BENEFIT	PROVIDER	POLICY NUMBER
Prescription Drug	Managed Health Care Services Inc. (Blue Cross)	91146
Extended Health Care	Manulife Financial	83059
Dental	Manulife Financial	83059
Travel Insurance	AIG Insurance Company of Canada (AIG Insurance)	SRG 902 66 62

www.saintjohn.ca

SAINT JOHN

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DISCLAIMER

The information in this booklet is a summary of the provisions of the Group Policy. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create nor confer any contractual rights or obligations. All rights and obligations of the City of Saint John, MHCSI, Manulife Financial and AIG are governed by the paper version of the Group Policy (available from your Employer). In the event of a discrepancy between this booklet (paper or electronic version) and the Group Policy, the terms of the Group Policy will apply. No alteration of this booklet is permitted by any person, except by an authorized representative of Manulife Financial, MHCSI or AIG Insurance.Possession of this booklet alone does not mean that you or your dependent(s) are insured. The Group Policy must be in effect and you must satisfy all the requirements of the Policy.

We suggest you read this benefit booklet carefully and then file it in a safe place with your other important documents.

WHO QUALIFIES FOR COVERAGE?

All Permanent, and Full-time Employees residing in Canada who are eligible for entry into the City of Saint John Shared Risk Plan are eligible to participate in this Plan. Holiday Relief Fire Fighters and Retired employees of the City of Saint John are also eligible to participate in this Plan. If you have dependents residing in Canada, you may insure them for Extended Health Care, Dental Care and Emergency Out-of-Province Medical benefits.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. Please note dependents are not automatically added to your coverage and you will need to enroll them in the Plan by contacting Human Resources.

DEFINITIONS

Dependent:

An Employee's Spouse or Child who is covered under the Plan as defined below.

Spouse:

The Employee's 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.

Only one Spouse will be eligible for benefits under this Plan, and will be as indicated by the Employee on his/her application for benefits under this Plan.

Child(ren):

An Employee's natural or adopted child, or stepchild, who:

a) Is unmarried;

b) Is either under 20 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age;

c) Is not employed on a full-time basis; and

d) Is not eligible for coverage as an employee under this or any other Group Benefit Program.

A stepchild must be dependent upon the Employee for support to be an eligible Dependent.

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

Disabled Dependent

A child who is disabled on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to the date they became disabled.

A child is considered disabled 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, acting on behalf of your employer, may require written proof of the child's condition as often as may reasonably be necessary.

EFFECTIVE DATE OF COVERAGE

For active employees:

You and your dependents will become eligible for coverage under this Plan once you commence employment for full-time and full pay. Additionally, at your option, coverage for you and your dependents may continue under this Plan upon your retirement. Please refer to your relevant collective agreement or terms and conditions of employment.

If one of your dependents is hospitalized (other than a newborn infant) on the date of coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Additional dependents will be covered from the date eligible, regardless of hospital confinement.

If you have initially selected Single coverage because you do not have any eligible dependents, and later you acquire a dependent, your dependent will be enrolled in the Plan. You should contact Human Resources, as soon as possible of the change in status.

For Retired Employees:

Coverage may be maintained upon retirement. Coverage becomes effective on the date you retire, provided you have submitted your application. If you elect to remain in the Plan, Extended Health, Dental and Prescription Drug coverage must be maintained.

Employees that elect a single plan at the time of retirement are not eligible to switch to a family plan during retirement under any circumstance.

Employees can opt out of the plan completely at the time of retirement, but once this option has been exercised employees are not eligible to re-enroll in the Plan.

Employees can opt out of the Emergency Out-of-Province Medical component of the Extended Health Care plan, but only at the time of retirement. However, once the Emergency Out-of-Province Medical coverage has been cancelled, you will not be eligible to receive Emergency Out-of-Province Medical benefits again.

TERMINATION OF COVERAGE

Coverage for you and your dependents will cease on the earliest of the following events:

1. Termination of your employment
2. Your death, unless your spouse continues coverage, provided that 100% of the cost of coverage is paid
3. You enter into the armed forces of any country on a full-time basis
4. Termination of the Policy or coverage on the Group, Division, or Class to which you belong
5. On the date you no longer contribute towards the cost of your benefits, where applicable
6. Age 76 with respect to the Emergency Out-of-Province Travel benefit

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

With respect to Dental Care, no expenses are payable for expenses incurred after the date your coverage terminates except under the following circumstances:

1. Where an impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date your coverage terminated and the denture is installed after the coverage terminates. Dental expenses in connection with this procedure, and incurred within 30 days after the termination of coverage, are eligible.

2. If your coverage terminates due to your death, dental expenses incurred on behalf of your dependents will be eligible for payment provided:
   a. The services are rendered within 90 days following your death; and
   b. The services are part of planned dental services started prior to your death or rendered at definite dental appointments made prior to your death.

CONTINUATION OF COVERAGE

If you cease to be actively employed on a full-time basis, unless it is due to retirement, your coverage will normally and automatically terminate as specified under the "Termination of Coverage" section in this booklet. However, coverage may continue under the circumstances specified below:

If you cease to be actively employed due to:

a) Sickness or injury

b) Maternity Leave, you may be covered for the duration of the leave provide you continue to pay your portion of the premiums
   • notify Human Resources well in advance of your leave to arrange a payment schedule

If the above provisions permit less than the minimum required by the governing legislation, the terms of this policy will be extended to agree with the minimum requirements of such law.

EXTENSION OF BENEFITS

If you are totally disabled and receiving a disability pension when your Extended Health Care, Prescription Drugs, Dental Care and Emergency-Out-of-Province Travel benefits terminate, benefits will be payable, as long as you remain disabled, up to a maximum period of 365 days after the termination of your benefits.

Payment will be made for pregnancy related eligible expenses if you or your dependant is pregnant on the date coverage would normally cease, as long as the group coverage is in force.

Extension of Extended Health Care, Prescription Drugs, Dental Care and Emergency-Out-of-Province Travel benefits will cease if the Policy should terminate.

COORDINATION OF 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 Coordination of Benefits. It allows for reimbursement of covered Prescription Drug, Extended Health Care, Dental Care and Emergency Out-of-Province Medical expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- Other Group Benefit Programs
- Any other arrangement of coverage for individuals in a group
- 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" (e.g. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (e.g. responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Coordination 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 has coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:
  - ~ The Plan where the person is covered as an active full-time employee, then
  - ~ The Plan where the person is covered as an active part-time employee, then
  - ~ The Plan where the person is covered as a retiree.

- For Claims incurred by your Dependent Child:
  The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
  However, if you and your Spouse are separated or divorced, the following order applies:
  - ~ The Plan of the parent with custody of the child, then
  - ~ The Plan of the spouse of the parent with custody of the child (e.g., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then

~ The Plan of the parent not having custody of the child, then

~ The Plan of the spouse of the parent not having custody of the child (e.g., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Care 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 Coordination of Benefits did not exist.
- If the person is also covered under an individual travel insurance plan, benefits will be coordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

PRESCRIPTION DRUG COVERAGE

MEDAVIE BLUE CROSS MANAGD HEALTH CARE SERVICES INC. (MHSCI)

Policy Number 91146

Certificate number is your 4 digit employee number

PRESCRIPTION DRUGS

Pay direct drug card:	Blue Cross card can be given at any preferred pharmacy location for pay direct.
Co-pay per prescription:	20% per prescription ($5.00 minimum co-pay) to a maximum of $400.00 per family per year; then $5.00 per prescription for the remainder of the year.

HOW TO SUBMIT A CLAIM

For prescriptions filled at a Preferred Provider Pharmacy i.e. Sobey's or Lawton's Drug Stores, you will be provided with a pay direct drug card (Blue Cross) which can be used to pay for eligible drugs for yourself and your eligible dependents. Present your drug card to the pharmacy and you pay your 20% deductible for each prescription purchased at the pharmacy MHCSI takes care of the settlement of the reminder of your claim.

If a prescription is filled at a non-participating pharmacy, you are initially required to pay the full cost. In addition, manual claims will only be paid at the MHCSI/Blue Cross preferred pharmacy rate. Any difference in drug cost will be borne by you.

Electronic Claim Submission

Blue Cross has an online claims portal which can be accessed at www.medavie.bluecross.ca. Initial registration is required. You will have access to direct deposit and online claim history through the online portal.

By Mail | In Person

Claim forms are available at the City of Saint John's Human Resources Department or the Saint John Police Commission Human Resources Department. Plan members can also access local Blue Cross Offices for reimbursement for claims filled at a pharmacy other than a preferred provider (i.e. Sobey's / Lawton's).

Blue Cross
P.O. Box 220
644 Main Street
Moncton, NB E1C 8L3
Toll free: 1-888-873-9200

COVERAGE DETAILS

This Plan covers the cost of the following medications/products:

- Medications which customarily or by law require a prescription from a licensed prescriber where their usefulness/cost effectiveness in therapy has been established based on clinical indication and/or evidence, and where their use is deemed medically necessary. The Plan is not responsible for deeming which drug is available by prescription or over the counter. This determination is done by a formulary committee of MHCSI who meets quarterly to review new and/or recently approved prescriptions. Formulary listings are subject to change as products enter the market, are removed or withdrawn from the market, and as assessed on an on-going basis. You may contact Blue Cross to confirm coverage status of a specific drug at 1-888-873-9200 (toll free).
- Eligible supplies for diabetes: Insulin and prescription antidiabetic agents, syringes, needles, insulin pump infusion sets and supplies, diagnostic test strips and lancets
- Aids in asthma therapy: Aerochambers and peak flow meters for dependent children
- Compounded products, defined as a mixture which does not duplicate the formulation of a commercially manufactured product and contains at least one ingredient which is an eligible benefit
- Vaccines and allergy serums as prescribed by a licensed prescriber

- Medications covered subsequent to the submission and approval of Prior Authorization request include prescription agents used in the management of:
  - ~ Erectile dysfunction (to a maximum of $1,000 per 12 month period)
  - ~ Smoking cessation (lifetime per individual maximum of $350)
  - ~ Dementia/Alzheimers (such as Aricept®, Exelon®, Reminyl®, Ebixa® etc)
  - ~ Obesity (such as Xenical®, Meridia®, etc.)
- Ostomy Supplies
- This Plan will cover costs at the rate of the generic equivalent, where available, and unless pursuant to a "Prescriber No Substitution" order expressed by the prescriber either verbally or in writing at the time of the prescription. *Please note that the Government of Canada makes decisions on whether a product requires a prescription or not based on the recommendations from a Health Canada Committee of experts.*

  Ex: Medication XYZ was a prescribed drug which is now available over the counter and therefore not reimbursable under the Plan.
- Days' supplies are administered at 90 for maintenance medications (defined as a stable dose of a regularly required medication), unless a lesser days' supply is warranted for valid clinical or patient care reasons. Otherwise, day's supplies are adjudicated as is customary for the chemical in question up to a maximum benefit of a 90 days' supply per fill.

EXCLUSIONS

This Plan excludes the cost of the following medications/products:

- Any medication/product which may be purchased without a prescription
- Specialty medications, including but not limited to the following conditions: infertility and cosmetic indications such as hair loss
- Vaccines which persons are eligible to receive through provincial/public funded health programs
- Devices for diabetes which are covered under your Extended Health Carrier – Manulife Financial
- Medications dispensed by a physician or dentist in office, unless otherwise directed

- Any benefit which a person is eligible to receive under any provincially funded drug benefit plan
- Charges for the administration of drugs, serums and vaccines and the completion of forms
- Experimental drugs

EXTENDED HEALTH CARE

MANULIFE FINANCIAL

Policy Number 83059

HOW TO SUBMIT A CLAIM

Electronic Claim Submission

Manulife Financial's plan member website: www.manulife.ca/groupbenefits

The online site allows you to electronically submit your claim, check status of claims or view history, and sign up to get claims directly deposited.

Direct payment is also available to those registered on the online site. Manulife Financial has arranged direct payment with various practitioners in the Saint John area. Examples of practitioners include Optometrists, Physiotherapists, Chiropractors, etc. that are approved services under your Benefits Program.

If your practitioner is participating in the direct payment arrangement, you will be responsible for paying the co-pay and Manulife Financial will be direct billed. Manulife Financial will accept direct payment from any practitioner as long as they submit the claim on a City of Saint John claim form. Manulife Financial is not restricting access to the "approved list" and the list of participating practitioners is continuously being updated by Manulife Financial.

If your practitioner is not participating in the direct payment arrangements, you will submit your claim as per the normal claims procedures outlined below.

Mail

When submitting Extended Health Care claims to Manulife Financial, a completed claim form plus a paid-in-full receipt is required.

Claim forms are available at the City of Saint John's Human Resources Department or the Saint John Police Commission Human Resources Department or online at www.manulife.ca/groupbenefits.

All Extended Health Care and Dental Care claims can be submitted directly to Manulife Financial at the following address:

Manulife Financial Group Health & Dental Claims
P.O. Box 1030
Halifax Nova Scotia, B3J 2X5.
You may also contact Manulife Financial at 1-800-268-6195 (toll-free) with any questions you may have.

COVERAGE DETAILS

The following eligible expenses are payable at 80% up to the specified maximums:

Hospital Coverage:	No additional coverage through the Plan above what is provided through Medicare i.e. ward coverage
Vision Care:	• $40 (maximum $32 reimbursed) per 12 consecutive Eye Exams months for persons under age 18 and • up to $40 per 24 consecutive months for persons age 18 and over
Glasses, Lenses, Contact Lenses or Laser Surgery	• $200 (maximum $160 reimbursed) per 12 consecutive months for persons under age 18 and • $200 (maximum $160 reimbursed) per 24 consecutive months for persons age 18 and over
Cataract Eye Surgery	Maximum of $200 per eye per lifetime

Professional services provided by the following licensed practitioners: (Recommendation by a physician for Professional Services is not required)

Chiropractor	$350 per calendar year
Osteopath	$350 per calendar year
Podiatrist / Chiropodist	$350 per calendar year
Naturopath	$350 per calendar year **Services must be provided by Naturopathic Doctor (ND)*
Speech Therapist	$350 per calendar year
Psychologist	$350 per calendar year
Physiotherpist Athletic Therapist Sports Therapist	Maximum of 20 visits per calendar year combined for all practitioners
Private Duty Nursing	Services of an RN, CAN, RNA, and VON for medically necessary nursing care subject to a maximum payable of $5,000 in any period of 12 consecutive months

Orthopedic Shoes	$150 payable per 12 consecutive months for stock orthopedic shoes. Includes purchase, repairs and adjustments (doctor's referral and diagnosis is required)
Casted, Custom Made Arch Supports	$150 payable every 24 consecutive months (doctor's referral and diagnosis is required)
Ambulance	• Unlimited • 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 evacuation for admission to hospital in the province where the patient normally resides including ground transportation to and from the hospital and airport at the point of departure and arrival is also eligible • If medically necessary, travel expenses for an ambulance attendant who is an RN up to a maximum payable of $600 in any 12 consecutive months
Insulin Pumps	Up to $5,000 payable every 5 years
Glucometers	Up to $300 payable every 3 years
Preci-jets	Up to $700 payable every 5 years
CPAP Machines and Supplies	Up to $1,800 payable per lifetime (requires doctor's referral and an oximetry test)
TENS Machines	Up to $700 payable per lifetime
Hearing Aids	$500 payable / person / 5 consecutive years ~ Includes repairs ~ Excludes batteries

Medical Equipment *(Lawtons Home Health Care is the preferred Medical Equipment supplier)*	Rental or, when approved by Manulife Financial, purchase of: ~ Mobility Equipment: cutches, canes, walkers, and wheelchairs (wheelchairs eligible every 5 years) ~ Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals
Non-Dental Prostheses and Supports	• External prostheses, eligible once every 3 years for limb, eye and breast prostheses • Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints eligible once every 3 years • Repairs or adjustments to limb, breast and eye prostheses, splints, casts, trusses, crutches and braces, limited to a maximum of $100 in any 12 consecutive months
Accidental Dental	• Unlimited • Treatment must be rendered within 180 days of accident • Charges for the treatment of accidental injuries to natural teeth or jaw • Excluding injuries due to biting or chewing
Other Supplies and Services	• Aerochambers (limited to dependent children only) • Allergy testing by a physician • Medicated dressings and burn garments • Oxygen • Incontinence supplies (requires doctor's referral)

Referrals out of Canada	• Charges for hospital and physician coverage as a result of a referral out of Canada for medical treatment which is not available in Canada • Referrals must be made by a physician practicing in Canada and covered expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan • Pre-approval is required for any coverage outside of Canada
Non-Emergency Out-of-province	Charges incurred while outside the province of residence are payable under the appropriate Covered Expense on the same basis as if they were incurred in the province of residence. *Charges for the following non-emergency expenses are payable under this expense. These expenses must be pre-approved by Manulife:* • Hospital room and board at standard ward rates. Charges in excess of ward rates are not payable • Medical transportation services • Medical supplies and services • Dental treatment • Professional services (other than physician's services) • Hearing aids • Vision care • Referral treatment • Pre- approval is required for any out-of-province coverage

Medical Services and Supplies

Lawtons Home Health Care is the preferred Medical Equipment supplier. 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.

Medical Equipment

Purchase of medical equipment must be approved by Manulife Financial. Application can be made using the extended health claim form, along with a letter from your attending physician.

~ Mobility Equipment: crutches, canes, walkers

~ Wheelchairs (eligible every 5 years)

~ Durable Medical Equipment:

- manual hospital beds
- respiratory and oxygen equipment
- other durable equipment usually found only in hospitals

Private Duty Nursing

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

- A registered nurse, or
- A registered nursing assistant (or equivalent designation) that has completed an approved medications training program

Covered Expenses are subject to a maximum of $5,000 per 12 consecutive months.

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

Non-Dental Prostheses, Supports and Hearing Aids

- External prostheses, limited to 3 years for limb, eye and breast prostheses
- Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- Repairs or adjustments to limb, breast and eye prostheses, splints, casts, trusses, crutches and braces, limited to a maximum of $100 in any 12 consecutive months check dollar amount
- Charges for the following, when recommended by a Physician:
  - ~ Stock-item orthopedic shoes; modifications or adjustments to stock-item
  - ~ orthopedic shoes or regular footwear; and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopedic shoe or a modified stock-item orthopedic shoe (must be constructed by a certified orthopedic footwear specialist), up to a maximum of $150 per 12 consecutive months
  - ~ Casted, custom-made orthotics, up to a maximum of $150 per 24 consecutive months
- Cost, installation, repair and maintenance of hearing aids, (excluding charges for batteries) to a maximum of $500 per person per 5 consecutive years
- Charges for hospital and physician coverage as a result of a referral Out-of-Canada for medical treatment which is not available in Canada. Referrals must be made by a physician practicing in Canada and covered expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan.

Non-Emergency Out-of-Province/Out-of-Canada

Charges for the following non-emergency expenses are payable under this expense:

- Hospital room and board at standard ward rates. Charges in excess of ward rates are not payable
- Medical transportation services
- Medical supplies and services
- Dental treatment
- Professional services (other than physician's services)
- Hearing aids
- Vision care
- Referral treatment

Charges incurred while outside the province of residence are payable under the appropriate Covered Expense on the same basis as if they were incurred in the province of residence.

Pre-approval is required for any referrals out-of-province or Canada.

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, acting on behalf of your employer, may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgment of your legal action, you will be required to reimburse Manulife Financial, acting on behalf of your employer, those amounts you recover which, when added to the payments you received from Manulife Financial, acting on behalf of your employer, exceed 100% of your incurred expenses.

EXCLUSIONS

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

- Self-inflicted injuries
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- Committing or attempting to commit an assault or criminal offence
- An illness or injury for which benefits are payable under any government plan or workers' compensation
- Charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- Services or supplies provided by an employer's medical or dental department
- Services or supplies for which no charge would normally be made in the absence of group benefit coverage
- Services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- Services or supplies which are not permitted by law to be paid
- Services or supplies which are required for recreation or sports
- Services or supplies which would have been payable by the Provincial Plan if proper application had been made
- Medical treatment which is not usual or customary, or is experimental or investigational in nature
- Medical or surgical care which is cosmetic
- Services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- Services or supplies which are provided while confined in a hospital on an in-patient basis
- Services or supplies which are not specified as a covered expense under this benefit

DENTAL

MANULIFE FINANCIAL

Policy Number G0083059

Basic Services (Includes routine check- ups, fillings, teeth polishing/ cleaning and root canal therapy)	• 100% of all eligible expenses	Maximum payable of $1,000 per calendar year per individual for Basic and Major Services combined
Major Services (Includes dentures, crowns, bridges)	• 70% of all eligible expenses	
Orthodontic Services	• 50% of all eligible expenses	Maximum payable of $2,000 per lifetime per individual
Fee Guide	Eligible expenses paid based on the Current Fee Guide for General Practitioners and Specialists for your Province of Residence	

HOW TO SUBMIT A CLAIM

With respect to Dental Care claims, provide your policy number to your dentist and ask if Manulife Financial can be billed directly. If your dentist does not bill Manulife Financial directly, you must pay the dentist, obtain an official receipt, as well as a completed Dental Claim form and submit them to Manulife Financial at the address on page 23.

Electronic Claims Submission

Manulife Financial's plan member website: www.manulife.ca/groupbenefits

The online site allows you to electronically submit your claim, check status of claims or view history, and sign up to get claims directly deposited.

Direct payment is also available to those registered on the online site.

Mail

Claim forms are available at the City of Saint John's Human Resources Department or the Saint John Police Commission Human Resources Department. You can also find the manual claim form online at www.manulife.ca/groupbenefits.

All Extended Health Care and Dental Care claims can be submitted directly to Manulife Financial at the following address:

Manulife Financial Group Health & Dental Claims
P.O. Box 1030
Halifax
Nova Scotia, B3J 2X5

You may also contact Manulife Financial at 1-800-268-6195 (toll-free) with any questions you may have.

COVERAGE DETAILS

The following expenses are covered if they:

- Are incurred for the necessary dental care of a covered person while covered under this benefit.
- Are incurred for services provided by a dentist, a dental hygienist working under the supervision of a dentist, or a denturist working within the scope of his or her license.
- Are reasonable as determined by your Employer or Manulife Financial, taking all factors into account.
- Do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your Employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide.

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, Manulife Financial, acting on behalf of your Employer, will pay benefits as if the least expensive course of treatment were used. Manulife Financial will determine the adequacy of the various courses of treatment available through a professional dental consultant.

Pre-determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Level I - Basic Services

(100% Reimbursement. Maximum payable of $1,000 per calendar year per individual for Basic and Major Services combined)

- Complete oral exam, one per 2 calendar years
- Full-mouth x-rays, one per 24 month period
- Panoramic x-rays, one per 24 month period
- Light scaling and one unit of polishing once every 6 months,
- Recall exams, bitewing x-rays, and fluoride treatments, once every 6 months
- Routine diagnostic and laboratory procedures
- Oral hygiene instruction
- Fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - ~ The existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - ~ The existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- Pre-fabricated full coverage restorations (metal and plastic)
- Space maintainers (appliances placed for orthodontic purposes are not covered), including maintenance and repairs
- Protective appliances, one per 12 months
- Minor surgical procedures and post-surgical care
- Extractions (including impacted and residual roots)
- Consultations, anesthesia, and conscious sedation
- Denture repairs, relines and rebases
- Injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

- Nutritional counseling
- Interproximal disking of teeth
- Habit-breaking appliances

Level II - Supplementary Basic Services

(100% Reimbursement. Maximum payable of $1,000 per calendar year per individual for Basic and Major Services combined)

- Surgical procedures not included in Level I (excluding implant surgery)
- Periodontal services for treatment of diseases of the gums and other supporting issue of the teeth, including:
  - ~ Scaling not covered under Level I, and root planning
  - ~ Provisional splinting
  - ~ Occlusal equilibration
- Periodontal appliances (limited to any one maxillary and any one mandibular appliance in a 24 month period)
- Maintenance, adjustments, repairs and relines of appliances
- Myofacial pain syndrome appliances (limited to any one maxillary and any one mandibular appliance in a 24 month period)
- 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

Level III - Dentures

(70% Reimbursement. Maximum payable of $1,000 per calendar year per individual for Basic and Major Services combined)

- 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 3 years old and cannot be made serviceable, or
  - ~ the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

Level IV - Major Restorative Services

(70% Reimbursement. Maximum payable of $1,000 per calendar year per individual for Basic and Major Services combined)

- 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 3 years old and cannot be made serviceable, or
  - ~ the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation.

Level V – Orthodontics

(50% Reimbursement. Maximum payable of $2,000 per lifetime per individual)

- Orthodontic services.

SUBROGATION (THIRD PARTY LIABILITY)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, Manulife Financial, acting on behalf of your employer, may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgment of your legal action, you will be required to reimburse Manulife Financial, acting on behalf of your employer, those amounts you recover which, when added to the payments you received from Manulife Financial, acting on behalf of your employer, exceed 100% of your incurred expenses.

EXCLUSIONS

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

- Self-inflicted injuries
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- Committing or attempting to commit an assault or criminal offence
- Dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- Anti-snoring or sleep apnea devices
- Broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- Services which are payable by any government plan
- Services or supplies provided by an employer's medical or dental department not applicable
- Services or supplies for which no charge would normally be made in the absence of group benefit coverage
- Treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- Replacement of removable dental appliances which have been lost, mislaid or stolen
- Laboratory fees which exceed reasonable and customary charges

- Services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- Implants, or any services rendered in conjunction with implants
- 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

EMERGENCY OUT-OF-PROVINCE MEDICAL

AIG INSURANCE

Policy Number SRG 902 66 62

This Plan provides extensive coverage for many services rendered outside the province you reside. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature. The Plan does not provide benefits for medical treatment if the purpose of your trip outside Province is to obtain that medical treatment.

AIG Insurance must be notified within 48 hours from the time of incident. If AIG Insurance is not notified within 48 hours from the time of incident, this could result in limitation of the claims payment. In the event of medical emergency, simply call one of the worldwide telephone numbers listed below:

U.S. and Canada: 1-877-204-2017 (toll free).
Elsewhere in the world: +1 715 295-9967 (collect)

You and your eligible dependents are covered if you belong to the following Classes:

Class	Description	Maximum Trip Duration	Overall Maximum Lifetime Expenses	Pre-existing Conditions
I	All active employees	180 days	100% of eligible expenses subject to a lifetime maximum of $1,000,000 per person	Not Applicable
II	All retirees under age 70	180 days	100% of eligible expenses subject to a lifetime maximum of $1,000,000 per person	Any medical condition which exists will be covered provided it is stabilized prior to travel and medical attention is not anticipated during the travel period
III	All retirees between age 70 and 75	45 days	100% of eligible expenses subject to a lifetime maximum of $250,000 per person	If Medical attention is received within the 6 months period prior to departure, you will not be covered for expenses relating to this condition

Termination Age: Age 75 for Retirees.

DEFINITIONS

"Pre-existing Conditions" means any medical condition for which the insured has received medical advice, treatment or for which he or she was aware of, during the 6 months immediately prior to the departure date.

"Injury" means bodily injury caused by an accident occurring anywhere in the world outside your province of residence while this policy is in force.

"Sickness" means sickness or disease which results in a claim while you are outside your province of residence.

HOW TO SUBMIT A CLAIM

With respect to the Emergency Travel Assistance benefit available under the Emergency Out-of-Province Medical benefit, AIG Insurance must be notified within 48 hours from the time of incident. If AIG Insurance is not notified within 48 hours from the time of incident, this could result in limitation of the claims payment.

In the event of medical emergency, simply call one of the worldwide telephone numbers listed below:

U.S. and Canada: 1-877-204-2017 (toll free)
Elsewhere in the World: +1 715 295-9967(collect)
General inquiries (non-emergency): 1-877-317-8060
Email: assistance@aig.com

Receipts submitted by mail should be sent to:
2000 Avenue McGill College
Bureau 1200
Montreal, QuebecH3A 3H3

COVERAGE DETAILS

Hospital Accommodation

In-patient hospital charges for the following:

1. The difference between the room and board benefit payable by the provincial health plan and the actual cost of ward accommodation
2. Medically necessary hospital services and supplies furnished during hospital confinement.
3. Hospital charges for medical and surgical treatment incurred by a person on out-of-patient basis.

Physicians and Surgeons
Customary charges of physicians and surgeons for services rendered, less the amount allowed under the provincial government health plan.

Medical Appliances
The cost of casts, crutches, canes, slings, splints, trusses, braces and/or temporary rental of a wheelchair when required as a result of sickness or accident. This benefit will be payable only when the sickness or accident occurs outside your province of residence and when ordered by a physician.

Nurse
Private duty nursing, including a Registered Nurse, Registered Nursing Assistant or Certified Nursing Assistant, when ordered by a physician at the usual and customary fee. Nurses providing the service must not be a relative or an employee of the hospital.

Ambulance
Normal charges for licensed ambulance service, including air ambulance and evacuation, to and from the nearest qualified medical facility.

Coming Home
Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that you must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, this coverage is included:

1. Two economy seats by most direct route to your home city in Canada, one for you and one round trip fare for a medical attendant
2. The number of economy seats required to accommodate if on a stretcher and one round trip for a medical attendant

Diagnostic Services
The cost of diagnostic laboratory and x-ray services, less the amount allowed under the provincial government health plan, when ordered by the attending physician.

Paramedical Services

The cost of services made by chiropractors, osteopaths, chiropodist/podiatrists and physiotherapists (not a relative), in excess of payment by a provincial government health plan, excluding charges for x-rays.

Prescriptions

Charges for prescription drugs in a quantity sufficient for the period of travel. Payment of eligible drugs will be made only when proof of purchase is supplied in the form of an account from a pharmacist, physician, or hospital located outside your province of residence and showing the name of the preparation, date of purchase, quantity, strength and total cost.

Dental Services

Charges for dental treatment to a maximum amount of $1,000 Canadian per accident when, as the result of accidental injury (direct accidental blow to the mouth), natural teeth have been damaged, or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by the Company within 180 days of the accident and be supported by proper certification.

Vehicle Return

An allowance of up to $500 Canadian for the cost of driving your vehicle, either private or rental, by commercial agency to your residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

Return of Deceased

Up to $3,000 Canadian towards the cost of preparation (including cremation) and homeward transportation of a deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

Meals and Accommodations

Up to $1,200 Canadian ($150 per day for 8 days) per trip for extra costs of commercial accommodation and meals incurred by the subscriber, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

Transportation Benefit

Up to a maximum of $10,000 Canadian for one return economy fare by the most direct route for transportation costs (air, bus, train), when you are confined to a hospital or have died and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

Return of the Dependent Children

If dependent children are left unattended while travelling with you or your spouse who is hospitalized for medical reasons, one-way economy transportation will be arranged and the extra cost over and above any allowance available under pre-paid travel arrangements will be paid for the return of such children by the most direct route to their normal place of residence in Canada, up to a maximum of $5,000 Canadian.

Trip Interruption/Delay

If a trip is interrupted or delayed due to your hospitalization outside your normal province of residence, one-way economy transportation will be arranged and the extra cost over and above any allowance available under pre-paid travel arrangement will be paid to enable each covered person to rejoin the trip or to return home by the most direct route, up to a maximum of $5,000 Canadian.

Emergency Evacuation

The Company will pay benefits for covered expenses incurred up to a maximum of $25,000 Canadian if an injury or sickness commencing during the course of a trip results in the necessary emergency evacuation. An emergency evacuation must be ordered by a legally licensed physician who certifies that the severity of your injury or sickness warrants the emergency evacuation.

Repatriation Benefit

Pays a benefit of up to $10,000 to cover the expenses to return your body to your city of residence if you die while at least 50 kilometers from home. Covered expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation.

Emergency Travel Assistance

Travel Assistance is provided by Travel Guard. With centers worldwide they will:

- Help you locate the most appropriate medical facility for you.
- Confirm coverage with AIG Insurance and assure the hospital that you are covered.
- Guarantee payment for hospitalization, if necessary.
- Arrange for admission to a hospital.
- Provide translation services.
- Contact your own doctor for recommendations, when required.
- Contact your family and employer, when required.
- Arrange for/coordinate emergency medical evacuation.
- Coordinate your return home.

Extended coverage after termination of coverage

In the event of the delayed arrival of a common carrier or hospitalization, this policy will automatically be extended at no charge 1) 24 hours in the event of a delayed common carrier, 2) the period of hospitalization plus 24 hours after you are released from hospital.

EXCLUSIONS

1. No benefits are available under this policy for residents traveling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.
2. No benefits are available under this policy for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the covered person has returned to Canada, or (c) which the covered person elects to have rendered or performed outside Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.
3. Benefits under this policy shall not be paid if the covered person receives the same from a third party.

4. No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol; suicide or attempted suicide; criminal acts; war; or other hostilities.
5. The Company, in consultation with the attending physician, reserves the right to return the patient to Canada. If any participant is (on medical evidence) able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the participant elects to have such treatment or services rendered or surgery performed outside Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan.
6. Coverage is limited to expenses incurred as a result of a sudden illness or accident which occurs outside the participant's province of residence. Pre-existing conditions will be covered as a benefit, provided the condition is stabilized prior to travel, and medical attention is not anticipated during the travel period.