CONTRACT IDENTIFICATION

The benefits outlined in this booklet are available to plan members under Contract Number 84444:

Division Numbers, Active Employees

Division 1 -Elementary Teachers
Division 2 -Secondary Teachers
Division 3 -Elementary Principals and Vice-Principals
Division 4 -Secondary Principals and Vice Principals
Division 5 -Occasional Teachers, Elementary
Division 6 -Occasional Teachers, Secondary
Division 7 -Professional Student Services Personnel - OSSTF, Unit A
Division 8 -Instructors - CUPE 4400, Unit B
Division 9 -School Office staff, Classroom Support staff and Central Administrative staff - CUPE 4400, Unit C
Division 10 -Custodial, Warehouse and Transportation staff -CUPE 4400, Unit D
Division 11 -Maintenance and Construction Skilled Trades -MCSTC, Unit E
Division 12 -Schedule I employees - Non-Union
Division 14 -Schedule II employees - Non-Union

Division Numbers, Retired Employees

Division 51 -Elementary Teachers
Division 52 -Secondary Teachers
Division 53 -Elementary Principals and Vice-Principals
Division 54 -Secondary Principals and Vice Principals
Division 57 -Professional Student Services Personnel - OSSTF, Unit A
Division 59 -School Office staff, Classroom Support staff and Central Administrative staff - CUPE 4400, Unit C
Division 60 -Custodial, Warehouse and Transportation staff -CUPE 4400, Unit D
Division 61 -Maintenance and Construction Skilled Trades -MCSTC, Unit E
Division 62 -Schedule I employees - Non-Union
Division 64 -Schedule II employees - Non-Union

Toronto District School Board

Group Contract Number: ASO 84444

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefits Program

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

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

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

Important Note

PLEASE NOTE THAT SEPARATE ENROLMENTS ARE REQUIRED FOR THE SEMI-PRIVATE HOSPITAL AND EXTENDED HEALTH CARE BENEFITS. COVERAGE UNDER EITHER BENEFIT DOES NOT AUTOMATICALLY MEAN COVERAGE IN THE OTHER.

Your Semi-private Hospital and Extended Health Care Benefits are provided directly by the Toronto District School Board. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following standard coverage rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

Claims payments are subject to Manulife Financial's administrative guidelines for claims adjudication.

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of the Toronto District School Board. The information in this booklet is a summary of the provisions of the Group Contract. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of the Toronto District School Board and Manulife Financial are governed by the paper version of the Group Contract. In the event of a discrepancy between this booklet (paper or electronic version) and the Group Contract, the terms of the Group Contract will apply. No alteration of the electronic copy of this booklet is permitted by any person, except by an authorized representative of Manulife Financial.

Possession of this booklet alone does not mean that you or your dependent(s) are covered. The Group Contract must be in effect and you must satisfy all the requirements of the Contract.

We suggest you read this benefit booklet carefully, then file it in a safe place with your other important documents. It supersedes and replaces all previous communication material.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR COVERAGE, CONTACT MANULIFE FINANCIAL AT (416) 310-6872 OR TOLL-FREE AT 1-800-268-6195.

This booklet redrafted 04/08/2004
TDSB Health.doc

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Explanation Of Common Terms

Explanation of Common Terms

Deductible

the amount of eligible expenses for which you are responsible prior to consideration of payment of benefits.

Drug

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

Medically necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

The Claims Process

How to Submit a Claim

How to Submit a Claim

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

If expenses are incurred due to hospital confinement, a claim form should be completed by the hospital and yourself. When completed, this claim form should be submitted to Manulife Financial at the address indicated below.

For other than hospital charges, once you have accumulated more than $25 in Extended Health Care expenses for one family member for the year (or more than $50 for more than one family member for the year), obtain a Group Benefits Extended Health Care Claim form from your School or Board Office. Complete the form and return it, along with all original receipts, to:

Manulife Financial
Group Benefits
P.O. Box 1658
Waterloo, Ontario
N2J 4W6

Please make sure that all appropriate areas on the claim form are completed properly.

Please be advised that, for the determination of eligible expenses, Manulife Financial requires that either the name of the drug or the drug identification number (D.I.N.) be reflected on the receipt.

When incurring expenses for any health related claims outside Canada, request detailed receipts (in duplicate if possible). Send one set of receipts to the Ontario Health Coverage Plan (OHIP) for their consideration and payment. When they have replied, send proof of their payment, together with receipts and/or completed claim forms to Manulife Financial.

Please note that you will be required to pay expenses incurred outside Canada up front. Submit your receipts to OHIP first and then to Manulife Financial for their consideration upon your return to Canada.

Please note that claims in a foreign language require an accompanying translation.

Reimbursement will be made by Manulife Financial directly to you, by cheque, in Canadian currency, based on the rate of exchange in effect at the time of payment of the claim, as determined by a Canadian chartered bank.

OHIP provides coverage for many drugs for Ontario residents age 65 and over. Please submit all drug claims for covered people who are age 65 or older first through OHIP. Any claims not paid by that plan should then be submitted to Manulife Financial for consideration.

Original receipts in support of claims will not be returned, but will be retained by Manulife Financial. Receipts will be held by Manulife Financial for a period of 12 weeks before being destroyed.

The Claims Process

When your coverage terminates for any reason, other than for termination of the contract, written proof of claim must be given to Manulife Financial within 180 days of the date of termination of coverage. No claims will be paid by Manulife Financial after the termination date of the contract.

If you have any enquiries regarding claim procedures, please call Manulife Financial at (416) 310-6872 or toll-free at 1-800-268-6195.

Co-ordination of Benefits

Co-ordination of Benefits

Many individuals are covered under more than one group plan for health and dental benefits. If you are covered under two plans, then co-ordinating benefits from both plans may increase your total reimbursement. Depending on the services submitted, amounts billed and plan coverages, you may receive full reimbursement. The insurance industry has developed the following COB guidelines to determine which plan pays first.

If you have coverage under more than one plan:

1. The basic rule is to submit your claims first to the plan where you are covered as an employee. If any unpaid balances remain, submit them to your spouse's plan.

2. The reverse is true for your spouse. Your spouse submits his/her claims to his/her plan first and then to yours.

3. For dependent children, claims should first be submitted to the plan of the parent with the EARLIER month and day, not year, of birth. For example, you should submit your child's claim to your spouse's plan first if you were born on August 4 and your spouse on July 11.

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

   - The plan of the parent with custody of the child, then
   - The plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's plan will pay benefits for the dependent child), then
   - The plan of the parent not having custody of the child, then
   - The plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's plan will pay benefits for the DEPENDENT child).

4. A claim for accidental injury to natural teeth will be determined under health care plans with accidental dental coverage before it is considered under dental Plans.
5. If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
6. If the covered person is also covered under an individual travel coverage plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Coverage Association.

The Claims Process

Please keep in mind...

If you plan to submit to more than one plan, take photocopies of claims and receipts before you submit them. You will be required to submit them to the second insurer, along with the reimbursement statement from the first insurer.

There is an added benefit if both the employee and the spouse have their coverage through Manulife Financial (either through different employers or when the employee and spouse are both employed by the Board).

In this case, you need only submit your claim once, indicating both plan numbers. Manulife Financial will automatically co-ordinate the benefits between the two plans.

Who Qualifies for Coverage?

Who Qualifies for Coverage?

Who's Covered?

Who's Covered?

The Plan may cover the following people, who are residents of Canada:

1. You.
2. Your spouse.
3. Your dependent children.

You may be eligible for Group Benefits if you:

- are within a class of individuals eligible for coverage under the terms of a current collective agreement or Board policy,
- are a retired employee who has elected early retirement in accordance with Board policy and you are under age 65.

Your ***Spouse*** may be eligible for Group Benefits if they are a person who either***:***

- is married to you through an ecclesiastical or civil ceremony, or
- although not legally married to you, continuously cohabits with you in a conjugal relationship, which is recognized as such in the community in which you reside. The term conjugal relationship shall be deemed to include a conjugal relationship between partners of the same sex.

Your ***Child(ren)*** must be your unmarried children (including natural, step-child, legally adopted, foster, and/or a child of a common-law spouse) who are financially dependent on you for support and are:

- less than 21 years of age, or
- in regular full-time attendance at an accredited institute of learning and are less than 25 years of age. A dependent child who is employed during a vacation or semester break from an accredited institute of learning remains covered until the date the child returns to full-time attendance at an accredited institute of learning, provided the child continues to meet all conditions for coverage. (Student status questionnaire forms are available in your Board office.), or
- any permanently mentally or physically handicapped child who was covered up to the maximum age may remain covered past the maximum age. The child, upon reaching maximum age, must be and remain incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

Note: Children are covered from birth. Please note that coverage terminates on the date the dependent child attains the limiting age.

Note: Where used in this Benefit Booklet, the term employee can also mean retiree.

Joining or Leaving the Plan

Joining or Leaving the Plan

You are entitled to the benefits outlined in this booklet if you join the plan, by submitting your application WITHIN 31 DAYS:

1. After starting work or completing an eligibility period.
2. After returning from an approved leave of absence without pay.

3. After losing dependent coverage in your spouse's plan. Termination of your spouse's employment, separation or divorce are possible circumstances that could lead to your loss of spousal coverage.

If you do not make application for coverage WITHIN 31 DAYS, other than during an open enrolment period, you will be considered a late applicant and you will be required to submit evidence of your and/or your dependent's acceptability for coverage along with your application. Coverage will become effective on the date Manulife Financial approves such evidence.

However, if you do not make application for coverage WITHIN 31 DAYS, you can join the plan during an annual open enrolment period, without having to submit evidence of acceptability for coverage.

The open enrolment period is for the month of October each year, with coverage becoming effective November 1st.

You must also elect family coverage WITHIN 31 DAYS after acquiring your first eligible dependent (spouse or child), or you will be considered a late applicant.

You may leave the plan at any time by providing written notice 31 days or more before the termination date. However once you leave the plan you must wait until the next open enrolment period (October) before you can rejoin.

If you are not actively at work on the date a change in coverage would normally become effective, the change in coverage will commence on your return to work. With respect to this provision, you are considered to be actively at work while on vacation, provided you are not confined to hospital or disabled due to sickness or injury.

If one of your dependents is hospitalized (other than a new-born infant) on the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Once you are covered for dependent coverage, additional dependents will be covered from the date eligible regardless of hospital confinement.

When Will Your Coverage End?

When Will Your Coverage End?

Your Group Coverage will terminate on the earliest of:

- the date you cease to be an eligible employee.
- the date you enter the armed forces of any country on a full-time basis.
- the date the Group Contract terminates.
- the date any required contribution is due but not paid.
- the date you retire. However, if you retire early, your coverage may be continued in accordance with the Collective Agreement or Board policy provided that you pay the required contribution.
- The date you die. Your dependents may be able to extend their coverage after your death. See your Collective Agreement or Board policy for details.

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

Your Group Benefits

Hospital

Benefits are payable on behalf of each covered individual of your family as follows:

1. Hospital charges incurred in an active treatment hospital in Ontario, up to the reasonable and customary cost of semi-private accommodation. Benefits are payable for an unlimited number of days. Manulife Financial will only consider that portion of the cost that is over and above any amount that would have been paid by the Ontario Health Coverage Plan (OHIP), regardless of whether the claimant has coverage under OHIP.

2. Hospital charges in an active treatment hospital incurred outside Ontario, but within Canada, are payable up to the cost of comparable semi-private accommodation in Ontario, when standard ward charges are paid by OHIP.

   Note: Active treatment hospitals include both licensed public general hospitals and certain private hospitals licensed by Ontario and listed in the Health Insurance Act.

3. Hospital charges for palliative care (care for a terminally ill person) up to the cost of semi-private accommodation, subject to a lifetime maximum of 45 days per person, if incurred in a chronic care institution or other institution licensed and approved by the Ontario Ministry of Health or equivalent body in other jurisdictions. Expenses incurred beyond the lifetime maximum of 45 days will be payable as outlined under the chronic care expense below.

4. Hospital charges for semi-private accommodation in a public chronic hospital or chronic wing facility, in Ontario, are payable for up to $3 per day for a maximum period of 120 days per 12 consecutive months. This does not include accommodation in a Tuberculosis sanatorium, mental hospital, or nursing home.

5. On a physician's recommendation, hospital charges up to the cost of semi-private accommodation in a convalescent or rehabilitation facility, in Ontario, for a maximum of 6 weeks per period of disability. Benefits will only be paid following at least 3 days confinement in an acute care facility.

Semi-Private Hospital charges in facilities not referred to above are not covered under the Plan. If you have any questions regarding specific facilities, contact Manulife Financial at (416) 310-6872 or toll-free at 1-800-268-6195.

All expenses listed above are in addition to and not a duplication or substitution of benefits payable by OHIP.

Note: In the event that a government plan of coverage (i.e. OHIP) discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan, the Board's Plan will not automatically assume or increase coverage of the charges for such services, treatments or supplies, but will reserve the right to determine, at the time of the change, whether expenses will be considered eligible.

PLEASE NOTE THAT SEPARATE ENROLMENTS ARE REQUIRED FOR THE SEMI-PRIVATE HOSPITAL AND EXTENDED HEALTH CARE BENEFITS. COVERAGE UNDER EITHER BENEFIT DOES NOT AUTOMATICALLY MEAN COVERAGE IN THE OTHER.

Extended Health Care

The Benefit

Extended Health Care – The Benefit

Deductible – The $25 individual deductible is applied once each calendar year to the eligible expenses incurred during that year. However, the maximum deductible per family per year is $50 with no one member contributing more than $25.

The deductible does not apply to expenses incurred outside of Canada, (#25 to #29).

Common Accident

In the case of a common accident which involves at least 2 members of your family who are covered under the same certificate, only the individual deductible will be applied (once each calendar year) to all eligible expenses in connection with the accident.

Benefit Percentage (Co-coverage) – 100% of eligible expenses

Eligible Expenses

Extended Health Care – Eligible Expenses

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

- medically necessary for the treatment of sickness or injury and recommended by a physician (except for paramedical practitioners under Professional Services),
- incurred for the care of a person while covered under this Group Benefit Program.

  All expenses listed are in addition to and not a duplication or substitution of benefits payable by OHIP.

  Note: In the event that a government plan of coverage (i.e. OHIP) discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan, the Board's Plan will not automatically assume or increase coverage of the charges for such services, treatments or supplies, but will reserve the right to determine, at the time of the change, whether expenses will be considered eligible.

Coverage for selected devices and supplies may also be provided under the Assistive Devices Program (A.D.P.) through the Ministry of Health. If the expense is covered under A.D.P., Manulife Financial will only consider the unpaid portion as an eligible expense, to which the deductible will apply.

The following is a list of some of the items currently payable under the A.D.P.:

Hearing Aids	Wheelchairs and walking aids
Orthotic devices	Prosthetic limbs
Breast Prostheses	Artificial Eyes
Genito-Urinary and Ostomy supplies	Respiratory supplies and equipment

In order to avoid unnecessary out-of-pocket expenses contact Manulife Financial at (416) 310-6872, or toll-free at 1-800-268-6195, prior to incurring any expense.

Extended Health Care - Prescription Drug Plan

Prescription Drug Plan

1. Drugs, sera and injectables available only on a prescription, when prescribed by a physician or dentist, and dispensed by a pharmacist, physician or dentist. Drugs, biological and related preparations which are not intended for a patient's use at home and which are administered in a hospital on an in-patient or out-patient basis are not eligible. Coverage for drugs is subject to the following:

   a) PDE-5 enzyme blockers (e.g. Viagra) are not eligible.

   b) Fertility drugs, subject to a lifetime maximum of 12 cycles of therapy, for any drug or combination of drugs required. Procedures such as in vitro fertilization are not covered.

   c) Pre-authorization is required for all meridia and Xenical claims.

   d) Injectable vitamins, when required for the treatment of a medical condition. Covered vitamins are limited to those available only by prescription when prescribed by a physician or dentist, and dispensed by a pharmacist, physician or dentist. In some instances, injectible vitamins may only be partially reimbursed. For example, reimbursement for vitamins B-6 and B-12 may be limited to $2 per injection. Please contact Manulife Financial at 416 310 6872, or toll-free at 1-800-268-6195, if you have questions regarding this coverage.

   e) Drugs and supplies of a non-prescription nature required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease. Feeding bags are also eligible.

      Other non-prescription drugs and supplies, that are life-sustaining based on the patient's individual need and the medical condition necessitating a specific drug and supplies, are payable. All requests for individual consideration of such non-prescription over-the-counter drugs and supplies should be forwarded with details concerning medical condition/need and the prescription receipt, for individual consideration to Manulife Financial.

   f) Anti smoking drugs available only by prescription are eligible, subject to a 3 months maximum supply during the person's lifetime.

   The above drug coverage is subject to the following limitation regarding generic product substitution. Wherever a brand name product is prescribed and an interchangeable generic product is available but not dispensed, ELIGIBLE EXPENSES shall be limited to the cost of the generic drug in the appropriate generic category that is suitable for the substitution of the drug that was dispensed. However, such limitation shall not apply to any prescription written by brand name and directed by the prescriber as not to be interchanged or substituted, provided a specified medical reason is also provided.

   Non-prescription over-the-counter drugs and supplies are not covered except as otherwise specified under ELIGIBLE EXPENSES, item 1 (e).

Health Care Facilities

Extended Health Care - Health Care Facilities

2. Hospital room and board charges in a private or public general hospital within Canada, up to the reasonable and customary cost for private accommodation (not a suite) less the cost for semi-private accommodation. Coverage for accommodation charges between ward and semi-private levels is provided under the Semi-private Hospital benefit. Charges for any portion of the cost of ward accommodation, utilization or copayment fees (or similar charges) are not eligible.
3. Hospital charges incurred as an out-patient for necessary medical or surgical treatment (excluding physicians' fees, and special nurses' fees).
4. Room, board and normal nursing care provided in a private hospital licensed under Section 4 of the Health Coverage Act of Ontario or equivalent legislation in another jurisdiction, which is under the supervision of a registered nurse or a physician.

Medical Transportation Services

Extended Health Care - Medical Transportation Services

5. Transportation by a licensed ground ambulance to and from the nearest medical facility for immediate treatment.

   Transportation by any form of licensed ambulance (including air-ambulance) or by any vehicle normally used for public transportation, for:

   a) transfer to the nearest appropriate medical facility or hospital for necessary treatment, and/or

   b) medical evacuation for admission to hospital in the province where the patient normally resides.

   Ground transportation to and from the hospital and airport at the point of departure and arrival is also eligible.

   Transportation is eligible when it is medically necessary or when deemed feasible in the opinion of the attending physician

Medical Supplies and Services

Extended Health Care - Medical Supplies and Services

6. Diagnostic procedures, including radium and radioactive isotope treatments, plasma and blood transfusions.
7. Purchase of:
   - trusses, braces, splints, cervical collars, artificial limbs or eyes;
   - casts (fibreglass cast only if medical condition necessitates a lighter weight casing);
   - elastic support stockings, subject to a maximum of 2 pairs per year;
   - catheters and urinary kits;
   - glucometers;
   - breast prosthesis following a mastectomy; and
   - bandages or surgical dressings, on the certification of the attending physician.

8. Purchase of custom-made orthopaedic shoes which are attached to and form part of a brace (including adjustments to such shoes). If the shoes are not part of a brace, they must be prescribed by a specialist physician (orthopaedic surgeon or physiatrist) and claims must be accompanied by a detailed receipt outlining the diagnosis, prognosis and mode of treatment. Coverage is limited to two pair per calendar year, whether or not the shoes form part of a brace.

9. Purchase of custom-made orthotics which are prescribed by a specialist physician (orthopaedic surgeon or physiatrist), a chiropodist, or a podiatrist.

   Orthotics will be provided when required for the medical correction of a deformity of the bones and/or muscles and will be excluded in the absence of recognized orthopaedic conditions.

   Orthotics prescribed by a chiropractor will be eligible if accompanied by a diagnosis from a medical doctor providing supporting documentation of an orthopaedic condition.

   Claims must be accompanied by a detailed receipt from the prescribing specialist outlining the diagnosis, prognosis and mode of treatment. All claims must be accompanied by confirmation that the orthotic is made from a cast impression of the patient's foot and a description of the casting technique used to make the foot impression.

   Orthotic coverage is limited to two pairs over two calendar years with a maximum payment of $950 in total.

10. Rental, or, at Manulife Financial's option, purchase of one feeding pump and pole per person per lifetime, subject to a combined maximum of $500. The pump must be prescribed by the attending physician, who must specify that the pump will be used to ingest food supplements required to prevent a life threatening situation, and that the person requires some form of medical assistance to enable the ingestion of such food supplements.

11. Rental, or, at Manulife Financial's option, purchase of a wheelchair, hospital bed, oxygen set, respirator, cane, walker or crutches, on the written recommendation of the attending physician.

12. Expenses for contraceptive appliances if they are prescribed by a physician due to medical conditions that prevent the person from taking oral contraceptive drugs.

13. Purchase of peak flow meters, when prescribed by a physician for the treatment of asthma, subject to a maximum payment of $100 per person during a lifetime.

14. Expenses for devices used to treat bedwetting such as the Mozes detector, subject to a lifetime maximum of $100 per person.

15. Expenses for PSA tests for male patients over age 50 with symptoms present and/or a strong family history of prostate cancer.

16. Wigs purchased on a physician's recommendation, which must provide a diagnosis or description of the treatment resulting in the necessity for a wig, up to a lifetime maximum of $150 per person.

Dental Services

17. Dental treatment for the repair of damage resulting directly from an accidental injury to natural teeth and not an object wittingly or unwittingly placed in the mouth. The treatment must be rendered within 6 months following the accident, and your coverage, as well as the Contract, must still be in force. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result. If such treatment is required while outside Canada, the expense is limited to treatment of natural teeth and the maximum payment is $500 per accident.

Extended Health Care – Professional Services

Professional Services

18. Physicians' services, where permitted by law for expenses incurred in Canada outside your province of residence. Reimbursement will be made up to the lesser of the Ontario Health Coverage Plan allowance for the service, and the reasonable and customary charge for the expense for the area where it is incurred.

19. Professional services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields) up to the levels specified in the following table:

Practitioner		Maximum Payable Per Person
Clinical psychologist	-	expenses of up to $35 for the initial assessment, and up to $20 per hour for subsequent treatments, up to a maximum payment per person of $200 per 12 consecutive months. Group psychological counselling must be for treatment related to serious, recognizable conditions and excludes preventative counselling.
Speech therapist	-	up to a maximum payment per person of $200 per 12 consecutive months.
Physiotherapist	-	up to a maximum of $20 per visit.
Massage Therapist	-	payments up to a total of $7 per treatment for a maximum of 12 treatments per person per 12 consecutive months.

Under some circumstances, benefits may not be payable until the government plan concerned has paid its yearly maximum. Check with Manulife Financial if you require further details

20. Professional services of a Registered Nurse (R.N.), while the patient is not confined to hospital, provided the services are certified as medically necessary, and ordered by a physician, and the claimant has received prior approval from Manulife Financial. For expenses incurred outside Canada, payment will be limited to $1,000 per period of disability.

Custodial care, homemaking services and supervision that could be performed by someone other than a Registered Nurse are not covered services.

If an R.N. is not available when required, expenses incurred for the services of a Registered Nursing Assistant, a licensed practical nurse or a certified nursing assistant will be considered eligible to the extent that such persons are qualified to provide the required nursing services. However, any such nurse must not ordinarily reside in the patient's home. Services of a nurse who is your spouse, or the child, brother, sister or parent of yourself or your spouse, will not be considered.

Hearing Aids

21. Purchase of hearing aids. Please call Manulife Financial for your maximum benefit amount.

Extended Health Care – Vision Care

Vision Care

22. Frames, lenses and the fitting of corrective prescription glasses, contact lenses and prescription sunglasses (but not the cost of eye examinations). Please refer to your Collective Agreement or call Manulife Financial for your maximum amount payable. The maximum benefit amount applies to all expenses incurred within 24 consecutive months. ***The date of purchase determines whether an expense falls within the 24-month benefit period.***
23. Lenses and frames following cataract surgery, subject to a lifetime maximum of two payments (based on the average current costs for major suppliers), subject to the following conditions:
    - the lenses and frames are required as a result of cataract surgery to both eyes and the surgeries are done on separate occasions.
    - the claim is accompanied by medical certification from the physician detailing the surgical date and type of surgery performed.

Vision Care expenses are eligible when recommended by a physician (including an ophthalmologist) or an optometrist.

Extended Health Care - Referral Treatment

Referral Treatment

24. Hospital and physicians' charges (as described under Outside Canada Coverage) shall also include medically necessary treatment, on the referral of a physician located in Canada, provided such treatment is not available in Canada, and provided the government plan of coverage pays a portion of the charges. A specialized or customized treatment shall not be considered an eligible expense where a general treatment is available in Canada.

Extended Health Care - Outside Canada Coverage

Outside Canada Coverage

Expenses incurred outside Canada for non-emergency treatment are limited to reasonable and customary charges for Ontario (restricted to employees on work assignment).

Expenses incurred outside Canada for emergency treatment are limited to reasonable and customary charges for the area in which the treatment is rendered.

The following expenses (#25 to #29) are payable for emergencies outside Canada.

An "emergency" means any sudden, unforseen and unexpected occurrence which requires medical treatment.

25. Hospital charges incurred for emergency treatment while travelling, vacationing or otherwise temporarily residing outside Canada, up to a maximum of 31 days per period of disability, as follows:

    - hospital charges for the difference between the benefit payable by the OHIP and the reasonable and customary charges for ward accommodation, plus charges for medically necessary hospital services and supplies.
    - hospital charges for the difference between ward accommodation and private room accommodation.

26. Hospital charges for medical and surgical treatment incurred by a person on an out-patient basis.
27. Physicians' charges for professional services.
28. Transportation by any form of licensed ambulance (including air-ambulance) or by any vehicle normally used for public transportation, for:

    - transfer to the nearest appropriate medical facility or hospital for necessary treatment, and/or
    - medical evacuation for admission to hospital in the province where the patient normally resides.

    Transportation of necessary qualified medical attendants to accompany the claimant, is eligible.

    Ground transportation to and from the hospital and airport at the point of departure and arrival is also eligible.

    Transportation is eligible when it is medically necessary or when deemed feasible in the opinion of the attending physician.

29. Subject to maximum payment (first) by OHIP, out-of-country charges made by chiropractors, chiropodists and podiatrists, to a maximum of $10 Canadian per treatment. Benefits for these expenses are only payable once OHIP has paid their annual maximum benefit (from April 1 to March 31).

OHIP has regulations regarding expenses incurred outside Canada due to pregnancy. In order to avoid unnecessary out-of-pocket expenses, please consult with OHIP for confirmation of their coverage prior to travelling outside Canada.

Expenses not Covered

Extended Health Care - Expenses not Covered

No payment will be made for expenses resulting from:

- Self-inflicted injuries or illness while sane or insane.
- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.
- Any illness or injury for which benefits are payable under any government plan or legally mandated program.
- Examinations required for the use of a third party.
- Travel for health reasons.

- Charges levied by a physician for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication, including paperwork or conferences with third parties, counselling by an experienced nurse, or completion of government forms.
- Cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries. Surgery or treatment for accidental injuries must commence within 90 days of an accident, or Manulife Financial must be notified in writing within the 90 day period of the need for treatment.
- Any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of coverage.
  - which are performed or provided by an immediate family member or a person who lives with the patient.
  - which are provided while confined in a hospital on an in-patient basis.
  - which are not specified as an Eligible Expense under this plan.

  Immediate family member *means you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.*
- Expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (Extended Health Care Eligible Expenses - Referral Treatment and Outside Canada Coverage). Such expenses incurred outside Canada on an elective basis are not payable.
- Expenses incurred for semi-private and/or private hospital charges in facilities not referred to under Semi-Private Hospital Plan.
- Expenses incurred in Canada for chiropractors, chiropodists or podiatrists.
- Drugs, sera, injectables and supplies which are not approved by Health and Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.
- Experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.
- Sunglasses or eye glasses for cosmetic purposes, and eye examinations.
- Orthotics that are used exclusively for sports.
- Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. Manulife Financial will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Expenses incurred for professional services from a Naturopath, Herbalist, or other alternative health practitioner.
- Any costs incurred for drug expenses which are used to satisfy the deductible or co-payment required under the Ontario Drug Benefit Program.
- Injected or implanted contraceptive drugs.
- Non-prescription over-the-counter drugs and supplies are not covered except as otherwise specified under Eligible Expenses, item 1e).

REMINDER

Employees covered under the Board's Health and Dental plans are reminded to retain all Explanation of Benefits forms (EOBs) that they receive from Manulife Financial in the event that they have the opportunity to claim a federal tax credit for expenses that were not reimbursed under the plans.

The Explanation of Benefits (EOB) form is the print-out attached to the cheque at the time that a claim payment is made. The EOB includes a summary of the submitted expenses and the amounts payable under the plan. The EOB also indicates expenses that were not reimbursed under the plan and provides the reason for declining those expenses.

In the event that a plan member feels that he/she might qualify for a federal tax credit, but he/she has not retained copies of all EOB forms, reprints may be obtained from Manulife Financial, (416) 310-6872, or toll-free at 1-800-268-6195.

Since the reproduction of these records can be very time consuming, Manulife Financial will charge an administrative fee of $45.00 for this service. Payment of this fee will be the responsibility of the employee. Retaining the Explanation of Benefits (EOB) form will help to avoid this fee.