Post Retirement Benefits (PRB'S) for Eligible Retirees under Lutheran Church – Canada's (LCC) Worker Benefit Plans

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Group Policy Number: G0036844

This booklet outlines the details of LCC's Post-Retirement Benefit Plans. It is prepared as information only and does not constitute an agreement, nor does it create or confer any contractual rights or obligations. This is only a summary of the main provisions of the outlined benefits. In the event of any inconsistency between this document and the official plan or policy, the plan or policy texts will govern.

Possession of this booklet alone does not mean that you or your dependents are covered. The Group Policy must be in effect and you must satisfy all the requirements of the Policy. Your right to benefits is determined by the provisions of the plans in place at the time.

While LCC expects to continue these plans indefinitely, future conditions cannot be foreseen, therefore, LCC reserves the right to amend, suspend or discontinue, in whole or in part, any benefit described within this summary.

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

For the current version of this document, please refer to the Worker Benefit Plans website.

POST – RETIREMENT BENEFITS

Eligibility

You are eligible for Post-Retirement Benefits (PRB) if at the time you retire you are a Permanent full or part time member and,

- You are age 55 or older with two or more years of Credited Service in the Lutheran Church – Canada Pension Plan (LCCPP) immediately prior to retirement; and
- You were eligible to participate in the LCC Flex Benefits program immediately prior to retirement; and
- You are a resident of Canada and are covered under a Provincial Health Insurance Plan; and
- You commence receiving your pension immediately at retirement; and
- You retire prior to July 1, 2012 **or** you have attained the age of 60 and have 15 years of service at July 1, 2010.

If you elect to waive coverage for yourself or your dependents under the PRB'S plans at the time of retirement you will not be permitted to elect coverage at a later date.

Benefit Programs

Post- Retirement Benefits consist of the following programs:

- Retiree Extended Health Care (including Emergency Travel Assistance)
- Retiree Dental
- Retiree/Spouse Death Benefit

Cost of Coverage

Information on the cost of premiums is contained on the premium sheet attached to this booklet (Appendix A). Premiums for the programs will typically change annually. The amount of the premium paid by you will depend on your age and service at the time of your retirement.

Your premium will be based on your Credited Service in the LCCPP at retirement as shown below:

Completed Years of Credited Service	% of Total Premium Payable
2	100%
3	100%
4	100%
5	100%
6	100 %
7	100%
8	95%
9	90%
10	85%
11	75%
12	65%
13	60%
14	55%
15 or more	45%

Premiums are deducted from your pension benefits paid by the pension custodian (CIBC Mellon). If your ongoing pension is insufficient to pay for the premiums you will be required to have your premiums debited from your bank account.

Electing Coverage

Post - Retirement Benefits (PRB) election forms are provided to you at the time of retirement.

Important Note: You must provide written confirmation to the Worker Benefit Plans' office within 30 days prior to the commencement of your LCCPP pension of your coverage election; otherwise, we will assume you have declined coverage.

If you decide at any time during your retirement that you do not wish to be covered under the Retiree Health and Dental Plans, you must provide the Worker Benefit Plan's Office 30 days notice in writing. Keep in mind that once you decline this coverage, it will not be reinstated.

Your Benefit Card

Your Benefit Card is the most important document issued to you; it identifies you as a Plan Member. The Group Policy Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment and they are also necessary for correspondence with the insurance company. Please be sure to carry it with you at all times.

Eligible Dependents

Eligible dependents are your spouse and eligible children, defined below.

Spouse

The person to whom you are legally married, or a domestic partner who has continuously lived with you in a role like that of a marriage partner for at least one year. Your spouse must be covered under a Provincial Health Insurance Plan to be eligible for coverage. Your spouse at the time of your retirement is considered to be your eligible spouse. Only one spouse is eligible for coverage under these programs.

The definition of spouse differs for the pension plan. Spouse for purposes of the pension plan is defined under provincial pension legislation.

Children

A dependent child is your natural or adopted child, or stepchild, who is:

- Unmarried
- Under age 21, or under age 26 if a full-time student
- Not employed on a full-time basis, and
- Not eligible for insurance as an employee under this or any other Group Benefit Program

A child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been insured under the benefit program immediately prior to that date. A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on you for support, maintenance and care, due to a mental or physical handicap.

The insurance company may require written proof of the child's condition as often as may reasonably be necessary.

A stepchild must be living with you to be eligible.

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

Children must be covered under a Provincial Health Insurance Plan to be eligible for coverage.

Upon Death

Upon death, coverage is extended for life to your surviving spouse. Dependent children continue to be covered for as long as they qualify.

Benefit Year

The benefit year is from January 1 of one year to December 31 of the same year. The benefit year is used to track maximums and determine limits.

Coordination of Benefits (COB)

Coordination of Benefits is a process where individuals or families with more than one benefit plan combine their coverage. This allows benefit plan participants to have coverage for up to 100 percent of eligible prescription drugs, dental and health service benefits.

In the event that you or your dependents are covered under more than one health or dental plan, payment under this plan will be coordinated so that you realize the maximum benefits. At no time can payment exceed 100% of your total cost. Plan means:

- Other Group Benefit Programs;
- Any other arrangement of coverage for individuals in a group; and
- Individual travel insurance plans.

Plans do 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" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expense).

If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.

If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier:

- For Claims incurred by you or your Dependent Spouse; the Plan covering you or your Dependent Spouse as a member pays benefits before the Plan covering you or your Spouse as a dependent.
    - In situations where you or your Spouse have coverage as a member under more than one Plan, the order of benefit payment is as follows:
        - The Plan where the person is covered as an active full-time member, then
        - The Plan where the person is covered as an active part-time member, 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.

- 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).
    - 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.

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

- If you purchase an individual travel insurance plan, the first insurance company contacted is deemed to be the first payer and will generally ask the plan member if there is additional coverage. First contact to the other insurance is recommended in order to preserve the $50,000 overall lifetime medical coverage.

Submitting a Claim for Co-ordination of Benefits

- To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

    - As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier. Submit all necessary claim forms and original receipts to the Primary Carrier.

- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.

- Once your claim has been settled by the Primary Carrier, you will receive an Explanation of Benefits (EOB) outlining how your claim has been handled. Submit the EOB along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Claiming Extended Health and Dental Benefits

Claims must be received by the insurance company by March 31 of the year following the year in which the expense was incurred to be eligible for reimbursement.

The dental plan allows you to assign your benefits to your dentist. This means your dentist can bill the insurance company directly and the insurance company pays the dentist. You pay your dentist for the amount not covered by your dental option.

If your dentist does not accept direct assignment, you will have to pay the dentist and then seek reimbursement from the insurance carrier.

Drugs, diabetic and intravenous supplies (acquired at a pharmacy) are on a pay direct basis. This means the insurance carrier pays the pharmacy or hospital directly. You are responsible for paying the amount not covered by the insurance carrier.

Health and vision care benefits are covered on a reimbursement basis. You must pay the provider, obtain a receipt and submit this to the insurance carrier.

Submitting Claims

Obtain a Health or Dental Claim form from the Worker Benefit Plans' website (www.lccbenefits.ca) or the insurance carrier's website (www.manulife.ca/planmember) or from your dentist.

- Complete the form (name, group policy number, certificate number etc (found on your Group Benefit Card) and sign and date it.
- Make copies of all forms and receipts for your records.
- Mail the form with original receipts to the insurance company.
- If you have additional Health or Dental coverage through your spouse's plan send a copy of the "Explanation of Benefits" (attached to your claim cheque) to your spouse's plan.

Payment of Extended Health and Dental Claims

Once the claim has been processed, the insurance company will send a claim statement to you by mail or electronically (whichever you have elected). You should receive settlement of your claim by cheque or direct deposit within three weeks from the date of submission to the insurance company.

Subrogation (Third Party Liability)

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

Keeping in Touch

Worker Benefit Plans is responsible for submitting premiums to the insurance company and keeping all records up to date. Please ensure you advise of any changes in your life such as an address change or a change in your dependent status so that your records are kept current. See the following paragraph on information on contacting us.

Additional Information and Assistance

If you have questions on your health and dental coverage, contact Manulife at 1-800-268-6195 (Toll Free) or

"Send a Note" on their website www.Manulife.ca/PlanMembers. If you are unable to obtain a satisfactory answer to your questions, please contact Worker Benefit Plans c/o Ellement at:

- Phone: **:** 1-844-440-1045 (Toll Free)
- Fax: 1-204-954-7310
- E-mail: LCCBenefits@ellement.ca
  Website : www.lccbenefits.ca
- Mailing Address**:**
  Worker Benefit Plans
  c/o Ellement
  503-1780 Wellington Ave.
  Winnipeg, MB R3H 1B3

RETIREE EXTENDED HEALTH CARE

INTRODUCTION

The Retiree Extended Health Care is designed to **assist** you in helping to pay for the **reasonable and customary costs** associated with **medically necessary** health related expenses for yourself and your family. The Extended Health Care benefits may not, however, cover all expenses or all services. The insurance company may require additional proof that a certain expense is medically necessary for coverage and coverage may be limited. Generally, coverage is only provided when services and supplies are not covered under existing government plans in your province of residence and are not prohibited from payment by the applicable government plans. There is an overall lifetime maximum of **$50,000** per person on the plan. Individual maximums may also apply to certain covered expenses. Claim amounts that will be applied to any maximums are the amounts paid after applying the deductible and/or the benefit percentage. **You are responsible for determining what is covered before proceeding with treatment**.

Summary of Coverage

Covered Expenses	
Plan Maximum	**$50,000 per person per lifetime**
Annual Deductibles	**Single - $25; Family - $50**
Prescription Drugs - Least-cost alternative - Pay-direct drug card - Certain limits may apply	**80%**
Vision Care -Eye exams - once per two calendar years for adults and once per calendar year for children -Glasses - $ 150 every 24 months	**80%**
Professional Services - Paramedical Practitioners - $500 per year per practitioner - Certain limits may apply	**80%**
Medical Services and Supplies -Ambulance Services -Home Nursing Services -Hearing Aids - $ 300 every 4 years	**80 %**
Emergency Out-of-Province/Country Coverage Physician and Hospital Benefits/ Emergency Travel Assistance	**100 % - Limited to overall plan maximum**

Enrollment

You must elect your coverage level prior to retirement.

Contract Maximum

The maximum benefit payable under this plan is $50,000 per person per lifetime for all Extended Health claims including any Out-of-Province/Out-of-Canada claims.

Deductible

You will be reimbursed for eligible expenses after the following annual deductibles have been met:

- Single - $25
- Family - $50

Expenses used to satisfy a deductible in the last three months of a calendar year may also be used to satisfy the deductible in the following calendar year.

Deductibles are reviewed annually and may increase in accordance with increases in cost of the Extended Health Care Plan.

Covered Expenses

The Extended Health Plan is designed to assist retirees in meeting the reasonable and customary costs associated with certain medically necessary expenses. The insurance company may require additional proof that a particular expense meets these criteria for coverage and reimbursement may be limited. Payment of any covered expenses which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

Prescription Drug Benefits

You may continue to use your Benefit Card issued to you as an active employee to pay for your prescription drugs. The card provides your pharmacist with immediate confirmation of covered drug expenses. You pay the portion of the cost not reimbursed by the plan and the insurance company will pay the balance to the pharmacy directly. If you are unable to use your card, pay for your drugs directly and submit a claim to the insurance carrier (see the previous section of this booklet under "Claiming Health and Dental Benefits"). Be sure to keep your drug receipts in case you need them for income tax purposes or for coordination of benefits with a spouse's plan.

Prescription drugs are reimbursed at 80%, subject to the following:

- The maximum dispensing fee paid per prescription is $7.00. (The total cost of a drug is comprised of both the cost of the drug and the dispensing fee amount the pharmacist's charges for distributing the drug and for other professional services such as counseling and advice. Note there can be wide variation in the dispensing fee charged by different pharmacies.)
- The drug must be prescribed by a licensed physician or dentist and dispensed by a licensed pharmacist. Certain drugs prescribed by other qualified health care professionals, who are permitted by provincial law to prescribe such drugs, will be covered as if a physician or dentist had prescribed the drug; and
- The plan will pay based on the least cost alternative drug where interchangeable drugs can be used to fill prescriptions Least cost alternatives drugs are the lowest cost product within a set of interchangeable products. They are typically generic equivalent drugs (generic equivalent drugs are copies of brand name drugs), however, sometimes a brand name drug can be priced lower than a generic drug. A generic drug provides the same active ingredient in the same amount as their brand name counterparts and is as effective as a brand name drug. However the filler, the colour or the shape of a generic drug may be different from the brand name drug. If you have a medical condition that necessitates you taking a brand name drug rather than a generic drug you will need to submit medical documentation to the insurance company outlining this requirement in order to receive reimbursement of your claim based on the cost of the brand name drug rather than the cost of the generic alternative. Medical documentation may be a letter from your physician or a copy of your prescription where your physician has indicated "no substitution" in his or her handwriting.

The plan will pay for the following drugs:

- Drugs that legally require a prescription - Coverage may be restricted or excluded for some drugs. For example:
    - Coverage for smoking cessation drugs are limited to a lifetime maximum of $300 per person.
    - Fertility drugs are limited to $15,000 per lifetime.
- The maximum quantity of drugs or medicines that will be payable for each prescription is limited to a 34 day supply. A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.
- Drugs and supplies available without a prescription which are required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, Parkinsonism or heart disease.
- Life sustaining drugs
- Oral contraceptives, intrauterine devices and diaphragms
- Preventive vaccines and medicines (oral or injected). (The administration of injectable medications is not covered).
- Diabetic supplies including syringes, needles and glucose test strips but excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment.

Note: If your Provincial Health Insurance Plan includes a Pharmacare Plan, you must provide Manulife with proof that you have registered with that plan. Otherwise, you may not be eligible for the maximum coverage provided under your Retiree Extended Health Plan.

Drug Benefit for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance legislation (An Act Respecting Prescription Drug Insurance and Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit For Persons Who Reside In Quebec, will apply to your drug benefit. (Further information is provided in Appendix B at the end of this booklet).

Vision Care

You will receive 80% reimbursement for the following:

- Eye exams, once per 2 calendar years for you and your spouse and once per calendar year for your dependent children.

- Purchase and fitting of prescription glasses or contact lenses, as well as repairs, or laser vision correction procedures, to a maximum of $150 per 24 months.

- If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per 24 months.

- Visual training, to a maximum of $200 per lifetime.

Professional Services

You will receive 80% reimbursement for the following services provided by licensed, certified and registered paramedical practitioners, up to $500 per year per practitioner:

- Acupuncturist
- Chiropractor (in addition one x-ray per calendar year to a maximum of $25 is covered)
- Massage Therapist
- Naturopath
- Osteopath (in addition one x-ray per calendar year to a maximum of $25 is covered).
- Physiotherapist
- Podiatrist/Chiropodist (Including up to $100 for the surgical removal of toenails or the excision of plantar warts)
- Psychologist
- Speech Therapist

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

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

You receive 80% reimbursement of the cost of the following services and supplies subject to specified maximums:

- ***Accidental Dental Care –*** charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing.

- ***Ambulance services –*** charges for licensed ambulance services provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available.

- ***Diabetic equipment and supplies –*** charges for insulin pumps, up to $ 5,000 per calendar year and insulin pump supplies to a maximum of $2,000 per calendar year.

- ***Home Nursing Services*** – To a maximum amount payable of $10,000 per person per calendar year. Covers services of a Registered Nurse or a Registered Nursing Assistant (or equivalent designation), provided the individual is not related to the patient and does not reside in the patient's home and does not include custodial care or homemaking duties. Services which can be performed by a person of lesser qualifications, a relative, friend, or a member of the patient's household are excluded. The insurer recommends that a detailed treatment plan be submitted with cost estimates before services begin so that they can advise you of the benefits that will be covered. Note: this benefit does not cover nursing services provided in a hospital.

- ***Hearing Aids –*** charges for the cost, repair and maintenance of hearing aids to a maximum of $300 every four calendar years.

- ***Ileostomy, colostomy and incontinence supplies.***

- ***Medical Equipment –*** charges for the rental or, when approved by the insurance carrier, the purchase of crutches, canes, walkers, wheelchairs, manual hospital beds, respiratory and oxygen equipment and other durable equipment found only in hospitals. In addition, charges for trusses, braces (other than foot braces), external prostheses, collars, leg orthosis, casts and splints.

- ***Orthopaedic shoes/orthotics –*** reasonable and customary charges incurred on the written order of a physician or podiatrist for stock-item orthopaedic shoes which are attached to or form part of a brace. If not part

of a brace, eligible expenses will be restricted to 2 pairs per calendar year to the greater of the actual cost of the adjustment or 50% of the total cost of the shoes. Casted, custom-made orthotics are also covered.

- ***Medicated dressings and burn garments***
- ***Oxygen***
- ***Surgical stockings and brassieres*** – up to a maximum of four pairs of stockings and four brassieres per calendar year.
- ***Wigs and hairpieces –*** for patients with temporary hair loss as a result of medical treatment, up to a maximum of $250 per lifetime.

Out-of-Province/Out-of-Canada Coverage

While the Extended Health plan does provide emergency out of province/country coverage, it is included in the lifetime maximum of $ 50,000 per person. This coverage may be insufficient for many travel destinations and we recommend you consider purchasing additional travel coverage. *(If a plan member purchases an individual travel plan, the first insurance company contacted is deemed to be the first payer and will generally ask the plan member if there is additional coverage. First contact to the other insurance is recommended in order to preserve the $50,000 overall lifetime medical coverage.)*

The plan provides 100% coverage for reasonable and customary hospital, and medical expenses for **emergency** treatment required outside your home province or outside Canada over and above the benefits payable by Provincial Medicare, to the plan's **overall lifetime maximum**, provided the emergency occurs within the first 31 days while temporarily outside your province of residence and you or your covered dependent are covered by the Provincial Medicare Plan during the absence.

A medical emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while you or your covered dependents are travelling outside your home province and requires immediate medical attention. The emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the insured person is stable enough to return to his province of residence.

Charges for the following are payable under this expense:

- Physician's services
- Hospital room and board at standard ward rates
- Hospital charges for out-patient treatment
- Licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- Medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

Expenses not Covered

The Retiree Extended Health Care Plan does not cover the following expenses:

- Services or supplies not specified as a covered expense
- Services or supplies where reimbursement would have been made under a government sponsored plan, in the absence of insurance
- Charges that are considered an insured service under your Provincial Health Insurance Plan
- Charges resulting from an occupational injury or disease covered by any Workers' Compensation law
- Services or supplies due to bodily injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot
- Services or supplies resulting from any intentionally self-inflicted injury or illness, while sane or insane
- Charges for periodic health examinations, broken appointments, examinations required for use of a third party, travel for health, or completion of claim forms
- Charges for services and supplies incurred while in relation to the committing of a criminal offence or assault

- Injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol or if the person's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury

- Services and supplies which are required for recreation or sports but are not medically necessary for regular activities

- Services or supplies which are performed by the insured person , an immediate family member or a person who lives with the insured person

- Services or supplies which are provided while confined in a hospital on an in-patient basis

- Room, board, and nursing care in a nursing home

- Referral treatment outside Canada (whether in or out of hospital)

- Semi-private or private hospital accommodation, whether inside or outside Canada

- Surgical procedures or treatments performed primarily for cosmetic reasons

- Charges that would not normally have been incurred but for the presence of this coverage, or for which you or your dependent is not legally obligated to pay

- Drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

- Medical treatment which is not usual and customary or which is experimental or investigational in nature or not approved by the Provincial Medical Association or the appropriate medical specialty society

- Charges that the insurer is not permitted, by any law or regulation, to cover

Emergency Travel Assistance (ETA)

ETA is a travel assistance program that provides assistance to you and your covered dependents in the event of a medical emergency while traveling outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a medical emergency during the first 31 days while travelling outside your province of residence.

ETA will pay for expenses in excess of **$200,** provided they are contacted before any expenses are incurred. If ETA is not contacted, or if expenses are $200 or less, you are responsible for payment and may submit a claim for reimbursement. Any claims for out-of-province expenses should be submitted first to your Provincial Health Insurance Plan. You may then submit a claim to the insurance company for any allowable expenses not covered by your Provincial Health Insurance Plan. Be sure to include the explanation of benefits (EOB) from the provincial plan.

What is a Medical Emergency?

A Medical Emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while an insured person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the insured person is stable enough to return to his province of residence.

24-Hour Access

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), or fax.

Medical Referral

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of insurance coverage, is provided.

Claims Payment Service

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the insured person.

Payment and co-ordination of expenses will take into account the insurance that the insured person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the insured person is entitled, the insurance company shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

Medical Care Monitoring

Medical care and services rendered to the insured person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the insured person, the attending physician, the insured person's personal physician and family.

Medical Transportation

If medically necessary, arrangements will be made to transfer an insured person to and from the nearest medical facility or to a medical facility in the insured person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Ambulance. If medically necessary for a qualified medical attendant to accompany the insured person, expenses incurred for round-trip transportation will be paid.

Return of Dependent Children

If dependent children are left unattended due to the hospitalization of an insured person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

Trip Interruption/Delay

If a trip is interrupted or delayed due to an illness or injury of an insured person, one-way economy transportation will be arranged to enable each insured person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the insured person, and whose fare for transportation and accommodation was pre-paid at the same time as the insured person's fare.

If the insured person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

After Hospital Convalescence

If an insured person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the established maximum.

Visit of Family Member

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit an insured person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance.

Vehicle Return

If an insured person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the insured person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

Identification of Deceased

If an insured person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

Meals and Accommodation

Under certain circumstances, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Return of Deceased to Province of Residence

In the event of the death of an insured person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

Lost Document and Ticket Replacement

Assistance in contacting the local authorities is provided, to help an insured person in replacing lost or stolen passports, visas, tickets or other travel documents.

Legal Referral

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the insured person's credit cards, family or friends, is provided.

Interpretation Service

Telephone interpretation service in most major languages is provided.

Message Service

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

Pre-trip Assistance Service

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the insured person plans to travel.

Exceptions

Manulife Financial, and the company contracted by Manulife Financial to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of an insured person to obtain medical treatment or emergency assistance services for any reason.

No benefit is payable for any expense related to war or hostile action by any armed forces. Before you travel, you may wish to check the Department of Foreign Affairs and International Trade website (www.voyage.gc.ca) for any travel advisories. If in doubt as to whether you will be covered in the country you are visiting, check with Manulife before you start your trip (information on contacting Manulife is available on your Benefits Card).

Your Benefits Card

Your Benefits card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your card also lists your I.D. number and plan document number, which the travel assistance organization needs to confirm that you are covered.

In an emergency contact:

In Canada and United States the phone number is:	1-800-265-9977
Fax number:	1-800-583-4827
From other countries, call collect:	1-519-741-8450

For more information about ETA, refer to Manulife's Emergency Travel Assistance brochure.

Dental Benefits

INTRODUCTION

Dental benefits are designed to assist you in helping to pay for dental related expenses for yourself and your family. Dental benefits may not, however, cover all expenses or all services. Payment of covered expenses are paid based on reasonable customary charges and are subject to any applicable maximums. Claim amounts that will be applied to any maximums are the amounts paid after applying the benefit percentage. **You are responsible for determining what is covered before proceeding with treatment.** Your dentist and the insurance carrier can assist you in determining your coverage.

Summary of Coverage

Covered Expense	Description	Coverage
Basic Services	• **diagnostic and preventive services such as recall examination, cleanings and bite-wing x-rays once every 9 months** • **basic restorative services such as fillings** • **extractions, denture relines and rebases** • **periodontics (treatment of the gums)** • **endodontics (root canal therapy)**	**90%**
Dentures and Major Restorative Services	• **initial and replacement dentures (certain restrictions apply)** • **crowns, bridges, inlays, and onlays (certain restrictions apply)**	**60%**
Combined Maximum Dentures and Major Restorative		**$ 2,500 per person per lifetime**

Fee Guide

Reimbursement under the dental plans is based on the current fee guide for General Practitioners for your province of residence.

The Alberta Dental Association does not publish a fee guide in Alberta. Instead, the insurer compiles a reimbursement schedule of standard reimbursement rates for different procedures. Their fee guide is reviewed each year and the dental fees adjusted based on:

- Inflationary increases so that procedures are paid based on the 70th percentile. This means 70% of claims by Alberta dentists are billed at or below this level
- Recent claims data from all Manulife groups that have dental coverage in Alberta

Reimbursement under the Workers Benefit Plans (WBP) is paid up to the rates established for general practitioners.

Pre- Determination of Benefits

In cases where dental treatment is likely to be costly, ask your dentist to complete a pre-treatment assessment form before treatment begins. Submission of the pre-treatment form identifies any costs not paid by the plan which would subsequently be your responsibility.

Covered Expenses

The following necessary dental expenses are covered up to the amounts specified in the applicable provincial Dental Fee Guide, or reasonable and customary charges, if the expenses are not listed in the Dental Fee Guide. Note, where any two or more courses of treatment would produce professionally adequate results, benefits will be paid based on the least expensive course of treatment consistent with good dental care. Coverage provided under the dental plan does not reflect the appropriateness of any course of treatment. You must decide this in consultation with your dentist.

Coverage limitations apply for certain services. Limitations may be based on the age of the patient or the number and frequency of treatments for which reimbursement will be made. Treatment must be performed by a dentist, dental hygienist or denturist who is practicing within the scope of his or her license.

Basic Services

The Dental Plan pays 90% of the following basic services:

- Recall exams, bitewing x-rays and fluoride treatments once every 9 months (full month x-ray and complete oral exam every 2 calendar years)
- One unit of light scaling and one unit of polishing once every 9 months
- Routine diagnostic and laboratory procedures
- Initial oral hygiene instruction, plus one recall
- 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 for missing primary teeth and habit breaking appliances
- Minor surgical procedures and post surgical care
- Extractions (including impacted and residual roots)
- Consultations, anaesthesia, and conscious sedation
- Denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- Injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- Periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including scaling and root planning, up to a combined maximum of 8 units per calendar year, provisional splinting,- occlusal equilibration, up to a maximum of 4 units per calendar year
- Endodontic services for treatment of the dental pulp which includes root canals and therapy and root amputation. 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

Dentures and Major Restorative Services

The Dental Plan pays 60% of the following denture and major restorative services up to the lifetime maximum of $ 2500 per person:

- Initial provision of full or partial removable dentures
- Initial provision of fixed bridgework
- Replacement of removable dentures or replacement of bridgework, provided the dentures or new bridgework are required because a natural tooth is extracted and the existing appliance cannot be made serviceable or the existing appliance is at least 60 months 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
- 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

Work In Progress When Coverage Terminates

Expenses related to dental treatment in progress at the time your dental coverage terminates will be paid provided the expense is incurred within 31 days after benefits terminate.

Expenses Not Covered

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

- Orthodontic treatment
- Services or supplies which are not specified as a covered expense
- Services which are payable by any government plan

- Broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms

- Dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit

- Services or supplies for which no charge would normally be made in the absence of insurance

- 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

- Anti-snoring or sleep apnea devices

- Treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction

- Replacement of removable dental appliances which have been lost, mislaid or stolen

- Laboratory fees which exceed reasonable and customary charges

- Services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person

- Implants, or any services rendered in conjunction with implants

- Treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition

DEATH BENEFIT

INTRODUCTION

The retiree death benefit pays a lump sum to your beneficiary in the event of your death. This benefit is provided and administered by Lutheran Church Canada.

Summary of Coverage

10 years of service in the Lutheran Church-Canada Pension Plan*	$ 3,000 payable in the event of your death.
10 years of participation in the Dependent Life Insurance	$ 3,000 payable in the event of your spouse's death
Less than 10 years of service/participation at retirement	**Amount Payable**
9 years	$ 2,700
8 years	$ 2,400
7 years	$ 2,100
6 years	$ 1,800
5 years	$ 1,500
4 years	$ 1,200
3 years	$ 1,900
2 years	$ 1,600
1 year	$ 1,300

***Note: The death benefit for plan members who were solely in the Pension Plan for Pastors and Teachers of the Lutheran Church – Missouri Synod is $500.**

Death Benefit - Member

Upon your death, after retirement, your surviving spouse or your estate will receive a $3,000 lump sum member's death benefit provided that you had 10 years of Credited Service in the Lutheran Church-Canada Pension Plan prior to retirement. Otherwise, the benefit amount will be reduced by $300 for each year less than 10 years.

Death Benefit - Spouse

After retirement, if you survive your spouse, you will receive a lump sum death benefit of $3,000 upon his /her death, provided that your spouse had been enrolled for Dependent Life insurance coverage for 10 years prior to your retirement. Otherwise, the benefit amount available will be reduced by $300 for each year less than 10 years. If you do not survive your spouse, the spouse's death benefit will be payable to his/her estate.

Claiming for Benefits

Notice and proof of death are to be provided as soon as possible. You or your beneficiary should contact Worker Benefit Plans for assistance in making a claim.

Benefits payable under this plan are not taxable.

Appendix A

Monthly Retiree Benefit Premiums
Effective January 1, 2017

WBP shares the cost of the benefits programs with you. Your cost depends on your service and points (age and service) you had at the time you retired.
Typically premiums are deducted from your pension benefits paid by the pension custodian (CIBC Mellon); otherwise, you will be required to have your premiums debited from your bank account.

Premiums for the programs will typically change annually.

Completed Years of Credited Service	% of Total Premium Payable	Monthly Cost to Member	
		Single	Family
2	100%	134.50	277.37
3	100%	134.50	277.37
4	100%	134.50	277.37
5	100%	134.50	277.37
6	100%	134.50	277.37
7	100%	134.50	277.37
8	95%	127.78	263.50
9	90%	121.05	249.63
10	85%	114.33	235.76
11	75%	100.88	208.03
12	65%	87.43	180.29
13	60%	80.70	166.42
14	55%	73.98	152.55
15 or more	45%	60.53	124.82

LCC Monthly Premium Cost is: Single - $134.50; Family - $277.37

Appendix B

Drug Benefit for Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

- Drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and

- Drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

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

Benefit Percentage

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

- For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by applicable Legislation

- For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:

  ° the benefit percentage stated under the plan; and

  ° the percentage as set out by applicable Legislation.

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

Annual Out-of-Pocket Maximum

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

- Deductible amounts, and
- The portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is as stipulated in Legislation and includes those portions of covered drug expenses paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses paid for your dependent children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

Deductible

Deductible amounts for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

Lifetime Maximums

Lifetime maximums for the drug benefit will not apply. Drug coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

- Only drugs that are on the RAMQ List are covered, and
- The percentage payable by the Administrator for covered expenses is the percentage as set out by applicable Legislation.

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

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

POST RETIREMENT BENEFITS (PRB'S) FOR ELIGIBLE RETIREES UNDER LUTHERAN CHURCH CANADA'S (LCC) WORKER BENEFIT PLANS

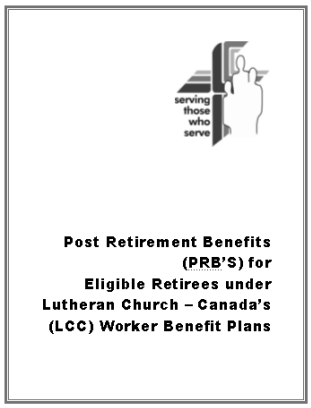
Correction to your
Post Retirement Benefits Handbook
LCC Worker Benefit Plans

Original Handbook October 2010
Revision One – February 2011 page 27&28
Revision Two – September 2011 page 35&36
Revision Three – February 2012 page 3&4 (not sent)
Revision Four – October 2012 page 3&4 and page 35&36
Revision Five – January 2013 page 3 & 6 (not sent)
Revision Six – October 2013 page 4, 11 & 35 (not sent)
Revision Seven – October 2014 page 4,35 (not sent)
Revision eight – December 2015 pages 3,4,11,33 &35
Revision nine – November 2016 pages 4,35

This revision November 2016 – Update Highlights:

1. Percentage changes in table to new rates for January 1, 2017.
2. Replaced premium rates effective January 1, 2017.

Filing Instructions



This change was made to the Post Retirement Benefit Handbook (as pictured on the left) according to the instructions given below:

Remove	Add
Page 3,4, 11,33.35	Page 3, 4, 11, 33,35