Manulife

Air Canada

Plan Document Numbers: G0788000, G0788021

Group Policy Numbers: G0788034

Plan G:	Active Unifor Crew Scheduling In Flight (CAI)
Plan GL:	Active Unifor Crew Scheduling In Flight (CAI) (Leave)
Plan H:	Full-Time Unifor Members
Plan HL:	Full-Time Unifor Members (Leave)
Plan H1:	Part-Time Unifor Members
Plan H1L:	Part-Time Unifor Members (Leave)
Plan I:	Active Unifor Crew Scheduling Flight Ops (CFO)
Plan IL:	Active Unifor Crew Scheduling Flight Ops (CFO) (Leave)

Note: The above are the main numbers you should provide as a reference when contacting Manulife. Be sure to record these numbers and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Plan Document Effective Date: April 1, 2024

Group Policy Effective Date: April 1, 2024

This booklet produced: October 11, 2024

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Explanation of Commonly Used Terms

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

Actively at Work

At work for your employer at your usual place of work.

On weekends or holidays, or when on vacation, you are deemed to be Actively at Work if you were Actively at Work on your last normal working day or on your last scheduled shift.

Adherence

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

Administrator

Manulife.

Advisory Body

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

Annual Enrolment Date

The date each year on which you are permitted to make changes to your benefits coverage.

Benefit Percentage (coinsurance)

The percentage of Covered Expenses which is payable by the plan.

Birth

The complete live delivery of a child from its mother.

Change in Life Event

A Change in Life Event occurs when:

a) you acquire an Eligible Dependent;

b) you have a change in marital status;

c) your Spouse's coverage ceases;

d) any Eligible Dependent ceases to qualify as an Eligible Dependent; or

e) any Eligible Dependent dies.

Covered Expenses

Expenses that will be considered in the calculation of payment due under your Drug, 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 the plan.

Explanation of Commonly Used Terms

Disease Management Programs

An approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

A medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

A process employed by Manulife to assess new Drugs, existing Drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial/Territorial formularies, recognized clinical practice guidelines, or an Advisory Body.

Earnings

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

Earnings may include other income as agreed to in writing by your employer and Manulife.

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

a) the amount reported on your claim form; or

b) the amount reported by Air Canada to Manulife and for which premiums have been paid.

Eligible Dependent

Your Spouse or Child who is covered under the Provincial/Territorial Plan.

- Spouse

Your Spouse is:

a) the person who is legally married to you; or

b) the person of the same or opposite sex who lives with you and is the mother or father (biological or adoptive) of at least one of your children; or

c) the person of the same or opposite sex who has been living with you in a conjugal relationship for at least 12 consecutive months; or

d) the person of the same or opposite sex who lives with you and had previously lived with you for a period of at least 12 consecutive months.

If more than one person meets the above definition, the person currently living with you will take precedence.

Coverage for common law partners is subject to submission of the affidavit form (ACF420K) and becomes effective on the date the duly notarized affidavit is received by Air Canada.

Explanation of Commonly Used Terms

- Child

Your natural or legally adopted Child, your Spouse's Child, or foster Child, who is:

a) unmarried;

b) under age 21 and depends solely on you for support; or

c) over age 21 and depends solely on you for support. They are covered up to age 25 provided they are a registered student in full-time attendance at a university or similar institution of learning (proof of registration is required). Coverage terminates on your Child's 26th birthday.

A Child who is totally and permanently disabled prior to reaching age 21 will continue to be an eligible Dependent as long as you remain covered, provided the Child was covered under this Benefit Program prior to their 21st birthday.

A Child is considered totally and permanently disabled if they are incapable of self-sustaining employment and are wholly dependent on you for support, maintenance and care. Their application for a disabled status must be approved and successfully added to your profile prior to their 21st birthday.

Essential Duties

The physical and cognitive functions or tasks, recognized by Manulife to be, fundamental to the occupation and are performed at a regular frequency and duration or are infrequent, seldom or rare, but if not performed, would not fulfil the requirements of the occupation.

These functions or tasks, if omitted, modified or changed, would leave the requirements of the occupation unfulfilled.

Experimental or Investigational

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

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

Includes but is not limited to:

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

b) a Drug that contains the same active ingredient that has not been deemed interchangeable in the province/territory where 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

Non-prescription Drugs which are necessary to sustain life.

Explanation of Commonly Used Terms

Lower Cost Alternative

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

Medically Necessary

Accepted and recognized by the Canadian medical profession and Manulife as effective, appropriate and essential treatment of an illness or injury. Manulife has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered.

Non-Evidence Limit

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

Patient Assistance Program

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

Pharmacoeconomics

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

Physician

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

Plan Year

April 1st to March 31st.

Prior Authorization

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

Provincial/Territorial Plan

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

Reasonable and Customary

The lowest of:

a) 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;

b) the amount shown in the applicable professional association fee guide; or

c) the maximum price established by law.

Explanation of Commonly Used Terms

Step

One level of identified Drugs, as determined by Manulife, for treating a listed medical condition.

Step Therapy

A program where certain Drugs, as determined by Manulife and identified on Manulife's Plan Member Secure Site, that would adequately meet the covered person's fundamental medical needs for any listed medical condition, are organized in a series of Steps.

Step Therapy Modules

A list of specified medical conditions and identified on Manulife's Plan Member Secure Site, to which Step Therapy is applied.

Waiting Period

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

Ward

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

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits as of your date of hire as long as you:

a) are an active permanent employee of Air Canada; and

b) are younger than the Termination Age; and

c) are residing in Canada.

Your Eligible Dependents are eligible for coverage on the date you become eligible or the date you first acquire an Eligible Dependent, whichever is later. You must apply for coverage for yourself in order for your Eligible Dependents to be eligible.

Medical Evidence

Medical evidence is required when you apply for insurance in excess of the Non-Evidence Limit.

In all cases, medical evidence can be submitted by completing the Evidence of Insurability form, available from your plan administrator, or at www.manulife.ca/groupbenefits. Further medical evidence may be requested by Manulife.

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, whichever is later.

You must be actively at work for 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 Eligible Dependent's coverage becomes effective on the date the Eligible Dependent becomes eligible, or the date any required medical evidence on the Eligible Dependent is approved by Manulife, whichever is later.

Your Eligible Dependent's coverage will not be effective prior to the date your coverage becomes effective.

For any changes in coverage (Eligible Dependent coverage, beneficiary information, name, applying for coverage that was previously waived), complete the Application for Change form, available at www.manulife.ca/groupbenefits.

Submitting a Claim

For fast, easy and secure claim payments, we encourage you to sign up for direct deposit and electronic claim statements when you set up your access on the Plan Member secure site. Even if you mail us your claims, by providing your banking and email information, your claim payments can be deposited quickly to your bank account and you will receive an email notification, including a link to manulife.ca, where you can sign in to view your electronic claim statement.

To submit a claim, you can do one of the following:

Submit Using the Mobile App (if applicable)

Sign up to use Manulife's Mobile App.

If your health care service provider cannot send Manulife electronic claim transmissions, you can still submit your claim electronically to us through the mobile app.

Submit Online (if applicable)

Sign up to use Manulife's Plan Member Secure Site at www.manulife.ca/groupbenefits.

If your health care service provider cannot send Manulife electronic claim transmissions, you can still submit your claim electronically to us online, right from the Plan Member Secure Site.

By Mail

You must complete an applicable claim form and mail it to Manulife. Mailing instructions are included on the claim form.

Claim forms are available at www.manulife.ca/groupbenefits.

Submission Requirements

Claims must be submitted within the following timeframes:

a) 365 days from the date of the loss, for claims for Life and Accidental Death and Dismemberment benefits; and

b) by the end of the calendar year following the year in which the expense was incurred, for claims for Drug, Extended Health Care and Dental Care benefits, while coverage under the plan is in force. Upon termination of a person's coverage under this plan, proof that Drug, Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

   i) the end of the calendar year following the year in which the expense was incurred; or

   ii) 90 days from the date of termination of coverage.

For Life and AD&D claims, complete the Life Claim form.

For Drug or Extended Health Care, complete the Extended Health Care form. Visit the forms section at www.manulife.ca/groupbenefits to determine which claimed expenses can be submitted via the website.

For Dental Care, claims can be submitted either electronically by your dentist, or by paper, using a standard dental claim form.

Co-ordination of Drug, Extended Health Care and Dental Care Benefits

Did you know that you can recover up to 100% of your expenses, subject to Reasonable and Customary limitations, if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works:

If you have a claim for yourself: then submit to Manulife first. For any unpaid balances, send a copy of your Manulife claim statement and the other insurance carrier's claim form to the other insurance company for processing.

If you have a claim for your Spouse: then submit the claim to your Spouse's insurance company. For any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing.

If you have a claim for an Eligible Dependent Child: then send the claim to the insurance carrier of the parent whose birthdate falls earliest in the calendar year first. Submit any unpaid balance to the other insurance company.

Naming a Beneficiary

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

You are automatically the beneficiary for the Dependent Optional Life Insurance and Dependent Optional Accidental Death and Dismemberment benefits. This designation cannot be changed.

Manulife only accepts beneficiary designations for Employee Life Insurance, Employee Optional Life Insurance and Employee Optional Accidental Death and Dismemberment.

Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against Manulife less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitation of Actions Act (NB)
Civil Code of Quebec (QC)

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

a) the date you cease to be an eligible employee;

b) the date you cease to be actively at work, unless the Group Policy or Plan Document allows for your coverage to be extended beyond this date;

c) the date your employer terminates coverage;

d) the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates;

e) the date you reach the Termination Age; or

f) the date of your death.

Your Eligible Dependents' coverage terminates on the date your coverage terminates or the date the Eligible Dependent ceases to be an Eligible Dependent, whichever is earlier.

Life Insurance Benefit
(Employee Life, Employee Optional Life, Dependent Optional Life)

Benefit Details

Employee Life

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.

Benefit Amount

For Plans G, GL, H, HL, I and IL:

30 times your monthly Earnings, to a maximum of $80,000

For Plans H1 and H1L:

30 times your monthly Earnings, to a maximum of $40,000

Non-Evidence Limit - equal to the maximum benefit amount

Benefit Reduction - your benefit amount reduces to 50% at age 65, and further reduces at age 70 to 25% of the amount in effect immediately prior to age 65

Termination Age - no maximum age. End of benefits is subject to the Termination of Coverage section.

Employee Optional Life

Benefit Amount - increments of $10,000 to a maximum of $400,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Optional Life Insurance if applied for within 31 days of the date eligible.

Termination Age - age 70. End of benefits is subject to the Termination of Coverage section.

For Employee Life and Employee Optional Life

Optional Life Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

For Your Eligible Dependents:

You must be covered for Employee Optional Life in order to elect Dependent Optional Life.

If one of your Eligible Dependents dies while insured, the amount of this benefit is paid to you.

Optional Benefit Amount

- **Spouse** - increments of $5,000 to a maximum of $100,000

- **Child** - increments of $2,500 to a maximum of $50,000

Non-Evidence Limit - All spousal amounts are subject to evidence of insurability. However, evidence of insurability will be waived for an amount of Spousal Optional Life Insurance if applied for within 31 days of the date eligible. Child amounts are not subject to evidence of insurability.

Termination Age - age 70. End of benefits is subject to the Termination of Coverage section.

Dependent Optional Life Exclusions

If death results from suicide any amount of Dependent Optional Life Insurance that has been in effect for less than one year will not be payable.

Naming a Beneficiary (all Employee Benefits)

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from the Plan Member site.

You should review your beneficiary designation to be sure that it reflects your current intent.

Conversion Privilege

If your or your Spouse's Group Benefits terminate or reduce, you and your Spouse may be eligible to convert your 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 within 31 days of the termination or reduction of your Life Insurance. If you [or your Spouse] die during this 31-day period, the amount of 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. Provincial/Territorial differences may exist.

Accidental Death and Dismemberment Benefit (Employee Optional AD&D, Dependent Optional AD&D)

Benefit Details

For You:

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

Employee Optional Accidental Death and Dismemberment

Benefit Amount - increments of $50,000 to a maximum of $500,000

Benefit Reduction - your benefit amount reduces to $50,000 at age 65

Termination Age - no maximum age. End of benefits is subject to the Termination of Coverage section.

For Your Eligible Dependents:

You must be covered for Employee Optional Accidental Death and Dismemberment in order to elect Dependent Optional Accidental Death and Dismemberment.

If one of your Eligible Dependents sustains an accidental injury while insured and suffers a loss specified in the Schedule of Losses below, this benefit provides financial assistance.

Benefit Amount

- **Spouse** -50% of the amount of the employee's Optional Accidental Death and Dismemberment Benefit if there are no children; 40% of the amount of the employee's Optional Accidental Death and Dismemberment Benefit if there are children

- **Child** - 15% of the amount of the employee's Optional Accidental Death and Dismemberment Benefit

Termination Age - no maximum age. End of benefits is subject to the Termination of Coverage section.

Schedule of Losses (for all Benefits)

A loss shown in this schedule is covered provided it:

a) is a direct result of the accidental injury;

b) occurs within 365 days from the date of the accidental injury; and

c) is total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of the Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of or Loss of Use of One Arm and One Leg - 200%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66.67%
- Loss of Sight of One Eye - 66.67%
- Loss of Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%
- Loss of All Toes of One Foot - 33.33%
- Loss of Hearing in One Ear - 33.33%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental injury, except in the case of loss of or loss of use of one arm and one leg, hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while the insured person is living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which the insured person was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If the insured person disappears after a conveyance in which he was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if the insured person's body is not found within 365 days after the incident occurred.

Rehabilitation Expenses (Employee only benefit)

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife will pay incurred expenses, provided the expenses are:

a) reasonable and necessary, as determined by Manulife; and

b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

If the insured person dies as a direct result of an accidental injury which occurs while travelling 150 kilometres or more from his place of residence, Manulife will pay for expenses incurred for the preparation and transportation of the insured person's body to his place of residence.

The amount payable is subject to a maximum of $10,000.

Family Transportation Expenses

If, as a direct result of an accidental injury, the insured person suffers a loss specified in the Schedule of Losses and is confined to a hospital located 150 kilometres or more from the insured person's place of residence, Manulife will pay the hotel and travel expenses incurred by an Immediate Family Member, provided the expenses are:

a) reasonable and necessary, as determined by Manulife;

b) for hotel accommodations in the vicinity of the hospital; and

c) for transportation by the most direct route to the hospital, including return fare.

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of $0.20 per kilometre travelled.

The amount payable is subject to a maximum of $3,000 per accident.

Dependent Education Expenses (Employee only benefit)

If you die as a direct result of an accidental injury, Manulife will pay the tuition for each Child who is under age 26 and enrolled as a full-time student:

a) in a school for higher learning above the secondary school level; or

b) at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death.

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionel (CEGEP), community college or trade school.

The maximum payable each year for each Child is $5,000.

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

a) tuition expenses incurred prior to your death; or

b) room and board expenses, or other living, travelling or clothing expenses.

If you have a Child at your death that is not eligible for this benefit, a flat amount of $1,000 will be paid to the beneficiary.

Spousal Occupational Training Expenses (Employee only benefit)

If you die as a direct result of an accidental injury and your Spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Manulife will pay for expenses incurred by your Spouse, provided the expenses are:

a) reasonable and necessary, as determined by Manulife; and

b) incurred within a period of 3 years from the date of the accidental injury.

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Coma Benefit

If the insured person suffers a loss specified in the Schedule of Losses which, independently of all other causes, results in a coma as a direct result of the accidental injury, Manulife Financial will pay a monthly benefit, provided:

a) the coma begins within 90 days of the accidental injury; and

b) the coma is continuous and persistent for a period of 6 consecutive months at which point the coma is determined by a Physician to be permanent.

The amount of benefit payable is equal to 1% of the Optional Accidental Death and Dismemberment benefit amount, less any other amount paid or payable under this benefit in connection with the same covered loss.

Benefits are payable while the insured person is in a coma, up to a maximum benefit of 100 payments.

Payments will cease on the earlier of the date the insured person dies or is no longer in a coma.

Survivor Benefit

If you or your Spouse die as a direct result of an accidental injury, Manulife will pay a survivor benefit. The benefit will be paid to the Spouse if living, or in equal shares to surviving Children in the absence of a surviving Spouse.

The amount of benefit payable is equal to 1% of the Optional Accidental Death and Dismemberment benefit amount per month, for 6 months.

The maximum payable is $5,000.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from the Plan Member site.

You should review your beneficiary designation to be sure that it reflects your current intent.

Exclusions

No Accidental Death and Dismemberment benefits are payable if the loss results from:

a) suicide or self-inflicted injuries;

b) war or insurrection, or participation in a riot or civil commotion;

c) an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity;

d) committing or attempting to commit an assault or criminal offence; or

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

Drugs

Your Drug Benefit is provided directly by Air Canada. Manulife 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 Eligible Dependents incur charges for any of the Covered Expenses specified, your Drug 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 (coinsurance), and any other applicable provisions.

The Benefit

Overall Benefit Maximum - $1,000,000 per lifetime per eligible person

Deductible - $10 Individual, $20 Family, per Plan Year, combined for Drug and Extended Health Care benefits

- Deductible Carry-Forward

Covered Expenses used to satisfy the Deductible in the last 3 months of the Plan Year may also be used to satisfy the Deductible in the following Plan Year.

Benefit Percentage (coinsurance)

100% of covered expenses for
Drugs

Termination Age - no maximum age. Benefits end the 1st of the month following retirement. End of benefits is subject to the Termination of Coverage section

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary (unless otherwise specified), as determined by Manulife, on behalf of your employer, provided they are:

a) Medically Necessary for the treatment of an illness or injury and recommended by a physician;

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

d) not covered under the Provincial/Territorial Plan or any other government-sponsored program;

e) legally insurable;

f) used as prescribed or recommended by a physician; and

g) associated with any drug, supply or service that was subject to the Due Diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the Plan as of the date of approval as determined by the Administrator and shared with your employer as required.

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

This plan will not automatically assume eligibility for all Drugs, services and supplies. New Drugs, existing Drugs with new indications, services and supplies are reviewed by Manulife using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include as a covered expense, include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife maintains a list of Drugs, services and supplies that require Prior Authorization. Prior Authorization is applied to ensure that the therapy prescribed is Medically Necessary. Where there are Lower Cost Alternative treatments or prescribing guidelines recommend alternative Drugs be tried first that are lower in cost, you or your Eligible Dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the Drug, service or supply.

Adherence

Non-compliance may result in the Drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife may require you or your Eligible Dependents to apply to and participate in any Patient Assistance Program to which you or your Eligible Dependents are entitled. Manulife reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance you or your Eligible Dependents are entitled to receive under a Patient Assistance Program.

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife.

Advance Supply Limitation

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.

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act). If you and your Eligible Dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your Drug benefit.

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

a) Drugs for the treatment of an illness or injury, which by law or convention require the written prescription of a physician or dentist;

b) oral contraceptives, intrauterine devices and diaphragms;

c) injectable medications (excluding viscosupplementation);

d) Life-Sustaining Drugs;

e) Sclerotherapy;

f) for you, your Spouse and Eligible Dependent Children age 6 and over, flu vaccines to a maximum of $40 per vaccination;

g) for Eligible Dependent Children under age 6, preventive vaccines and medicines (oral or injected);

h) prescription vitamins;

i) non-prescription injectable vitamins;

j) Freestyle Libre sensors are eligible only for covered persons who are insulin-dependent; and

k) charges for the following for the province of Quebec only if listed in the RAMQ Formulary:

   i) calcium supplements;

   ii) potassium supplements;

   iii) iron products;

   iv) nutritional supplements;

   v) topical over the counter preparations; and

   vi) aerochambers.

Charges for the following expenses are **not** covered:

a) charges for cotton swabs and rubbing alcohol;

b) charges made by a practitioner or physician to administer injectable medications;

c) Drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis;

d) Drugs determined to be ineligible as a result of Due Diligence;

e) for you, your Spouse and Eligible Dependent Children age 6 and over, preventive vaccines and medicines (oral or injected), other than flu vaccines;

f) anabolic steroids;

g) fertility Drugs; or

h) viscosupplementation.

- Drug Maximums

Anti-smoking Drugs (including Natural Health Products):

- $690 per lifetime for all provinces other than Quebec

- unlimited for the province of Quebec only if the Drug is listed in the RAMQ Formulary

Anti-obesity Drugs:

- $2,000 per lifetime for all provinces other than Quebec

- unlimited for the province of Quebec only if the Drug is listed in the RAMQ Formulary

Drugs used in the treatment of a sexual dysfunction - $1,000 per Plan Year

Sclerotherapy - $250 per visit for drug cost, physician fees are not covered

All other covered Drug expenses – Subject to the Overall Benefit Maximum

- Payment of Covered Expenses

Payment of your covered Drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage (coinsurance) for Drugs and any maximum.

Covered Expenses for any prescribed Drug will not exceed the price of the Lower Cost Alternative Drug that can legally be used to fill the prescription, as listed in the Provincial/Territorial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by Manulife.

Manulife can limit the covered expense for any Drug to that of a lower cost Interchangeable Drug at the time the Drug is purchased.

If there is no Lower Cost Alternative Drug for the prescribed Drug, the amount payable is based on the cost of the prescribed Drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed Drug is not to be substituted with another product and the Drug is a covered expense under this benefit, the cost of the prescribed product is covered.

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

Payment of your covered Drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage (coinsurance) for Drugs and any maximum.

- Step Therapy

A covered person will not be eligible for any Drugs in Step 2 (or Step 3) of a Module unless they have tried one or more Drugs in Step 1 first.

A Drug listed in Step 1 of any Module is reimbursed in accordance with the terms of this plan. When the covered person has tried one or more Drug(s) from Step 1 for any Module, as required by Manulife, and the Drug(s) have:

a) failed to adequately treat the medical condition, or

b) the covered person is intolerant to the Drug(s), or

c) the covered person is unable to use the Drug(s) for any other medical reason,

Drug(s) listed in the next Step in the Module will be eligible. For Modules with 3 Steps, one or more Drugs from Step 1 and Step 2 must have been tried before any Drug(s) in Steps 3 will be covered.

The Step Therapy program is applied to the Modules identified on Manulife's Plan Member Secure Site.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered Drug expenses. Payment is processed automatically.

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:

a) you cannot locate a participating Pay Direct Drug pharmacy

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

c) the prescription is not payable through the Pay Direct system

For details on how to receive reimbursement after paying the full cost of the prescription, please see the Submitting a Claim section.

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 Drug benefits are payable for expenses related to:

a) war, whether declared or undeclared, insurrection, willing participation in a riot or civil commotion;

b) your involvement in the commission or attempted commission of an assault, criminal offence, or illegal act;

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

d) an illness or injury for which benefits are payable under any government plan or workers' compensation;

e) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

f) services or supplies provided by an employer's medical or dental department;

g) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

h) services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage;

i) services or supplies which are not permitted by law to be paid;

j) services or supplies which are required for recreation or sports;

k) services or supplies which would have been payable by the Provincial/Territorial Plan if proper application had been made;

l) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

m) medical or surgical care which is cosmetic, except Sclerotherapy;

n) x-ray fees;

o) 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;

p) services or supplies which are provided while confined in a hospital on an in-patient basis; or

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

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

If you and your Eligible Dependents reside in Quebec, the following provisions apply to your Drug benefit coverage.

Covered Expenses

The following expenses are covered:

a) Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List, provided such Drugs are on the list at the time the expense is incurred; and

b) covered pharmacy services that are to be paid when the drug is on the Quebec Basic Prescription Drug Insurance Plan List; and

c) Drugs that are listed as a Covered Expense in this Benefit Booklet, but are not on the Quebec Basic Prescription Drug Insurance Plan List.

Coverage for Drugs on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services published for private plans

The following provisions apply to the coverage of Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act. Coverage for all other Drugs will be subject to the regular provisions included in this Benefit Booklet:

a) **Benefit Percentage (coinsurance)**

Prior to the annual out-of-pocket maximum being reached, the percentage of covered Drug expenses payable will be:

i) for any Drugs on the Quebec Basic Prescription Drug Insurance Plan List which are not otherwise covered under the terms of the plan, the Benefit Percentage (coinsurance) stated under The Benefit.

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

iii) for any Drug on the Quebec Basic Prescription Drug Insurance Plan List which is covered under the terms of the plan, the greater of:

- the Benefit Percentage (coinsurance) stated under The Benefit, or

- the percentage as set out by the then applicable Legislation.

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

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

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

i) Deductible amounts, and

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

iii) covered pharmacy services that are performed by pharmacists for Drugs on the Quebec Basic Prescription Drug Insurance Plan List.

The annual out-of-pocket maximum for you and your Spouse is as stipulated in the Legislation and includes those portions of covered Drug expenses and covered pharmacy services relating to a drug on the Quebec Basic Prescription Drug Insurance Plan List paid for your Eligible Dependent Children.

For the purposes of calculating the out-of-pocket maximum for you and your Spouse, those portions of covered Drug expenses and covered pharmacy services paid for your Eligible Dependent Children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) **Deductible**

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

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to Drugs on the Quebec Basic Prescription Drug Insurance Plan List or covered pharmacy services. Drug and covered pharmacy service 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 Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services that are performed for Drugs on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) 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 Commonly Used Terms), and

ii) the date of their 26th birthday.

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

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

ii) only covered pharmacy services performed for a Drug on the Quebec Basic Prescription Drug Insurance Plan List are covered, and

iii) the percentage payable by the Administrator for Covered Expenses is the percentage as set out by the then applicable Legislation.

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

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

i) only Drugs that are on the Quebec Basic Prescription Drug Insurance Plan List are covered,

ii) only covered pharmacy services related to a drug on the Quebec Basic Prescription Drug Insurance Plan List are covered,

iii) the percentage payable by the Administrator for Covered Expenses is the percentage as set out by the then applicable Legislation,

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

v) the contributions required for the Drug coverage is the contribution for the Drug benefit.

Coverage for Drugs that are listed as a covered expense in this Benefit Booklet but are not on the Quebec Basic Prescription Drug Insurance Plan List

Coverage for Drugs that are listed as a covered expense under this Benefit but not on the Quebec Basic Prescription Drug Insurance Plan List will be subject to all the standard provisions included in this Benefit Booklet.

Extended Health Care

Your Extended Health Care Benefit is provided directly by Air Canada. Manulife 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 Eligible 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 (coinsurance), and any other applicable provisions.

The Benefit

Deductible - $10 Individual, $20 Family, per Plan Year, combined for Drug and Extended Health Care benefits

- Deductible Carry-Forward

Covered Expenses used to satisfy the Deductible in the last 3 months of the Plan Year may also be used to satisfy the Deductible in the following Plan Year.

Benefit Percentage (coinsurance)

100% of covered expenses for
- Hospital Care
- Vision
- Professional Services (other than mental health practitioner)
- Medical Services and Supplies (other than private duty nursing and electric wheelchair)
- Out-of-Province/Territory or Out-of-Canada Emergency Medical Treatment

60% of covered expenses for
- Medical Services and Supplies (private duty nursing)

50% of covered expenses for
- Professional Services (mental health practitioner)
- Medical Services and Supplies (electric wheelchair)

Termination Age - no maximum age. Benefits end the 1st of the month following retirement. End of benefits is subject to the Termination of Coverage section.

Covered Expenses

The expenses specified are covered to the extent that they are Reasonable and Customary (unless otherwise specified), as determined by Manulife, on behalf of your employer, provided they are:

a) Medically Necessary for the treatment of an illness or injury and recommended by a physician;

b) incurred for the care of a person while covered under this Group Benefit Program;

c) reasonable taking all factors into account;

d) not covered under the Provincial/Territorial Plan or any other government-sponsored program;

e) legally insurable;

f) used as prescribed or recommended by a physician; and

g) associated with any drug, supply or service that was subject to the Due Diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the Plan as of the date of approval as determined by the Administrator and shared with your employer as required.

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

This plan will not automatically assume eligibility for all Drugs, services and supplies. New Drugs, existing Drugs with new indications, services and supplies are reviewed by Manulife using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife to include as a covered expense, include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife maintains a list of Drugs, services and supplies that require Prior Authorization. Prior Authorization is applied to ensure that the therapy prescribed is Medically Necessary. Where there are Lower Cost Alternative treatments or prescribing guidelines recommend alternative Drugs be tried first that are lower in cost, you or your Eligible Dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the Drug, service or supply.

Adherence

Non-compliance may result in the Drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife may require you or your Eligible Dependents to apply to and participate in any Patient Assistance Program to which you or your Eligible Dependents are entitled. Manulife reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance you or your Eligible Dependents are entitled to receive under a Patient Assistance Program.

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife.

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.

Your Group Benefits

Hospital Care

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

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

   ii) the accommodation was specifically elected in writing by the patient

b) charges for the following are not covered:

   i) private hospitals, nursing homes, chronic care facilities, addiction centers, homes for the aged, rest homes and palliative care

   ii) any portion of the cost of Ward accommodation, utilization or co-payment fees (or similar charges)

Vision Care

a) eye exams, up to $125 per 24 consecutive months;

b) purchase and fitting of prescription glasses (including sunglasses and safety glasses) or elective contact lenses, as well as repairs, to a maximum of $350 per 24 consecutive months;

c) laser vision correction procedures, to a maximum of $600 per 48 consecutive months;

d) if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $1,050 per lifetime; and

e) an initial pair of frames and one corrective lens, contact lens or prosthetic lens per eye per lifetime after cataract surgery.

If a covered person is reimbursed for elective laser vision correction procedures, no claims for prescription glasses or elective contact lenses will be considered for a 48-month period.

Professional Services

Services provided by the following licensed practitioners:

* Mental Health Practitioners include Clinical Counsellors, Marriage and Family Therapists, Psychoanalysts, Psychologists, Psychotherapists and Social Workers only

a) Athletic Therapist - no maximum

b) Chiropractor - $50 per visit to a maximum of $2,000 per family per Plan Year, limited to expenses of not more than $1,000 per person per Plan Year, including $100 per Plan Year for x-rays

c) Massage Therapist - $80 per visit to a maximum of $800 per family per Plan Year

d) Mental Health Practitioners* - 50% per visit to a maximum of $1,500 per family per Plan Year, limited to expenses of not more than $750 per person per Plan Year

e) Naturopath - $50 per visit to a maximum of $2,000 per family per Plan Year, limited to expenses of not more than $1,000 per person per Plan Year

f) Osteopath - $50 per visit to a maximum of $2,000 per family per Plan Year, limited to expenses of not more than $1,000 per person per Plan Year, including $100 per Plan Year for x-rays

g) Physical Rehabilitation Therapist - no maximum

h) Physiotherapist - no maximum

i) Podiatrist/Chiropodist - $50 per visit to a maximum of $2,000 per family per Plan Year, limited to expenses of not more than $1,000 per person per Plan Year, including $100 per Plan Year for x-rays

j) Speech Therapist - $2,000 per family per Plan Year, limited to expenses of not more than $1,000 per person per Plan Year

For massage therapist, naturopath, osteopath, physiotherapist, physical rehabilitation therapist, podiatrist/chiropodist and speech therapist expenses for some of these Professional Services may be payable in part by Provincial/Territorial Plans. In those provinces/territories, expenses under this Benefit Program are payable after the Provincial/Territorial Plan's maximum for the benefit year has been paid.

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

Medical Services and Supplies

Note: *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) a registered nurse; or

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

Covered Expenses are subject to a maximum of $30 per day.

Charges for the following services are **not** covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

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

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

Pre-Determination of Benefits

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

Ambulance

Charges for a licensed ambulance service provided in the patient's province/territory of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available, or from hospital to hospital. Ambulance services other than ground ambulance require Prior Authorization.

Medical Equipment

Rental or, when approved by Manulife or your employer, purchase of:

a) Mobility Equipment: crutches, canes, walkers, and wheelchairs (repairs to electric wheelchairs are eligible if the cost of repairs is less than 50% of the cost of a new electric wheelchair); and

b) Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment (including aerochambers, maximist machine and iron lung), and other durable equipment usually found only in hospitals.

Non-Dental Prostheses, Supports and Hearing Aids

a) external prostheses;

b) surgical stockings, up to a maximum of 4 pairs per Plan Year;

c) surgical brassiere or camisole, up to a maximum of 2 per Plan Year;

d) braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;

e) head halters, traction apparatus, trapeze bars;

f) orthopedic back support including Obus Form;

g) stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of 1 pair per Plan Year for stock-item orthopaedic shoes and custom-made shoes combined, limited to expenses of not more than $150 per pair (recommendation of either a physician or a podiatrist is required). In order for shoes to be considered as orthopaedic, they must have a broad sole (full sole, option of steel shank for stability) and meet at least two of the following criteria:

   i) Removable insole
   ii) Wide widths
   iii) Firm or extended heel counter
   iv) Adjustable closure
   v) Smooth protective lining
   vi) Breathable/modifiable materials used for the uppers
   vii) High, broad toe shape;

h) custom-made shoes (including safety shoes and boots) 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, up to a maximum of 1 pair per Plan Year for stock-item orthopaedic shoes and custom-made shoes combined, limited to expenses of not more than $500 per pair (must be constructed by a certified orthopaedic footwear specialist and referred by a Physician, podiatrist or chiropodist. A chiropodist cannot prescribe and dispense shoes unless the shoes are being sent to an offsite lab). In order for shoes to be considered as orthopaedic, they must have a broad sole (full sole, option of steel shank for stability) and meet at least two of the following criteria:

   i) Removable insole
   ii) Wide widths
   iii) Firm or extended heel counter
   iv) Adjustable closure
   v) Smooth protective lining
   vi) Breathable/modifiable materials used for the uppers
   vii) High, broad toe shape;

i) casted, custom-made orthotics (including repairs), up to a maximum of $400 per Plan Year (recommendation of either a physician, podiatrist/chiropodist or a chiropractor is required); and

j) cost, installation, repair and maintenance of hearing aids, (including charges for hearing tests and batteries, and excluding charges for moulds) to a maximum of:

   i) $1,500 per 60 months for Plans G, GL, I and IL; and

   ii) $2,000 per 60 months for Plans H, HL, H1, H1L.

Other Supplies and Services

a) ileostomy, colostomy and incontinence supplies, including urethral catheters;

b) medicated dressings and burn garments;

c) wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $200 per lifetime;

d) oxygen;

e) CPAP/APAP machines, to a maximum of $2,000 per 60 months (BPAP/VPAP is not covered). Masks and nasal tubes are the only covered CPAP supplies;

f) hyperbaric oxygen therapy and chamber treatment;

g) continuous glucose monitoring systems, to a maximum of $2,000 per 60 months;

h) diabetic supplies: alcohol swabs, lancets, test strips, syringes and needles only;

i) glucometers, 1 per person, up to a maximum of $350 per calendar year;

j) insulin jet injectors, to a maximum of $1,000 per lifetime;

k) custom-made pressure supports for lymphedema;

l) punctal plugs;

m) TENS machine, to maximum of $500 per 60 months;

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

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

Out-of-Province/Territory or Out-of-Canada

IMPORTANT NOTICE

Your Group Policy includes travel coverage – what's next? We want you to understand (and it is in your best interests to know) what your Policy includes, what it excludes, and what is limited (payable but with limits). Please take time to read through this benefits booklet before you travel.

- This benefit covers claims arising from sudden and unforeseen situations (example: accidents and emergencies) and typically not follow-up or recurrent care.
- To qualify for this benefit, you and your Eligible Dependents must meet all of the eligibility requirements (example: covered by your provincial/territorial health insurance plan for the duration of your trip).
- This benefit contains limitations and exclusions. Examples may include: Medical Conditions that are not Stable, Medical Emergencies related to pregnancy or delivery within 4 weeks of the expected date of delivery.
- This benefit may not cover claims related to Pre-Existing Medical Conditions, whether diagnosed or not at the time of departure.
- In the event of a claim your prior medical history may be reviewed.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. IF YOU HAVE QUESTIONS, PLEASE CONTACT THE MANULIFE CUSTOMER SERVICE CENTRE AT 1-800-268-6195 OR ONLINE AT MANULIFE.CA

Special definitions

The following terms apply for the purposes of medical Treatment provided outside of the Employee or Eligible Dependent's province/territory of residence.

Hospital

a Hospital is an institution that is licensed as an accredited hospital that is staffed and operated for the care and Treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment.

a Hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the older adults or health spa.

Medical Condition

any disease, illness or injury (including symptoms of undiagnosed conditions).

Medical Emergency

a sudden and unforeseen Medical Condition that requires immediate Treatment. A Medical Emergency no longer exists when the evidence reviewed by Manulife indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment.

Physician

a Physician is a person licensed in the jurisdiction where the services are provided, to prescribe and administer medical Treatment.

Pre-existing Medical Condition

a Pre-Existing Medical Condition is any Medical Condition that exists prior to the insured person's date of departure from their province/territory of residence.

Reasonable and Customary Charges

charges incurred for drugs, services and supplies that are comparable to what other providers charge for similar drugs, services and supplies in the same geographical area.

the lowest of:

a) The prevailing amount charged in the absence of insurance for the same or comparable drug, services or supply in the same geographical area in which the charge is incurred, as determined by Manulife; or

b) the amount shown in the applicable professional association fee guide; or

c) the maximum price established by law; or

d) the amount as determined by Manulife as reasonable to be charged for the drug, service, or supply.

Stable

a Medical Condition is considered Stable when in the 90 days prior to departure **all** of the following statements are true:

a) there has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment, and

b) there has not been any change to any existing prescribed drug, or any recommendation or starting of a new prescription drug, and

c) the Medical Condition has not become worse, and

d) there have not been any new, more frequent or more severe symptoms, and

e) there has been no hospitalization or referral to a specialist, and

f) there have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

g) there is no planned or pending treatment.

All of the above conditions must be met for a Medical Condition to be considered Stable.

Treatment, Treat

a procedure prescribed, performed or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing and surgery.

Out-of-Province/Territory or Out-of-Canada

Coverage Information

a) Treatment required as a result of a Medical Emergency which occurs while temporarily outside the province/territory of residence, provided the insured person who receives the Treatment is also covered by the Provincial/Territorial Plan during the absence from the province/territory of residence, up to a maximum of $25,000 per lifetime.

Charges for the following are payable under this expense:

a) Physician's services;

b) 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;

c) the cost of special Hospital services;

d) hospital charges for out-patient Treatment;

e) licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or Hospital where adequate Treatment is available; and

f) medical evacuation for admission to a Hospital or medical facility in the province/territory 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/Territorial Plan.

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

Exclusions

No Out-of-Province/Territory or Out-of-Canada Medical Emergency benefits are payable for expenses directly or indirectly related to:

a) any Medical Condition which is not Stable in the 90 days before the scheduled date of departure from the province/territory of residence;

b) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

c) further related medical Treatment if Manulife determines that you should transfer to another facility or return to your home province/territory of residence for treatment;

d) tests, Treatment or surgery for which you could have returned home, after your Medical Emergency Treatment has started. This includes but is not limited to invasive or investigative testing, MRI, CT, surgery, cardiac catheterization, other cardiac procedures, transplant, and follow up appointments;

e) non-Emergency or elective Treatment (e.g. cosmetic surgery, chronic care, rehabilitation, or any Treatment not immediately medically required, including any expenses for directly or indirectly related complications);

f) any claim, if you or your Eligible Dependent are not covered under the Government Health Insurance Plan (GHIP) of your province or territory of residence for the entire duration of the trip. It is your responsibility to check that you do have this coverage;

g) any charges incurred relating to a trip made for the purpose of obtaining a diagnosis, Treatment, surgery, investigation, palliative care, or any alternative therapy, as well as any related complication;

h) any Medical Condition or symptoms for which it is reasonable to believe or expect that Treatment will be required during your trip;

i) the continued Treatment, recurrence or complication of a Medical Condition or related condition, following Emergency Treatment during your trip, if Manulife determines that your Emergency has ended and you are able to return to your province/territory of residence for further Treatment;

j) a Medical Condition that is the result of you or your covered Eligible Dependent not following Treatment as prescribed, including prescribed prescription or over-the-counter medication;

k) any Medical Emergency related to a to pregnancy, delivery, or complications of either, for insured persons who are pregnant and travelling within 4 weeks of the expected date of delivery;

l) a Medical Condition arising during your trip from, or in any way related to, the operation of a motor vehicle or watercraft of any kind by you or your covered Eligible Dependent while impaired by a drug or any intoxicant or having a blood alcohol level of more than 80 mg of alcohol per 100 ml of blood.

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:

a) war, whether declared or undeclared, insurrection, willing participation in a riot or civil commotion;

b) your involvement in the commission or attempted commission of an assault, criminal offence, or illegal act;

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

d) an illness or injury for which benefits are payable under any government plan or workers' compensation;

e) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

f) services or supplies provided by an employer's medical or dental department;

g) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

h) services and supplies where reimbursement would have been made under a government-sponsored plan;

i) services or supplies which are not permitted by law to be paid;

j) services or supplies which are required for recreation or sports;

k) services or supplies which would have been payable by the Provincial/Territorial Plan if proper application had been made;

l) medical treatment which is not usual or customary, or is Experimental or Investigational in nature;

m) medical or surgical care which is cosmetic;

n) x-ray fees, unless otherwise specified;

o) 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;

p) services or supplies which are provided while confined in a hospital on an in-patient basis; or

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

Dental Care Benefit

Your Dental Care Benefit is provided directly by Air Canada. Manulife 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 Eligible 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 (coinsurance), and any other applicable provisions.

The Benefit

Deductible - $25 Individual, $50 Family, per Plan Year

Not applicable to:
Level I - Basic Services (Diagnostic and Preventive)

- Deductible Carry-Forward

Covered Expenses used to satisfy the Deductible in the last 3 months of the Plan Year may also be used to satisfy the Deductible in the following Plan Year.

Dental Fee Guide - Current Fee Guide for General Practitioners and Specialists for the Province/Territory in which the services are rendered

Benefit Percentage (coinsurance)

100% of covered expenses for Level I - Basic Services (Diagnostic and Preventive)

90% of covered expenses for Level I - Basic Services (Restorative, Surgical and Prosthetic)

90% of covered expenses for Level II - Supplementary Basic Services

50% of covered expenses for Level III - Dentures

50% of covered expenses for Level IV - Major Restorative Services

50% of covered expenses for Level V - Orthodontics

50% of covered expenses for Level VI - TMJ

Benefit Maximums

$2,000 per Plan Year combined for Level I, Level II, Level III and Level IV

$2,500 per lifetime for Level V

$1,000 per lifetime for Level VI

Termination Age - no maximum age. Benefits end the 1st of the month following retirement. End of benefits is subject to the Termination of Coverage section.

Covered Expenses

The following expenses are covered if they:

a) are incurred for the necessary dental care of a covered person while covered under this benefit;

b) 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;

c) are reasonable as determined by Manulife, on behalf of your employer, taking all factors into account; and

d) do not exceed the fees recommended in the Dental Fee Guide, or Reasonable and Customary charges as determined by Manulife, on behalf of your employer, 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 would produce professionally adequate results for a given condition, Manulife, on behalf of 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 – Diagnostic and Preventive

a) complete oral exam, once per 12 months;

b) full-mouth or panoramic x-rays, one per 24 months;

c) one unit of light scaling and one unit of polishing, once every 6 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months, when the service is performed in Quebec;

d) recall exams, bitewing x-rays, and fluoride treatments, once every 6 months;

e) routine diagnostic and laboratory procedures;

f) oral hygiene instruction, once per lifetime;

g) periodontal scaling and root planing, up to a combined maximum of 16 units per calendar year;

h) application of an antimicrobial agent; and

i) microbiological tests.

Level I - Basic Services – Restorative, Surgical and Prosthetic

a) fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:

   i) 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

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam;

b) pre-fabricated full coverage restorations (metal and plastic);

c) space maintainers (appliances placed for orthodontic purposes are not covered);

d) minor surgical procedures and post-surgical care;

e) extractions (including impacted and residual roots)

f) other surgical procedures not specifically listed (excluding implant surgery);

g) consultations, anaesthesia, and conscious sedation;

h) 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; and

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

Level II - Supplementary Basic Services

a) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

   i) provisional splinting;

   ii) occlusal equilibration, up to a maximum of 8 units per calendar year; and

   iii) chemotherapeutic and antimicrobial agents.

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

   i) root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime.

   ii) re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment.

   iii) bleaching of endodontically treated teeth.

Level III - Dentures

a) initial provision of full or partial removable dentures;

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

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 60 months old and cannot be made serviceable, or

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

Level IV - Major Restorative Services

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

b) inlays, covering at least 3 surfaces, provided the tooth cusp is missing;

c) initial provision of fixed bridgework;

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

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable,

   ii) the existing appliance is at least 60 months old and cannot be made serviceable, or

   iii) the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation.

Level V - Orthodontics

Orthodontic services for Eligible Dependent Children only, provided treatment commences prior to reaching age 21.

Level VI - TMJ

Treatment and management of temporomandibular joint dysfunction, including x-rays, appliances, maintenance, repairs and surgery.

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

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

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:

a) war, insurrection, or participation in a riot or civil commotion;

b) committing or attempting to commit an assault or criminal offence;

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

d) dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit;

e) anti-snoring or sleep apnea devices;

f) broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms;

g) services which are payable by any government plan;

h) services or supplies provided by an employer's medical or dental department;

i) services or supplies for which no charge would normally be made in the absence of group benefit coverage;

j) treatment rendered for a full mouth reconstruction or for a vertical dimension;

k) replacement of removable dental appliances which have been lost, mislaid or stolen;

l) laboratory fees which exceed Reasonable and Customary charges;

m) 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;

n) implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the plan will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge;

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

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

Important information about your benefits:

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. Every effort has been made to describe the program accurately. However, should there be a question of interpretation, the terms outlined in the official plan documents will prevail.

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

a) the Group Policy and/or Plan Document;

b) your application for group benefits; and

c) any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

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

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