term Disability

Your Long Term Disability Benefit is provided directly by City of Hamilton. 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 become Totally Disabled while covered and meet the Entitlement Criteria for this benefit, a disability benefit will be paid.

Definition of Totally Disabled

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.

The Benefit

Benefit Amount - 66.7% of monthly earnings, rounded to the next higher $1, if not already a multiple thereof

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

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

Waiting Period

120 calendar days or accumulated 6 months aggregate service

Entitlement Criteria

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

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within one month 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.

- 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

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 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

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:

- sick pay from the City of Hamilton

- any other group insurance disability benefits arranged through the Employer or any professional association

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans, excluding dependent benefits
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law

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 earnings. All sources include those sources stated above and any benefit you are entitled to receive from:

- any retirement or pension plan
- earnings or payments from any employer, including severance payments and vacation pay, incentive retirement/exit packages and salary continuance payments
- self-employment
- any government plan, excluding Employment Insurance Benefits
- Canada or Quebec Pension Plans' dependent benefits

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

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

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

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

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

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

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

You will continue to be entitled to disability benefits while participating in the Vocational Plan. Your disability benefit will be reduced by an amount equal to 50% of earnings received from any employment while participating in the Vocational Plan. The benefit amount payable will be further reduced so that your total income from all sources does not exceed 90% of your pre-disability earnings.

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.

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
- 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 date you have been rehabilitated into a new or modified position, or the date you refuse to participate in modified or alternate work which accommodates the limitations of your total disability
- the date you participate in any educational program for remuneration or profit
- the date of your death

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.

Submitting a Claim

To submit a claim, you must complete the Long Term Disability claim form which is available from your Plan Administrator. 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

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
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if your blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial

Explanation of Commonly Used Terms

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

Benefit Percentage (Co-insurance)

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

Covered Expenses

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

Deductible

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

Dependent

means either:

- your legally married spouse or a person of either sex who has continuously cohabited with you for at least one year in a common-law relationship.
- you or your spouse's natural or adopted child or stepchild, who is:
    i) unmarried;
    ii) under 21 years of age but less than 25 years of age if a full-time student;
    iii) not employed on a full-time basis, and
    iv) not eligible for coverage as an employee under this or any other Group Benefit Program.

It is your responsibility to advise your Plan Administrator when your dependents no longer meet the definition of a dependent, as coverage must be terminated.

Your spouse or child must be covered under the Provincial Plan.

Coverage for an unmarried dependent child who is incapable of self support due to mental or physical handicap shall continue beyond the limiting age stated above, provided satisfactory proof is given to Manulife Financial that disability occurred while an eligible dependent:

a) within thirty days after attainment of the limiting age, and

b) as often as Manulife Financial may reasonably require thereafter.

A newborn child shall become eligible from the moment of birth.

Drug

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

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.

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.

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.

Interchangeable Drug

drugs that can legally be substituted for the prescribed drug, as specified by the provincial formulary in the province in which the drug is dispensed.

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.

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.

Non-Evidence Limit

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

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

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.

Explanation of Commonly Used Terms

Reasonable and Customary

the lowest of:

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

Respirator

an apparatus used for the purpose of providing artificial respiration over a prolonged period of time, in cases where the respiratory muscles are paralyzed.

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for plan benefits.

Ward

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

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.