Mohawk Canada Corporation

Plan Number: G0633399
Class: A - Mohawk Employees

A message from your plan sponsor

Mohawk Canada Corporation is pleased to be able to offer you medical and financial security by sponsoring your group benefits program. We have selected Manulife Financial as a partner to help us deliver the program. They are committed to providing excellent service for us.

At this point, you will have received some basic information about how you can connect with Manulife Financial and how to submit claims. Now, I would encourage you to spend a few moments reviewing our plan's coverage so you can better understand what's available. You'll learn about not only the more routine things, but also about some of the benefits available that you may need to draw on in a time of crisis. Your plan is here to offer you some support in the event you encounter unforeseen circumstances in the future.

After reviewing the coverage, if you have any questions, check in with our plan administrator.

Your Group Benefit Program

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What you need to know about your plan

Who and what your plan covers

We are Manulife Financial, your plan sponsor's partner in supporting the group insurance benefits you receive at work. We know how important your coverage is and that you count on us to give you great tools to help you understand what you have.

Your dependents - your spouse, child or children who are insured under the Provincial/Territorial Health Plan - may also be eligible for some of the coverage provided through this benefits program. Your plan sponsor's plan must be in effect and you and your dependents must have satisfied all of the participation requirements first, for your coverage to be active.

In the event that a provincial/territorial plan or government-sponsored program or plan or legally mandated program discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, your group benefits 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.

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. It doesn't include reference to all of the plan details, limitations and exclusions or terms and conditions your employer has arranged. Those are set out in your plan sponsor's group benefits plan documents (for example, the policy or plan document and any plan amendments). Manulife's administrative team will refer to those plan documents when evaluating claims, your eligibility for coverage, and for the general administration of the program. In the event of a discrepancy between this coverage overview and the plan documents, the terms outlined in the plan documents will apply.

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

- the 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 policy.

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

Time Limit on Legal Action

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.

Your plan sponsor is Mohawk Canada Corporation

This booklet produced: December 27, 2023

Your plan number is G0633399
This is the main number you should provide as a reference when contacting Manulife Financial. Be sure to record this number and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Your coverage class is:
A - Mohawk Employees
A1 - Mohawk Employees with Single-Parent Coverage
B - Dale-Tile Employees
B1 - Dale-Tile Employees with Single-Parent Coverage

The plan effective date is January 01, 2016

This is the official day when all of the coverage and services your plan sponsor has arranged with us begins. Coverage starts once you have fulfilled any waiting period requirements set for your plan.

Your plan may include a waiting period for some benefits.

The day after the waiting period has finished is the earliest date you can use this coverage.

Enhanced information is also available on the Internet
There may be times when you may not have coverage details with you, but you need to find out about some portion of your coverage quickly. Know that you can always find the most up-to-date plan information - including an electronic version of this document - on the Plan Member Secure Site. Once registered, you can log-in any time from any Internet connection. Go to **www.manulife.ca/groupbenefits** and input your plan number and plan member certificate number. The site will tell you everything else you need to do to finish the registration process.

The electronic version also includes links to definitions, forms, and enhanced information that may help you understand how your benefits program can support you.

HOW LONG COULD IT TAKE TO HAVE MY CLAIM PROCESSED?

This will depend largely on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form. Be sure to record your plan contract number and plan member certificate number on all correspondence and claim forms.

USE MORE THAN ONE PLAN TO GET MORE MONEY BACK
Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works.

CLAIM IS FOR...	FIRST...	THEN...
You	submit to Manulife	for any unpaid balance, send a copy of your Manulife claim statement and the other insurance company's claim form to the other insurance company for processing.
Your spouse	submit claim to 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
Your children	send to the insurance company of the partner who has the earlier birth month and day	submit any balance to the other insurance company

Manulife Financial does not accept beneficiary appointments for any benefits under this Plan.

This Policy 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.

Core Coverage and Services

Your plan sponsor has chosen to offer the following benefits to form the coverage in this program.

Dental

Benefit Details	Your Plan's Coverage
Waiting Period	2 months
Deductible	None
Dental Fee Guide	Current Fee Guide for General Practitioners for the Province/Territory in which the services are rendered
Coverage ends	At your retirement
Maximum applies to: Level I	$1,500 per calendar year
Combined Maximum applies to: Level II Level III Level IV	$1,500 per calendar year
Maximum applies to: Level V	$2,000 per lifetime
Level I - Basic Services Includes items such as: • complete oral exam, one per 2 calendar years • full-mouth x-rays, one per 2 calendar years • one unit of light scaling and one unit of polishing once every 6 months, when the service is performed outside Quebec, or prophylaxis once every 6 months, when the service is performed in Quebec • bitewing x-rays, two films, once every 6 months • recall exams, and fluoride treatments, once every 6 months (fluoride treatments are a covered expense for dependent children under 19 years of age) • routine diagnostic and laboratory procedures • fillings, retentive pins and pit and fissure sealants Replacement fillings are covered provided: - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling	100% to a maximum of $1,500 per calendar year

or recurrent decay, or - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam • pre-fabricated full coverage restorations (metal and plastic) • space maintainers (appliances placed for orthodontic purposes are not covered) • minor surgical procedures and post surgical care • extractions (including impacted and residual roots) • consultations, anaesthesia, and conscious sedation • denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture • injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery	
Level II - Supplementary Services Includes items such as: • surgical procedures not included in Level I (excluding implant surgery) • periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including: - scaling not covered under Level I, and root planing, up to a combined maximum of 12 units per calendar year(s) ; - provisional splinting; and - occlusal equilibration, up to a maximum of 8 units per calendar year(s) • endodontic services which include root canals and therapy, root amputation, apexifications and periapical services • root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime • re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment	100% to a combined maximum of $1,500 per calendar year
Level III - Dentures Includes items such as:	50% to a combined maximum of $1,500 per calendar year

• initial provision of full or partial removable dentures • replacement of removable dentures, provided the dentures are required because: - a natural tooth is extracted and the existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation • dentures required solely to replace a natural tooth which was missing prior to becoming insured for this eligible expense, are not covered	
Level IV - Major Restorative Services Includes items such as: • crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay • inlays, covering at least 3 surfaces, provided the tooth cusp is missing • initial provision of fixed bridgework • replacement of bridgework, provided the new bridgework is required because: - a natural tooth is extracted and the existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation • bridgework required solely to replace a natural tooth which was missing prior to becoming insured under this Plan is not covered	50% to a combined maximum of $1,500 per calendar year
Level V - Orthodontics Includes items such as: • orthodontic services for dependent children only, provided treatment commences prior to reaching age 19	50% to a maximum of $2,000 per lifetime
Exclusions	

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

- *war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion*
- *the committing of or the attempt to commit an assault or criminal offence*
- *injuries sustained while operating a motor vehicle while under the influence of any intoxicant or if blood contains more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury.*
- *dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit*
- *anti-snoring or sleep apnea devices*
- *broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms*
- *services which are payable under any other part of this policy, by any government plan or legally mandated program*
- *services or supplies provided by an employer, association or trade union's medical or dental department*
- *services or supplies for which no charge would normally be made in the absence of insurance*
- *treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction*
- *replacement of removable dental appliances which have been lost, mislaid or stolen*
- *laboratory fees which exceed reasonable and customary charges*
- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *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, Manulife Financial 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*
- *treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition*
- *services or supplies which are not specified as a covered expense under this benefit*

If you anticipate charges for any treatment to exceed $500, please submit a pre-treatment plan before receiving the service so you can understand what portion your plan may cover.

Your plan will pay benefits for the least expensive course of treatment when there are two or more courses of treatment covered that would produce professionally adequate results for a given condition. Manulife's professional dental consultant will aid in evaluating the various courses of treatment available to determine which is professionally adequate.

If you apply for coverage for Dental insurance late, Late Dental Application insurance will be limited to $125 for each insured person for the first 12 months of coverage.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Extended Health Care Benefit

This benefit has many components that extend your coverage to a wide variety of health care providers and services. Under the broad category there may be coinsurances, deductibles, maximums and limitations that apply to specific components of the coverage.

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 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.

Benefit Details	Your Plan's Coverage
Waiting Period	2 months
Maximum	Unlimited
Deductible	Nil
Co-insurance	80% for Hospital Care, Professional Services, Vision, Medical Services & Supplies, Drugs
Coverage Ends	At your retirement
Personalized Medicine Testing	100% Co-insurance Personalized medicine testing and counseling under Manulife Financial's personalized medicine program provided you have satisfied the medical conditions and criteria established by Manulife Financial. Manulife Financial will use the expertise of an approved vendor to provide the testing and counseling.

Exclusions

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

(not applicable to Health Service Navigator®)

- *war, whether declared or undeclared, insurrection, the hostile actions of any armed forces, willing participation in a riot or civil commotion or any service in the armed forces of any country*
- *your involvement in the commission or attempted commission of an assault, criminal offence or illegal act*
- *injuries sustained while operating a motor vehicle while under the influence of any intoxicant or if blood contains more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury.*
- *an illness or injury for which benefits are payable under any government plan, workers' compensation or legally mandated program*
- *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, association or trade union'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/Territorial 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*

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

EHC - Drugs

80% **Co-insurance**

Benefit Details	Your Plan's Coverage
Prescription Drugs with **Generic Substitution** Includes the following drug classes: • drugs for the treatment of an illness or injury which by law or convention requires the written prescription of a physician or dentist when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist • oral contraceptives • life-sustaining drugs • preventive vaccines and medicines (oral or injected) • injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered) • standard syringes, needles and diagnostic aids, required for the treatment of diabetes No coverage for / excludes: • fertility drugs • sexual dysfunction drugs • drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis • drugs determined to be ineligible as a result of due diligence • cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment used in the treatment of diabetes • charges to administer serums, vaccines & injectable drugs • experimental or investigational drugs not approved as an effective, appropriate and essential treatment of an illness or injury • natural health products (products with a	$300 lifetime maximum on anti-smoking prescription drugs *Payment of Covered Expenses - 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 Financial.* *Manulife Financial 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, the maximum amount covered is 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 Financial.* *If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.* *Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.* *There is a limitation on quantity of drugs that can be dispensed and claimed at one time, to the lesser of:*

NPN)	*a) the quantity prescribed by the Physician or Dentist; or* *b) a 34 day supply; or* *c) up to a 100 day supply may be payable in long term therapy where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.* *If you are a Quebec resident, your plan's coverage will coordinate with **RAMQ**.*
Specialty Drug Care	Specialty Drug Care is a program that helps manage specialty drug costs while providing the additional support of a nurse case manager for individuals taking medications to treat complex chronic or life threatening conditions. *For non-Quebec Employees*: To confirm if the drug you are taking is part of this program, access the List of Drugs Requiring Prior Authorization on our Plan Member Secure Site at manulife.ca/planmember. If you or your dependents are already taking a high cost drug and want to learn more about **Specialty Drug Care,** call the toll-free number **1-844-MSDCARE (1-844-673-2273).** You are welcome to join the program and take advantage of the savings and the additional support of the nurse case manager. *For Quebec Employees*: Specialty Drug Care includes case management services for Specialty Drugs. More information is available by clicking here **Specialty Drug Care.**

EHC - Vision

80% **Co-insurance**

Benefit Details	Your Plan's Coverage
Prescription Glasses, Contact Lenses, Laser Eye Surgery, Eye Exams, Visual Training	$250 per 24 months for prescription glasses, elective contact lenses , repairs and elective laser vision correction procedures If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 during any 24 months Eye Exams - once per 24 months Visual Training - $200 per lifetime

EHC - Health Care Professionals (Professional Services)

80% **Co-insurance**

Benefit Details	Your Plan's Coverage
Services provided by the following licensed practitioners: Chiropractor, Osteopath, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Speech Therapist, Physiotherapist, Psychologist, Acupuncturist, Dietician, Social Worker, Psychoanalyst, Psychotherapist	$750 per calendar year(s) for Psychotherapist $750 combined per calendar year(s) for Chiropractor, Osteopath, Podiatrist/Chiropodist, Massage Therapist, Naturopath, Speech Therapist, Physiotherapist, Psychologist, Acupuncturist, Dietician, Social Worker, and Psychoanalyst *Expenses are covered to the extent that they are Reasonable and Customary, as determined by Manulife Financial.* *Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses prior to reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this benefit program are payable after the Provincial Plan's maximum for the benefit year has been paid.* *Recommendation by a physician for Professional Services is not required.*

EHC - Medical Supplies and Services

80% **Co-insurance** (unless otherwise stated)

For all medical equipment and supplies, coverage is limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Benefit Details	Your Plan's Coverage
Private Duty Nursing Services Provided by a registered nurse or registered nursing assistant who has completed an approved medications training program Excludes: • custodial care, homemaking duties or supervision • services performed by a nurse practitioner who is an immediate family member or who lives with the patient • services performed while confined to a hospital, nursing home or other similar institution • services that could be performed by a person with lesser qualifications, a relative, a friend or a member of the patient's household	$10,000 per calendar year(s) *Submit a detailed treatment plan estimate before Private Duty Nursing services begin so we can advise you of what benefit may be provided.*
Hearing Aids	$700 per 60 month(s) *Includes cost, installation, repair and maintenance of Hearing Aids (including charges for batteries)*
Orthopaedic Shoes/Orthotics	$300 per 12 month(s) for Stock-item Orthopaedic Shoes 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, up to a maximum of 1 pair per calendar year (must be constructed by a certified orthopaedic footwear specialist)

	$400 per 36 month(s) for Custom Made Orthotic Foot Appliances *Must be recommended by a physician or podiatrist.*
Medical Equipment Includes items such as: • ambulance (licensed including air ambulance, provided in province/territory of residence) • mobility equipment (crutches, canes, walkers, wheelchairs) • manual hospital beds • respiratory and oxygen equipment • other equipment usually found only in hospitals • non-dental external prostheses • braces (other than foot braces), trusses, collars, leg orthosis, casts and splints • ileostomy, colostomy and incontinence supplies • medicated dressings and burn garments • oxygen • charges for the treatment required as a result of an injury to natural teeth or jaw • surgical brassieres • wigs and hairpieces for temporary hair loss associated with medical treatment • breast prostheses • viscosupplementation	4 per calendar year for surgical brassieres $200 per lifetime for wigs and hairpieces 2 per calendar year for breast prosthesis *Medical equipment dispensed by a hospital is not an eligible expense.* *In the province of Quebec, microscopic and other similar diagnostic tests and services rendered in a licensed laboratory, up to a maximum of $1,000 per calendar year.* *Accidental dental treatment to the natural teeth or jaw must be provided within 12 months of the accident. Injuries sustained while biting or chewing are not covered.*
Surgical Stockings	$400 per calendar year

EHC - Hospital	
80% **Co-insurance**	
Benefit Details	Your Plan's Coverage
General or Rehabilitation hospitals	• in a Semi-Private Room • in excess of the hospital's public ward charge Rehabilitation Hospital (Chronic Care Facility): 180 days per disability provided admission starts within 14 days of discharge from a hospital confinement of at least 5 days.
	Charges for any portion of the cost of ward accommodation, utilization or copayment fees (or similar charges) will not be covered. *Manulife Financial will coordinate payment after any provincial/territorial plan coverage has first been applied.*

EHC - Medical and Non-Medical Travel Emergencies

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 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 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 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.

Reasonable and Customary Charges
Charges incurred for goods and services that are comparable to what other providers charge for similar drugs, services and supplies in the same geographical area. The lowest of:
a) prevailing amount charged in the absence of coverage 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, not including regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition, and
c) the Medical Condition has not become worse, and
d) there has 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.

Benefit Details	Your Plan's Coverage
Emergency medical coverage Conditions: • Coverage is for immediate medical Treatment required for: - a sudden, unforeseen injury or a new Medical Condition which occurs while an insured person is travelling outside of their province of residence/territory; or - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure. • Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependents.	100% with a lifetime maximum of $5,000,000 Coverage is limited to 180 days per trip.
Non-Emergency medical coverage Conditions: • recommendation by a practicing Physician in Canada is required	50% with a maximum of $3,000 every 3 calendar year(s)

• suggests that you submit a detailed Treatment plan with cost estimates before Treatment begins. You will then be advised of any benefit that will be provided.	
Emergency Travel Assistance Including: • 24 hour access to multi-lingual service representatives • referral to local medical care and Treatment monitoring • payment of medical bills, medical transportation, return home of dependent children, visit by a family member, trip interruption/delay coverage, support through convalescence after hospital discharge, identification and/or return of a deceased traveller, meals and accommodation, vehicle return, pre-trip advice on passport, visa, vaccination and inoculation requirements for a destination, assistance in replacing lost documents and tickets, referral to legal assistance in your foreign destination, telephone interpretation service, emergency message service, and • after-hours medical advice phone support	100% with all maximums below stated in Canadian Funds. $1,000 for return of vehicle $2,000 for meals and accommodations $5,000 for return of deceased *See **Emergency Travel Assistance** for additional information, a list of phone numbers for frequent Canadian travel destinations and for participating countries.*

Exclusions

No Emergency Medical and Emergency Travel Assistance 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, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness;

c) further related medical Treatment if the Administrator 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 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 changes 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 directly or indirectly-related complication;

h) any Medical Condition or symptoms for which it is reasonable to believe or expect that Treatments 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 the Administrator 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 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 covered 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 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.

Health Service Navigator®

Whether you or a family member have been diagnosed with a critical or chronic health condition, or you are simply curious about the services available in your area, Health Service Navigator® points you to agencies or resources that may be able to provide the information you need, including:

- tips and tools you can use to navigate through the Canadian health care landscape
- a national physician search database
- provincial/territorial health plan information
- health, medical condition, treatment plan options and medication information you can trust, and
- a second medical opinion service for times when you may want to double check a serious medical diagnosis you, your spouse or your child has received

With the exception of the second opinion service (which is available by phone only), Health Service Navigator tools are all available for you or your spouse or children any time on the Plan Member Secure Site.

Survivor Benefit

Benefit Details	Your Plan's Coverage
If you die while your dependents are insured under the program, Manulife Financial will continue coverage for some benefits without payment of premium: • Extended Health Care	Coverage will continue until the earliest of: • the date your dependent is no longer a dependent • the date similar coverage is obtained elsewhere • the date which is 24 months from your death or • the date the Group Policy terminates

Individual plan options available to purchase if you are leaving the plan

When your group coverage ends, your relationship with Manulife doesn't have to stop there. You have the option to purchase your own personal plans.

FollowMe™ Health

The FollowMe Health plan is specially designed for those whose group health coverage has recently or will soon come to an end. FollowMe Health allows you to continue enjoying health and dental benefits without completion of a medical questionnaire, so there's no need to worry about interruption of coverage for you or your loved ones.

If you apply within 60 days of your loss of group health and dental benefits, you will qualify without having to complete a medical questionnaire.

With four different plans and levels of coverage to choose from, you're certain to find the FollowMe Health plan that meets your needs.

To find out more, request a brochure, get a quote, apply online or print an application, go to ***www.coverme.com*** *or call 1-877-COVER ME® (1-877-268-3763)*

Definitions

Explanation of some of the terms used in this document

Co-insurance

The way the cost of a service is shared between you and your plan. It exists in addition to any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your plan will cover up to 80% of the bill and you would pay the rest.

Co-payment

The fixed amount that you must pay towards the cost of a service each time you use your plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, you might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, you are required to pay $2.00.

Dependent

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

Spouse

- your legal spouse, or a person continuously living with you in a role like that of a marriage partner

Child

- your natural or adopted child, or stepchild, who is:
    - unmarried
    - under the age stated below:
      for Dental coverage - under age 21, or under age 26 if a full-time student;
      for Extended Health Care coverage - under age 21, or under age 26 if a full-time student
    - not employed on a full-time basis
    - not eligible for insurance as an employee under this or any other Group Benefit Program

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

- a child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical disability. Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary

- a stepchild must be living with you to be eligible

Drugs

- must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province/territory permits them to write a prescription;
- must be dispensed by a licensed pharmacist;
- must have been approved for use by Health Canada and have a drug identification number(DIN).

RAMQ - 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:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and
- 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 under your drug plan but are not on the RAMQ List.

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 your benefit plan.

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

i) For any drug on the RAMQ List which is not otherwise covered under the terms of this benefit, the percentage payable is the percentage stated under the Benefit.

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

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

- the benefit percentage stated under the benefit; 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 an insured 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.

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 pharmacy service coverage provided after the lifetime maximum stated under this plan is reached is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered, and
ii) covered pharmacy services that are performed for drugs on the RAMQ List, and
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by 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 or
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:

- only drugs that are on the RAMQ List are covered, and
- covered pharmacy services performed for a drug on the RAMQ List, and
- the percentage payable by Manulife Financial for covered expenses is the percentage as set out by 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,
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the legislation
iv) the Annual Out-of-Pocket Maximum is as stipulated in the legislation

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.

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 plan. 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

Earnings are your regular rate of pay from your employer (prior to deductions)

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

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

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

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 fulfill 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.

Interchangeable Drug

Includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province/territory where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

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.

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province/territory or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

Accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of a phase 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 eligible under the Plan.

Non-Evidence Limit

The amount of insurance benefits you can receive without needing to provide proof of good health. Anything over this figure means that Manulife must review medical evidence before you are approved for the higher amount.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Personalized Medicine Test

a pharmacogenomic test that provides information on a person's response to medication.

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.

Pyogenic Infection

A bacterial infection or inflammation that produces a generally viscous, yellowish-white fluid formed in infected tissue. The fluid consists of white blood cells, dead tissue and cellular debris.

Reasonable and Customary Charges

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; or
- the amount shown in the applicable professional association fee guide; or
- the maximum price established by law

Single-Parent Coverage

You and one or more dependent children

NOTE

The spouses of the employees who have elected a Single-Parent coverage are not covered for Extended Health Care and Dental Care Benefits.