College of New Caledonia

CNC

Welcome to the **Administrative Staff**

Benefits Booklet

Full-time & Part-time Employees

The information in this document was last reviewed on July 15, 2024

Prince George Campus
3330-22nd Avenue,
Prince George,
BC, V2N 1P8
T 1 250 562 2131

Lakes District Campus
545 Highway 16 West
Burns Lake,
BC, V0J 1E0
T 1 250 692 1700

Fort St. James Campus
179 Douglas St
Fort St. James,
BC, V0J 1P0
T 1 250 996 7019

Mackenzie Campus
540 Mackenzie Blvd.
Mackenzie,
BC, V0J 2C0
T 1 250 997 72009

Quesnel Campus
100 Campus Way
Quesnel,
BC, V2J 7K1
T 1 250 991 7500

Vanderhoof Campus
3231 Hospital Rd.
Vanderhoof,
BC, V0J 3A2
T 1 250 567 3200

College of New Caledonia

Plan Document Number: G0083709, G0083710

Group Policy Number: G0039949

Plans: A - Full-time Administration Staff earning less than $84,000 per year
B - Full-time Administration Staff earning $84,000 or more per year

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: October 1, 2009

Group Policy Effective Date: October 1, 2009

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

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

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

Table of Contents

Benefit Summary **3**

How to Use Your Benefit Booklet **9**

Explanation of Commonly Used Terms **11**

Why Group Benefits? **14**
- Applying for Group Benefits 15
- Making Changes 15

The Claims Process **16**
- Naming a Beneficiary 16
- How to Submit a Claim 16
- Co-ordination of Extended Health Care and Dental Care Benefits 16

Who Qualifies for Coverage? **19**
- Eligibility 19
- Medical Evidence 19
- Late Application 19
- Late Dental Application 20
- Effective Date of Coverage 20
- Termination of Coverage 20

Your Group Benefits **21**
- Employee Life Insurance 21
- Employee Optional Life Insurance 23
- Spousal Optional Life Insurance 24
- Accidental Death and Dismemberment 25
- Extended Health Care 31
- Medical Travel Referral Benefit (MTB) 44
- Dental Care 47
- Health Care Spending Account 52
- Survivor Extended Benefit 52
- Long Term Disability 52

Notes **59**

This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

Benefit Amount

For Plan A - 3 times your annual earnings, to a maximum of $500,000

For Plan B - 3 times your annual earnings, to a maximum of $700,000

Benefit Reduction - your benefit amount reduces by 50% at age 65

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

Benefit Amount - increments of $10,000 to a maximum of $250,000

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Spousal Optional Life Insurance

The Spousal Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $250,000

Termination Age - employee's or spouse's age 70, or employee's retirement, whichever is earlier.

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0039949.

Benefit Amount

For Plan A - 3 times your annual earnings, to a maximum of $500,000

For Plan B - 3 times your annual earnings, to a maximum of $700,000

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $25 Individual, $25 Family, per calendar year(s)

Not applicable to:
Vision (Eye Exams)

Benefit Percentage (Co-insurance)

100% for
Vision (Eye Exams)

95% of the first $1,000 of paid expenses and 100% thereafter for
Hospital Care
Drugs
Vision (other than Eye Exams)
Professional Services
Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

Termination Age - employee's retirement

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- B12 injections (excluding injections that relate to weight loss)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- fertility drugs
- oral drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Anti-smoking drugs - $500 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

Benefit Summary

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, $125 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a combined maximum of $400 per 12 consecutive months for persons under age 18 and $650 per 24 consecutive months for persons age 18 and over

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $400 per calendar year
- Podiatrist/Chiropodist - $400 per calendar year
- Massage Therapist - $500 per calendar year
- Naturopath - $400 per calendar year
- Speech Therapist - $500 per calendar year
- Physiotherapist - $500 per calendar year
- Mental Health Practitioners* - $2,000 per calendar year
- Acupuncturist - $500 per calendar year

*Mental Health Practitioners include Psychologists, Clinical Counsellor and Psychiatrist only

Medical Travel Referral (MTB)

The Benefit

Overall Benefit Maximum - $10,000 per person per calendar year

Deductible - Nil

Benefit Percentage (Co-insurance) - 100%

Benefit Amount - $125 per day, to a maximum of 50 days in any calendar year for all eligible meal and accommodation expenses combined. However, where eligible expenses exceed $125 per day, but do not exceed the average of $125 per day for the year, the average will be paid

Termination Age - employee's retirement

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current British Columbia Dental Association Approved Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

80% for Level III - Dentures

80% for Level IV - Major Restorative Services

60% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I, Level II, Level III and Level IV

$3,000 per lifetime for Level V

Termination Age - employee's retirement

Long Term Disability

The Long Term Disability Benefit is insured under Manulife Financial's Policy G0039949.

Benefit Amount

For Plan A - 60% of monthly earnings, to a maximum of $5,000 and a minimum benefit, after reductions, of $100 or 10% of the benefit amount, whichever is greater

For Plan B - 50% of monthly earnings, to a maximum of $12,000 and a minimum benefit, after reductions, of $100 or 10% of the benefit amount, whichever is greater

Qualifying Period

For Plan A - 120 days

For Plan B - the lesser of 120 days or 90 days if the sick leave credits have been used

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Designed with Your Needs in Mind

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

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits,
- information you need, and simple instructions, on how to submit a claim.

Important Note

This information has been prepared to help you towards a better understanding of your Group Benefits coverage. It does not create or confer any contractual or other rights. The terms and conditions governing the coverage are set out in your collective agreement and the Group Policy/ies and Plan Document(s) issued by The Manufacturers Life Insurance Company. In the event of any variation between the information provided in this booklet and the provisions of the collective agreement or Group Policy/ies and Plan Document(s), the provisions of the collective agreement or Group Policy/ies and Plan Document(s) shall prevail, in that order.

Your employer reserves the right to amend or discontinue any of the benefit programs referred to in this booklet at any time without notice, subject only to the terms of the collective bargaining agreement. If government legislation changes or if benefits or subsidies under government benefit plans are reduced or eliminated, your benefit programs do not automatically replace or supplement such reductions or eliminations. Your employer takes no responsibility for any changes in federal or provincial income or other taxes or levies or the impact of these changes on the taxation of any of the benefit programs. This booklet describes benefit programs for active employees and does not describe any retiree or post-employment benefit programs.

Copyright: The information in this booklet, along with the manner of presentation, is copyrighted by Manulife Financial. Any unauthorized reproduction, duplication or re-distribution in any form is expressly prohibited.

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

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

- the Group Policy and/or Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

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

How to Use Your Benefit Booklet

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

Your Group Benefit Card

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

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

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

Explanation of Commonly Used Terms

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

Adherence

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

Administrator

Manulife Financial

Advisory Body

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

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the administrator, acting on behalf of your employer.

Covered Expenses

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

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by the administrator, acting on behalf of your employer.

Dependent

your Spouse or Child who, for Extended Health Care benefits only, is covered under the Provincial Plan.

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner prior to the date that a claim arose.

- Child

- 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 coverage 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 covered under this Benefit Program immediately prior to that date.

  A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical handicap.

  The administrator, acting on behalf of your employer, 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

Disease Management Programs

an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

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

Earnings

your normal earnings, and shall not include bonus, overtime, incentive pay and automobile allowance

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

- the amount reported on your claim form, or

- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

not approved as an effective, appropriate and essential treatment of an illness or injury.

Immediate Family Member

for Accidental Death and Dismemberment Benefit, a person who is at least 18 years of age who is your son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the above include natural, adopted or step relationships), spouse, grandson, granddaughter, grandmother or grandfather.

for Extended Health Care, Medical Travel Referral and Dental Care Benefits, you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Interchangeable Drug

includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;

- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

if two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Plan Document.

Non-Evidence Limit

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

Patient Assistance Program

a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Explanation of Commonly Used Terms

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Prior Authorization

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

Provincial Plan

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

Qualifying Period

a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

Take Home Pay (Net Earnings)

your earnings, less deductions normally made for federal and provincial income tax.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

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

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

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

Your Employer's Representative

Your employer is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer with the necessary information to perform such duties.

Your Employer's representative is _____

Phone Number: _____

Please record the name of your representative and the contact number in the space provided.

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your employer. Your employer then forwards the application to Manulife Financial.

Making Changes

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

- change in Dependent Coverage
- change in Beneficiary
- applying for coverage previously waived
- change in Name

The Claims Process

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance, Employee Optional Life Insurance, and Accidental Death and Dismemberment

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

How to Submit a Claim

All claim forms, available from the Group Benefits Secure Site - www.manulife.ca/groupbenefits, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number, Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Your employer can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

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

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your employer will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact your employer.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

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

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (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 an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

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

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

  - 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 birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

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

    - The Plan of the parent with custody of the child, then
    - The Plan of the spouse of the parent with custody of the child (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 birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

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

- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

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

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

- Submit all necessary claim forms and original receipts to the Primary Carrier.

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

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

Eligibility

You are eligible for Group Benefits if you:

- are a permanent, full-time administrative employee of College of New Caledonia and work at least the Required Number of Hours
- are a member of an eligible class,
- are younger than the Termination Age,
- for Extended Health Care and MTB benefits, are covered under the Provincial plan, and
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Required Number of Hours

Full-time employee - 17.50 hour(s) per week

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan, or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your employer. Further medical evidence may be requested by Manulife Financial.

Who Qualifies for Coverage?

Late Dental Application

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to $300 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.

- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

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

Your dependent’s coverage will not be effective prior to the date your coverage becomes effective. This does not apply to Spousal Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee

- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date

- the date your employer terminates coverage

- the date you enter the armed forces of any country on a full-time basis

- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates

- the date you reach the Termination Age

- the date of your death

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

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

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

The Benefit

Benefit Amount

For Plan A - 3 times your annual earnings, to a maximum of $500,000

For Plan B - 3 times your annual earnings, to a maximum of $700,000

Non-Evidence Limit

Plan A - $500,000

Plan B - $700,000

Qualifying Period for Waiver of Premium

For Plan A - 120 days

For Plan B - the greater of 90 calendar days or the expiration of sick leave credits, not exceeding 120 calendar days

Benefit Reduction - your benefit amount reduces by 50% at age 65

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Waiting Period - None

Naming a Beneficiary

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

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

Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 180 days from the end of the Qualifying Period.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing any and every duty of:

- your own occupation, during the Qualifying Period and the 24 months immediately following the Qualifying Period

- any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 14 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing any and every duty of:

  - your own occupation, during the Qualifying Period and the following 24 months, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above

- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit

- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following 24 months, and

- any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above

- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial
- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date of your death
- the date of your 65th birthday

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife Financial will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

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

The Benefit

Benefit Amount - increments of $10,000 to a maximum of $250,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability

Qualifying Period for Waiver of Premium

For Plan A - 120 days

For Plan B - the greater of 90 calendar days or the expiration of sick leave credits, not exceeding 120 calendar days

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Waiting Period - none

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Spousal Optional Life Insurance

The Spousal Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039949.

If your Spouse dies while insured, the amount of this benefit will be paid to you.

The Benefit

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $250,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability.

Qualifying Period for Waiver of Premium:

For Plan A - 120 days

For Plan B - the greater of 90 calendar days or the expiration of sick leave credits, not exceeding 120 calendar days

Termination Age - employee’s or spouse’s age 70, or employee’s retirement, whichever is earlier

Waiting Period - none

To apply for Spousal Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

Submitting a Claim

To submit a Spousal Optional Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Please refer to Employee Life Insurance for details on the Waiver of Premium provision.

Exception

If you are not insured for Employee Optional Life, the Waiver of Premium provision will not apply to your spouse's Optional Life Insurance, unless:

- at the time you applied for Spousal Optional Life Insurance on your spouse, you also provided Manulife Financial with evidence of insurability for yourself, and
- Manulife Financial approved your evidence of insurability

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Exclusions

If death results from suicide any amount of Spousal Optional Life Insurance that has been in effect for less than one year will not be payable.

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0039949.

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

Aggregate Limit - $5,000,000

Benefit Amount

For Plan A - 3 times your annual earnings, to a maximum of $500,000

For Plan B - 3 times your annual earnings, to a maximum of $700,000

Qualifying Period for Waiver of Premium

For Plan A - 120 days

For Plan B - the greater of 90 calendar days or the expiration of sick leave credits, not exceeding 120 calendar days

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier.

Waiting Period - none

Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 75%
- Loss of Sight of One Eye - 75%
- Loss of Speech or Hearing in Both Ears - 75%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%

- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Aggregate Limit

In no event will the amount paid for total lives exceed $5,000,000.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife Financial will pay incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $15,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

If you die as a direct result of an accidental injury which occurs while travelling, Manulife Financial will pay for expenses incurred for the preparation and transportation of your body to your place of residence.

The amount payable is subject to a maximum of $15,000.

Family Transportation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and are confined to a hospital located 150 kilometres from your place of residence, Manulife Financial will pay the hotel and travel expenses incurred by an immediate family member, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- for hotel accommodations in the vicinity of the hospital
- for transportation by the most direct route to the hospital, including return fare

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of $0.20 per kilometre travelled.

The amount payable is subject to a maximum of $10,000 per accident.

Dependent Education Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay the tuition for each child who is enrolled as a full-time student:

- in a school for higher learning above the secondary school level, or
- at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionel (CEGEP), community college or trade school.

The maximum payable each year for each child is the lesser of:

- 5% of your Accidental Death and Dismemberment benefit amount, or
- $5,000

The benefit is payable for up to a maximum of 4 years. If there are no children, an additional $2,500 will be paid to your designated beneficiary.

No payment will be made for:

- tuition expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Manulife Financial will pay for expenses incurred by your spouse, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Seat Belt Benefit

If you die as a direct result of an accidental injury sustained while driving or riding in an automobile, Manulife Financial will pay an additional amount equal to 10% of your Accidental Death and Dismemberment benefit, provided you were wearing your seat belt and it was properly fastened at the time of the accidental injury.

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay day-care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 12 months from the date of your death.

The maximum payable each year for each child is the lesser of:

- 5% of your Accidental Death and Dismemberment benefit amount, or
- $10,000

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, you:

- suffer a loss of, or loss of use of, both feet or both legs, or
- become a hemiplegic, paraplegic, or quadriplegic

and require the use of a wheelchair to be ambulatory, Manulife Financial will pay for incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within 3 years from the date of the accidental injury
- for alterations to your home for the purpose of making it wheelchair accessible
- for modifications to one motor vehicle for the purpose of making it wheelchair accessible

The amount payable is subject to a maximum of $10,000.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

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

If you have not appointed a beneficiary under this policy, but you had appointed a beneficiary under a prior policy where you were covered prior to becoming covered under this policy, then the most recently appointed beneficiary under that prior policy is considered your beneficiary under this policy.

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

Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form.

Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Exclusions

No Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer

Extended Health Care

Your Extended Health Care Benefit is provided directly by College of New Caledonia. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance 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.

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

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act And Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your drug benefit.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $25 Individual, $25 Family, per calendar year(s)

Not applicable to:
Vision (Eye Exams)

- Deductible Carry-Forward

Covered Expenses used to satisfy the deductible in the last 3 months of the calendar year may also be used to satisfy the deductible in the following calendar year.

Benefit Percentage (Co-insurance)

100% for
Vision (Eye Exams)

95% of the first $1,000 of paid expenses and 100% thereafter for
Hospital Care
Drugs
Vision (other than Eye Exams)
Professional Services
Medical Services and Supplies

Note:
The Benefit Percentage for Out-of-Province/Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

Termination Age - employee’s retirement

Waiting Period - none

Covered Expenses

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

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

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

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

At Manulife Financial's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the drug, service or supply.

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

Adherence

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

Patient Assistance Programs

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

Disease Management Programs

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

Advance Supply Limitation

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

- Drug Expenses

The maximum quantity of drugs that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by your physician or dentist, or

b) a 90 day supply.

Hospital Care

- charges, in excess of the hospital's public ward charge, for private accommodation for up to 90 days per calendar year, provided:

  - the person was confined to hospital on an in-patient basis, and

  - the accommodation was specifically elected in writing by the patient

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- B12 injections (excluding injections that relate to weight loss)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- fertility drugs
- oral drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Anti-smoking drugs - $500 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, $125 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a combined maximum of $400 per 12 consecutive months for persons under age 18 and $650 per 24 consecutive months for persons age 18 and over

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $400 per calendar year
- Podiatrist/Chiropodist - $400 per calendar year
- Massage Therapist - $500 per calendar year
- Naturopath - $400 per calendar year
- Speech Therapist - $500 per calendar year
- Physiotherapist - $500 per calendar year
- Mental Health Practitioners* - $2,000 per calendar year
- Acupuncturist - $500 per calendar year

*Mental Health Practitioners include Psychologists, Clinical Counsellor and Psychiatrist only

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

Recommendation by a physician for Professional Services is not required

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

- Private Duty Nursing

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

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

Covered Expenses are subject to a maximum of 30 days in any calendar year.

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available, and including, if medically required, charges for a medical attendant who is neither a resident in your home nor a relative of yourself or your spouse

Medical Equipment

- rental or, when approved by Manulife Financial or your employer, purchase of:

  - Mobility Equipment: crutches, canes, walkers, and wheelchairs

  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses. Charges for myoelectrical limbs are not covered.
- surgical stockings/support hose, up to a maximum of 4 pairs per calendar year
- surgical brassieres, up to a maximum of 4 per calendar year

- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of $200 per calendar year for dependent children under age 21 and $400 per calendar year for any other person
- casted, custom-made orthotics (recommendation of either a physician or a podiatrist is required)
- cost for installation of hearing aids, (including charges for batteries) to a maximum of $600 in any 60 consecutive months. Charges for maintenance and repair are not covered.

Other Supplies and Services

- blood glucose monitoring machines and blood-letting devices, to a maximum of $200 per lifetime
- ileostomy, colostomy and incontinence supplies
- insulin infusion pumps, to a maximum of $500 per lifetime (charges for insulin pump supplies are unlimited)
- insulin syringes and Clinitest or similar home clinical testing supplies for diabetes
- medicated dressings and burn garments
- synvisc, to a maximum of 9 injections per 12 month
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $500 per lifetime
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing. If a covered person's plan benefit coverage terminates under this plan for reasons other than termination of this plan or this Dental Care Benefit, and out-of-hospital treatment is required as a result of an accidental injury to the natural teeth or jaw which occurred prior to the person's plan benefit coverage terminating, the administrator, acting on behalf of your employer, will pay for expenses related to the accident provided the expense is incurred and completed within 52 weeks of the date of the accident.

Gender Affirmation Treatment

Charges for feminization procedures as follows:

- breast/chest surgery - augmentation mammoplasty (implants/lipofilling)
- genital surgery - penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, scrotectomy, labiaplasty

- non-genital, non-breast interventions - facial femininization surgery such as rhinoplasty, and blepharoplasty, abdominoplasty, liposuction, lipofilling, gluteal augmentation (implants/lipofilling), hair reconstruction, electrolysis or laser hair removal of facial, body hair or skin graft, reduction thyroid chondroplasty and laryngoplasty/vocal cord surgery

Charges for masculinization procedures as follows:

- breast/chest surgery - mastectomy, chest masculinization
- genital surgery - hysterectomy, salpingo-oophorectomy, metoidioplasty or phalloplasty, urethroplasty, vaginectomy, glansplasty, scrotoplasty and insertion of testicular implants; and insertion of an erectile device
- non-genital, non-breast interventions – facial masculinization surgery such as facial bone reconstruction, rhinoplasty and blepharoplasty, abdominoplasty, liposuction, lipofilling, pectoral implants, electrolysis or laser hair removal of skin graft and laryngoplasty/vocal cord surgery

Charges for the following expenses are not covered:

- expenses related to travel or accommodation under this benefit
- services obtained outside of Canada
- services that are considered cosmetic, except as otherwise provided under the list of eligible expenses as outlined in the feminization and masculinization procedures mentioned above
- expenses related to the reversal of gender affirmation treatments
- expenses related to sperm preservation and/or cryopreservation of fertilized embryos and expenses related to infertility
- any services/expenses payable under any Provincial/Territorial Plan.

The purpose of this coverage is related to masculinization or femininization, not elective cosmetic enhancement. All eligible services must be medically necessary and ordered by a physician involved in the transitioning treatment.

In order to be eligible for the gender affirmation treatment expenses outlined in this section, the covered person must go through the provincial/territorial process, where provincial/territorial coverage exists.

A covered person must provide the Administrator with one of the following:

- proof of approval from the province/territory that has accepted coverage under their gender affirmation program, where provincial/territorial coverage exists, OR
- proof of completing a recognized program at a specialized gender identity treatment centre (such as the CAMH Gender Identity Clinic), OR
- proof that the covered person has met the clinical eligibility for gender affirming surgery as determined by the World Professional Association for Transgender Health (WPATH) Standards of Care (SoC) criteria and have been assessed by a physician, specialist, nurse practitioner (NP) and/or a health care professional (HCP) trained in the WPATH SoC.

If the covered person elects not to follow the WPATH identity treatment guidelines or not to go through the provincial/territorial process (where provincial/territorial coverage exists), the covered person will not be eligible for any of the gender affirmation treatment expenses outlined in this section.

Only expenses incurred while the covered person is covered under this plan and while this benefit provision is in force will be eligible for consideration.

Manulife is responsible for determining a covered person's eligibility for coverage under the gender affirmation benefit. Before incurring an expense, the covered person must contact the Administrator to predetermine the eligibility of their claim. The Administrator reserves the right to request details of the services, along with provincial/territorial approval with respect to the assessment/approval for coverage under the provincial/territorial gender affirmation program. The Administrator will assess all medical expenses based on the terms of this plan and considering WPATH's standards of care for Gender Identity Dysphoria.

Covered Expenses are subject to a maximum of $30,000 per lifetime.

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs during the first 365 days while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence. Expenses are not subject to an overall maximum.

  A Medical Emergency is:

  - a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or

  - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

  - been treated or tested for any new symptoms or conditions

  - had an increase or worsening of any existing symptoms

  - changed treatments or medications (other than normal adjustments for ongoing care)

  - been admitted to the hospital for treatment of the condition

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

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

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

- referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar year(s)

  If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar year(s).

For all non-emergency medical treatment out of Canada:

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

Charges for the following are payable under this expense:

- physician's services
- hospital room and board up to the hospital maximum under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

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

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

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, available on the Group Benefits Secure Site - www.manulife.ca/groupbenefits, 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 employer.

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

All claims must be submitted within 15 months after the date the expense was incurred.

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

Subrogation (Third Party Liability)

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

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

Exclusions

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

- any illness or injury arising out of or in the course of employment when the person is covered by or is eligible for coverage by workers' compensation
- any illness or injury for which benefits are payable under any government plan or legally mandated program
- for Out-of-Province/Out-of-Canada only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- charges for services or supplies:
  - when there would have been no charge at all in the absence of plan benefit coverage
  - when reimbursement would have been made under a government-sponsored plan in the absence of plan benefit coverage
  - which are received from a medical or dental department maintained by an employer, association or trade union
  - which are required for recreation or sports but which are not medically necessary for regular activities
  - which are provided while confined in a hospital on an in-patient basis
  - which would have been payable by the Provincial Plan if proper application had been made
  - which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
  - which are not specified as a covered expense under this benefit
-
- medical or surgical care which is cosmetic
- medical treatment which is not usual and customary, or which is Experimental or Investigational in nature
- charges which were considered an insured service of any provincial government plan at the time this plan benefit was issued and subsequently were modified, suspended or discontinued
- charges for general health examinations, and examinations required for use of a third party
- charges for eye examinations, except where included as an eligible expense
- charges for transport or travel, other than as specifically provided under this benefit

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

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

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

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

a) **Benefit Percentage**

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

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

ii) for any Legislated pharmacy services which are not otherwise covered under the terms of this Benefit, the percentage payable is as set out by the then applicable Legislation

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

- the benefit percentage stated under The Benefit, and
- the percentage as set out by the then applicable Legislation.

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

b) **Annual Out-of-Pocket Maximum**

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

i) deductible amounts, and

ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%, and

iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

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

c) **Deductible**

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

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and

iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms), and

ii) age 26.

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

i) only drugs that are on the RAMQ List are covered, and

ii) only covered pharmacy services performed for a drug in the RAMQ List are covered, and

iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered,

ii) only covered pharmacy services related to a drug on the RAMQ List are covered,

iii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,

iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

v) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

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

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

Medical Travel Referral Benefit (MTB)

Your Medical Travel Referral Benefit is provided directly by College of New Caledonia. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance 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.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Overall Benefit Maximum - $10,000 per person per calendar year

Deductible - Nil

Benefit Percentage (Co-insurance) - 100%

Benefit Amount - $125 per day, to a maximum of 50 days in any calendar year for all eligible meal and accommodation expenses combined. However, where eligible expenses exceed $125 per day, but do not exceed the average of $125 per day for the year, the average will be paid.

Termination Age - employee's retirement

Covered Expenses

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

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable

Eligible Expenses

When referred by a licensed physician to a hospital, medical treatment centre or medical specialist because, in his or her opinion, adequate medical treatment is not available within 100 kilometres of your home campus, the following are included as eligible expenses:

- charges for transportation to and from the nearest locale equipped to provide the required treatment for the covered person by automobile (to a maximum of $0.52 per kilometre), scheduled air, rail, bus, taxi or ferry
- charges for accommodation, where transportation has been provided under one of the conveyances as described above, in a commercial facility or hotel, Easter Seal House, Heather House, Vancouver Lodge, Ronald McDonald House, or other similar institution approved by the administrator, acting on behalf of your employer, before and after medical treatment
- charges for meals
- Charges for transportation of a family member or a medical attendant if medically necessary and requested by a licensed physician, combined with the transportation and accommodation charges listed above

Charges are subject to the following conditions and limitations:

- referral treatment must be performed by a licensed medical specialist or ophthalmologist
- charges for travel and eligible expenses incurred outside the covered person's province or residence are not covered, unless such expenses are lesser than those incurred in the covered person's province of residence
- the benefit does not apply to dental treatment unless:
  - such services are required by a licensed physician and/or when hospitalization for treatment is required
  - such treatment is performed by an oral surgeon, except in the case of emergency dental assessment or treatment, in which case treatment may be performed by a specialist in the field of dentistry

Submitting a Claim

To submit a Medical Travel Referral (MTB) claim, you must complete an Extended Health Care Claim form. Claim forms are available on the Group Benefits Secure Site - www.manulife.ca/groupbenefits,

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

All claims must be submitted within 15 months after the date the expense was incurred.

Subrogation (Third Party Liability)

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

On settlement or judgement of your legal action, you will be required to reimburse the administrator those amounts you recover which, when added to the payments you received from the administrator, exceed 100% of your incurred expenses

Exclusions

No benefit is payable for any expense which is directly or indirectly related to:

- charges which are considered an insured service of any provincial government
- charges which are considered a covered service under the Extended Health Care plan, or any other group plan in force at the time
- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment
- charges for medical treatment, transport or travel, other than as specifically provided under eligible expenses
- charges not specified in the foregoing list of eligible expenses
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy
- charges which are from an occupational injury or disease covered by any Workers' Compensation legislation or similar legislation
- charges which 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
- charges for dental work where a third party is responsible for payment of such charges
- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind
- for Out-of-Province only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness

- charges for experimental procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society

- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies

Dental Care

Your Dental Care Benefit is provided directly by College of New Caledonia. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance 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.

If you or your dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide – Current British Columbia Dental Association Approved Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

80% for Level III - Dentures

80% for Level IV - Major Restorative Services

60% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I, Level II, Level III and Level IV

$3,000 per lifetime for Level V

Termination Age - employee's retirement

Waiting Period - none

Covered Expenses

The following expenses are covered if they:

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

Alternate Treatment

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

Level I - Basic Services

- complete oral exam, one 36 months
- full-mouth x-rays, one per 36 months
- panoramic x-rays, one per 60 months
- one unit of light scaling and one unit of polishing:
  - for Plan A, once every 6 months for dependent children under age 19 and once every 9 months for any other person, when the service is performed outside Quebec, or prophylaxis (polishing) once every 6 months for dependent children under age 19 and once every 9 months for any other person, when the service is performed in Quebec
  - for Plan B, twice per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing) twice per calendar year, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments:
  - for Plan A, once every 6 months for dependent children under age 19 and once every 9 months for any other person
  - for Plan B, twice per calendar year
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction, plus one recall
- diagnostic models, 2 per calendar year

- fillings (including gold foil), gold onlays, retentive pins and pit and fissure sealants. Gold onlays are limited to one every 60 months. Bonded amalgam fillings are not subject to alternate treatment. 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). Stainless steel crowns are limited to one per 60 months

- space maintainers (appliances placed for orthodontic purposes are not covered)

- minor surgical procedures and post surgical care

- extractions (including impacted and residual roots)

- consultations, anaesthesia, and conscious sedation

- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

- oral disease, nervous/muscular disorders, up to 2 units of time

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)

- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

  – scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year

  – provisional splinting

  – occlusal equilibration

- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services

  – root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime

  – re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

Level IV - Major Restorative Services

- crowns and onlays (other than gold onlays) when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays (not subject to alternate treatment)
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:
  - a natural tooth is extracted and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable, or
  - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

Level V - Orthodontics

- orthodontic services

Late Entrant Limitation

If you or your dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $300 for each covered person.

Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within 15 months after the date the expense was incurred.

Subrogation (Third Party Liability)

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

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

Exclusions

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

- a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this plan, or through a government plan or legally mandated program
- charges which were considered an insured service of any provincial government plan at the time this plan benefit was issued and subsequently were modified, suspended or discontinued
- services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind
- charges for broken appointments, third party examinations, travel to and from appointments, or completion of claim forms
- charges for services or supplies:
  - when there would have been no charge at all in the absence of plan benefit coverage
  - which are received from a medical or dental department maintained by an employer, association or trade union
  - which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
  - which are not specified as a covered expense under this benefit
- treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction
- cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan
- implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the Administrator, acting on behalf of your Employer, will consider benefits as if the least expensive of a denture or bridge were used
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- replacement of removable dental appliances which have been lost, mislaid or stolen

- laboratory fees which exceed reasonable and customary charges, as determined by your Employer or the Administrator
- related hospital charges as a result of dental surgery
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease

Health Care Spending Account

Your benefit program includes a health care spending account, which provides you and your dependents with financial assistance for medical and dental expenses. Please refer to your **Health Care Spending Account - Plan Member Guide** for complete details on this benefit.

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue Extended Health Care and Health Care Spending Account benefits without requiring any contribution from you, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms)
- the date similar coverage is obtained elsewhere
- the date which is 12 months from your death, or
- the date the Plan Document terminates

Long Term Disability

The Long Term Disability Benefit is insured under Manulife Financial's Policy G0039949.

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Manulife Financial will pay a disability benefit.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- your own occupation, during the Qualifying Period and the 24 months immediately following the Qualifying Period
- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 24 months specified above

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

The Benefit

Benefit Amount

For Plan A - 60% of monthly earnings, to a maximum of $5,000 and a minimum benefit, after reductions, of $100 or 10% of the benefit amount, whichever is greater

For Plan B - 50% of monthly earnings, to a maximum of $12,000 and a minimum benefit, after reductions, of $100 or 10% of the benefit amount, whichever is greater

Non-Evidence Limit

For Plan A - $5,000

For Plan B - $10,000

Qualifying Period

For Plan A - 120 days

For Plan B - the greater of 90 calendar days or the expiration of sick leave credits, not exceeding 120 calendar days

- Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.

- You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Taxability - Non-taxable

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period - none

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 14 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled.

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  – your own occupation, during the Qualifying Period and the following 24 months, and

  – any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 24 months specified above

- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial
- receiving Employment Insurance maternity or parental benefits
- on lay-off or strike during which you become Totally Disabled, subject to any provincial employment or labour standards act
- on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan
- residing outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period unless:
  - you remain under the regular care of a licensed physician deemed appropriate by Manulife Financial
  - you have previously notified and received approval in writing from Manulife Financial
  - proof of the ongoing Disability can be determined on evidence satisfactory to Manulife Financial within 30 days of request
- working in any occupation, except as provided for under the Rehabilitation Assistance provision
- incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans, excluding dependent benefits

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

- any government motor vehicle automobile insurance plan or policy, unless prohibited by law
- any group, association or franchise plan
- any retirement or pension plan

- earnings or payments from any employer
- self-employment
- any government plan, excluding Employment Insurance Benefits

Benefit Calculation Rules

Manulife Financial will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial
- subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established
- benefits payable under individual disability income insurance will not be taken into account
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial, and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

Tax Status of Benefits

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

Rehabilitation Assistance

Once Manulife Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife Financial will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- the nature, scope, objectives and cost of a Vocational Plan

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife Financial will provide a structured Vocational Plan that will prepare you for a return to work, either:

- with your employer
- with an alternate employer
- in a self-employed capacity

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan, but in no event, for a period greater than 24 months. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings; net earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife Financial will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:
  - your own occupation, during the Qualifying Period and the following 24 months, and
  - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 24 months specified above

- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit
- the date of your death

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Waiver of Premium

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

Survivor Benefit

If you die while disability benefits are payable and you have been disabled for at least 180 days, Manulife Financial will pay a benefit to your surviving dependents. If there are no surviving dependents, the benefit is payable to your estate.

The amount of the Survivor Benefit payable is 3 times your last monthly benefit payment, less the amount of any outstanding benefit overpayments.

Submitting a Claim

To submit a claim, you must complete the Long Term Disability claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Manulife Financial within 180 days from the end of the Qualifying Period.

Exclusions

No benefits are payable for any disability related to:

- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness
- active duty in the armed forces or any country, state or international organization or for disability resulting from war or act of war, whether declared or undeclared
- participation in the commission of a criminal offence
- an accident which occurs while you are operating a motor vehicle and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%)
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial
- any Total Disability commencing within 12 months of your effective date of insurance if the Disability is caused or contributed to by, or is a consequence of, a sickness or injury for which you have received medical treatment or services or have taken prescribed Drugs or Drugs and medicines at any time or times within 90 days before the effective date of insurance.

  In the event that this is a replacement Policy, then for the purposes of the above point only, the effective date of insurance (if you were insured under a previous Policy covering this group) will be deemed to be the last date from which you have been continuously insured.

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.