

Ball Packaging Products Canada Corp.

Group Policy Number: G0037952, G0085237

Plan E1: Salaried Retirees Who Retired Prior to January 1, 1993

Plan F1: Salaried Retirees Who Retired On or After January 1, 1993

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Group Policy Effective Date: June 1, 2009

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

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

Manulife Group Benefits Customer Service can answer any questions you may have about your benefits or how to submit a claim. Please contact them at 1-800-268-6195. Information is also available on Manulife's Group Benefits website at www.manulife.ca/groupbenefits.

This booklet produced: October 11, 2017

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Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for
- Explanation of Common Insurance Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet
- a clear, concise explanation of your Group Benefits
- 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 Ball Packaging Products Canada Corp. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (both available from your employer), the terms of the Group Policy will apply.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

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

- the Group Policy,
- your application for group benefits, and
- 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.

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

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

How to Use Your Benefit Booklet

Your Group Benefit Card

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

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

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

Explanation of Common Insurance Terms

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

Adherence

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

Advisory Body

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

Benefit Percentage (Co-insurance)

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

Covered Expenses

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

Deductible

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

Dependent

your Spouse who is insured under the Provincial Plan.

- Spouse

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

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

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 Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Group Policy. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Explanation of Common Insurance Terms

Exclusive Distribution

Manulife Financial approved vendors.

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.

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.

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 Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Group Policy.

Natural Health Products

products licensed for sale in Canada by Health Canada as a Natural Health Product.

Non-Evidence Limit

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

Patient Assistance Program

a program that provides assistance to you or your 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 Financial.

Explanation of Common Insurance Terms

Prior Authorization

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

Provincial Plan

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

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.

Ward

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

The Claims Process

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 can create financial hardship for you and your family.

Private health care supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by Ball Packaging Products Canada Corp., in partnership with The Manufacturers Life Insurance Company.

Making Changes

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your Plan Administrator. Such changes could include:

- change in Dependent Coverage
- change in Beneficiary
- change in Name

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

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance and Employee Optional Life Insurance.

This Plan contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

How to Submit a Claim

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

Manulife Group Benefits Customer Service can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Extended Health Care 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 Manulife Group Benefits Customer Service 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 Manulife Group Benefits Customer Service at 1-800-268-6195.

Alternatively, you can register for direct deposit of Extended Health Care claims by going to www.manulife.ca/groupbenefits.

Co-ordination of Extended Health 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 expenses from all Plans, up to a total of 100% of the actual expense incurred.

The Claims Process

Plan means:

- other Group Benefit Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

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

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:

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

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

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

- are a retired employee of Ball Packaging Products Canada Corp.,
- are a member of an eligible class, with 10 or more years of service, and
- are residing in Canada.

The Termination Age 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 insurance for yourself in order for your dependents to be eligible.

Evidence of Insurability

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

Medical evidence can be submitted by completing the Evidence of Insurability form, available on Manulife's Group Benefits website. Further medical evidence may be requested by Manulife Financial.

Effective Date of Coverage

- If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are Eligible.
- If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

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

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

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- the date of your death

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

Dependent coverage may be extended under the Survivor Extended Health Benefit.

Employee Life Insurance

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

The Benefit

Benefit Amount

- Plan E1

Retirees under age 65 - full amount of insurance in effect immediately prior to your retirement
Retirees age 65 and over with 10 years but less than 15 years of service - \$2,500
Retirees age 65 and over with 15 years but less than 25 years of service - \$5,000
Retirees age 65 and over with 25 years or more of service - \$10,000

- Plan F1

\$15,000

Non-Evidence Limit

-Plan E1

not applicable

-Plan F1

\$15,000

Termination Age - your benefit amount terminates upon your death

Naming a Beneficiary

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

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

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 6 months from the date of the loss.

Your Group Benefits

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. Provincial differences may exist.

Employee Optional Life Insurance

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

The Benefit

Benefit Amount

- Plan E1

If you retired with 10 years or more of service - 90% of the full amount of insurance in effect on the first day of the month following your attainment of age 65.

- Plan F1

not covered

Termination Age - your benefit amount is reduced by 10% on the first of the month following your 65th birthday or retirement, whichever is earlier, and 9 subsequent anniversaries, and terminates at your attainment age 75.

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.

Survivor Income Benefit

Benefit Amount

- Plan E1

\$100 per month or 15% of the Employee's Pension Benefit, whichever is greater

- Plan F1

not covered

Maximum Benefit Period

your benefit period continues until your Spouse's death

Termination Age

your benefit amount terminates the date the eligible Survivor dies

Definition of Survivor

your legal Spouse, or the person who has, for at least 12 months, been continuously living with the Employee in a role like that of a marriage partner, on the date of your death.

Payment of Survivor Income Benefits

The Survivor Income Benefit will be paid from the first day of the month following the date on which the employee dies, if there is a surviving Spouse, the benefit is paid to the Spouse.

Termination of Benefit Payments

Benefit payments will cease on the date the eligible Survivor dies.

Extended Health Care

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

Payment of Covered Expenses is subject to any maximum amounts shown 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

You may select no coverage or coverage

Overall Benefit Maximum

- Plan E1

\$50,000 per lifetime

Not Applicable to:
Hospital

- Plan F1

\$50,000 per lifetime. However, when an insured person's maximum is at least \$10,000 lower than the Overall Plan Maximum, such person may have it reinstated to the Overall Benefit Maximum by submitting evidence satisfactory to Manulife Financial that such person's health has been restored.

Not Applicable to:
Hospital

Deductible

Individual	\$25 per calendar year
Family	\$25 per calendar year

Not applicable to:
Hospital

Your Group Benefits

Benefit Percentage (Co-insurance)

- Plan E1

100% for

Hospital Care

Drugs

Professional Services

Medical Supplies and Services (excluding Orthopaedic Shoes when not part of a brace or splint)

50% for

Orthopaedic Shoes when not part of a brace or splint

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

The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 100%.

- Plan F1

100% for

Hospital Care

80% of expenses up to the Out-Of-Pocket maximum, and 100% thereafter for

Drugs

Professional Services

Medical Supplies and Services (excluding Orthopaedic Shoes when not part of a brace or splint)

50% for

Orthopaedic Shoes when not part of a brace or splint

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

Out-of-Pocket Maximum

- Plan E1

not applicable

- Plan F1

\$250 per calendar year for single coverage and \$500 per calendar year for family coverage

Termination Age - employee's death

Survivor Extended Insurance Benefit

subject to the spouse's eligibility for the Extended Health Care Benefit

Covered Expenses

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

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account

- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- 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 policy as of the date of approval as determined by Manulife Financial and shared with your employer as required.

In the event that a provincial 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 policy 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 policy will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife Financial using the due diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife Financial'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.

Manulife Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

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

Patient Assistance Programs

Manulife Financial may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Manulife Financial reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

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

Advance Supply Limitation

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

Your Group Benefits

Hospital Care

-Plan E1

- charges, in excess of the hospital's public ward charge, for semi-private accommodation to a maximum of 240 days per confinement, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges, in excess of the hospital's public ward charge, for private accommodation, to a maximum of \$15 per day for a maximum of 240 days per confinement, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges, to a maximum of \$15 per day, for semi-private confinement in a rehabilitation hospital which starts within 3 days of discharge from a hospital confinement. A new maximum stay will apply if the covered person has not been confined in a rehabilitation hospital for at least 30 days

Covered Expenses are subject to a maximum of \$5,000 per lifetime.

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

- Plan F1

- charges, in excess of the hospital's public ward charge, for semi-private accommodation to a maximum of \$125 per day for a maximum of 365 days per confinement, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges for semi-private confinement in a rehabilitation hospital which starts within 3 days of discharge from a Hospital confinement for a maximum of 180 days per confinement. A new maximum stay will apply if the covered person has not been confined in a rehabilitation hospital for at least 30 days

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

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

Prescribed Drugs

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

- drugs prescribed by a physician or dentist for the treatment of a sickness or injury
- oral contraceptives, intrauterine devices and diaphragms
- hematinic vitamins (vitamins to treat blood disorders) properly identified in the Compendium of Pharmaceuticals and Specialties

- preventive vaccines and medicines (oral or injected)
- prescription vitamins
- non-prescription injectable vitamins
- smoking cessation aids (including Natural Health Products as specified by Manulife)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes
- anti-obesity drugs

The following are not Covered Expenses:

- charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment
- charges made by a practitioner or physician to administer injectable medications
- charges for 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
- charges for dietary supplements, health foods, nutritional products and vitamins (except injectable and hematinic vitamins) and Natural Health Products (unless otherwise specified)

- Drug Maximums

Fertility Drugs: \$6,000 per lifetime

Anti-smoking Drugs: \$125 per lifetime (including Natural Health Products)

All other Covered Drug Expenses: Unlimited

Professional Services

- Plan E1

Services provided by the following licensed practitioners:

- Chiropractor: \$8 per visit to a maximum of 20 visits per calendar year
- Speech Therapist: Unlimited
- Physiotherapist: Unlimited
- Psychologist: Unlimited
- Occupational Therapist: Unlimited

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

Your Group Benefits

- Plan F1

Services provided by the following licensed practitioners:

- Chiropractor: \$500 per calendar year
- Speech Therapist: \$500 per calendar year
- Physiotherapist: \$500 per calendar year
- Psychologist: \$500 per calendar year
- Occupational Therapist: \$500 per calendar year

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

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, or under the supervision of, an LPN, or RPN Home Health Care Services include the following treatments:

- part-time or intermittent nursing care by, or under the supervision of, an RN or LPN;
- part-time or intermittent home health aide services which consist primarily of caring for the patient;
- physical therapy, occupational therapy, speech therapy, respiratory therapy, medical social services, nutritional guidance, hemodialysis, oxygen and its administration, and diagnostic services;
- medical supplies, drugs and medications prescribed by a physician provided such supplies would have been prescribed if the patient had remained in the hospital.

Covered Expenses are subject to a maximum of \$25,000 per calendar year for Plan E1 and \$5,000 per calendar year for Plan F1.

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

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

Medical Equipment

- rental or, when approved by Manulife Financial, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs
 - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- contact lenses or glasses following cataract surgery, limited to 1 pair per lifetime
- external prostheses
- surgical stockings
- surgical brassieres
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, (recommendation of either a physician or a podiatrist is required)
- for Plan F1, cost, installation, repair and maintenance of hearing aids, (excluding charges for batteries) to a maximum of \$500 per 5 calendar years

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment
- oxygen
- CPAP masks, including replacements
- handrails
- raised toilet seats

Your Group Benefits

- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

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

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while an insured person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

Stable means that, in the 90 days before departure, the insured person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

- for Plan E1, referral outside Canada for treatment which is available in Canada, provided part of the charge is payable under the covered person's Provincial Health Plan, included in the Extended Health Care Maximum.

If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment is included in the Extended Health Care Maximum.

For all non-emergency medical treatment out of Canada:

- the treatment must be recommended by a physician practicing in Canada, and
- it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

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

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

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your Plan Administrator.

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

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

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, Manulife Financial 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 Manulife Financial those amounts you recover which, when added to the payments you received from Manulife Financial, exceed 100% of your incurred expenses.

Exclusions

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

- for Out-of-Province/Out-of-Canada only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion

Your Group Benefits

- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Continuation of Coverage

If a person is Disabled when insurance under this Benefit terminates, Covered Expenses related to the treatment of the Disability will continue to be payable by Manulife Financial.

Coverage will be continued for up to 90 days after insurance would otherwise have terminated while the person remains Disabled. However, coverage will terminate if the disabled person becomes eligible for insurance under another group plan.

You will be considered Disabled if you are eligible for disability benefits under any other provision of this Policy.

A Dependent will be considered Disabled if he is receiving medical treatment from a Physician and confined to a Hospital or to his home.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred,
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

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

a) Benefit Percentage

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

- i) for any drugs on the RAMQ list which are not otherwise covered under the terms of the plan, the percentage as set out by the then applicable Legislation.
- 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 RAMQ List which is covered under the terms of the plan, the greater of:
 - the benefit percentage 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%.

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%. 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 RAMQ formulary.

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 RAMQ formulary paid for your dependent children.

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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 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 RAMQ 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 RAMQ List are covered, and
- ii) only covered pharmacy services that are performed for drugs on the RAMQ 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 Common Insurance Terms), and
- ii) age 26.

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

- i) only drugs that are on the RAMQ List are covered, and
- ii) only covered pharmacy services performed for a drug on the RAMQ 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 specified under the benefit is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services related to a drug on the RAMQ 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 premium required for the drug coverage is the premium for the Extended Health Care benefit.

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

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

Survivor Extended Benefit

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

- for Plan F1, the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Common Insurance Terms)
- the date similar coverage is obtained elsewhere
- the date the Group Policy terminates

