

College
of New
Caledonia

CNC

Welcome to the
FACULTY
Benefit Booklet
for
Full-Time and Sessional Faculty Employees

The information in this booklet was last updated November 22, 2018

College of New Caledonia

Plan Document Numbers: G0083709, G0083710

Group Policy Number: G0039949

Plans: D - Full-time and Sessional Faculty with all benefits

DD - Sessional Faculty with no Disability coverage

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Documents 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
Your Employer's Representative.....	14
Applying for Group Benefits.....	14
Making Changes.....	14
The Claims Process	15
Naming a Beneficiary.....	15
How to Submit a Claim.....	15
Co-ordination of Extended Health Care and Dental Care Benefits.....	15
Who Qualifies for Coverage?	19
Eligibility.....	19
Medical Evidence.....	19
Late Application.....	19
Late Dental Application.....	19
Effective Date of Coverage.....	20
Termination of Coverage.....	20
Your Group Benefits	21
Employee Life Insurance.....	21
Employee Optional Life Insurance.....	24
Spousal Optional Life Insurance.....	25
Accidental Death and Dismemberment.....	27
Extended Health Care.....	32
Medical Travel Referral Benefit (MTB).....	46
Dental Care.....	49
Survivor Extended Benefit.....	54

Benefit Summary

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

Employee Life Insurance

For Plan D and Plan DD

*Employee Life
Insurance*

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

Benefit Amount - 3 times your annual earnings, to a maximum of \$500,000

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

Termination Age - age 70 or retirement, whichever is earlier.

Employee Optional Life Insurance

For Plan D only

*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

For Plan D only

*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

Benefit Summary

Accidental Death and Dismemberment

*Accidental Death and
Dismemberment*

For Plans D and DD

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

Benefit Amount - 3 times your annual earnings, to a maximum of \$500,000

Termination Age - age 70 or retirement, whichever is earlier

Extended Health Care

Extended Health Care

For Plan D and Plan DD

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

- Medical Services & Supplies

- Professional Services

- Vision (other than Eye Exams)

- Drugs

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

*Extended Health Care -
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

Benefit Summary

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 intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

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

- Drug Maximums

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

For Pay Direct drug card submissions only, covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug, the amount covered is the cost of the prescribed product.

- Payment of Covered Expenses

- 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.

- No Substitution Prescriptions

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.

Benefit Summary

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

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

Extended Health Care - Vision Care

- eye exams, \$75 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 \$500 per 24 consecutive months for persons age 18 and over

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year
- Podiatrist/Chiropodist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year
- Massage Therapist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year
- Naturopath - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year. Lab fees are not subject to the per visit maximum.

Benefit Summary

Speech Therapist - \$500 per calendar year

Physiotherapist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year

Psychologist - \$500 per calendar year

Acupuncturist - \$100 per calendar year

Medical Travel Referral (MTB)

For Plan D and Plan DD

**Medical Travel Referral
(MTB)**

The Benefit

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

**Medical Travel Referral
(MTB) - The Benefit**

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

For Plan D and Plan DD

Dental Care

The Benefit

Deductible - Nil

**Dental Care - The
Benefit**

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 Summary

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

How to Use Your Benefit Booklet

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.

***Your Benefit Booklet
includes...***

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.

Important Note

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.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

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.

How to Use Your Benefit Booklet

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.

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

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.

Addiction Facility

A licensed facility that specializes in the evaluation and treatment of drug addiction, alcoholism and associated disorders.

Addiction Facility

Administrator

Manulife Financial

Administrator

Benefit Percentage (Co-insurance)

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

**Benefit Percentage
(Co-insurance)**

Covered Expenses

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

Covered Expenses

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.

Deductible

Dependent

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

Dependent

- 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

Explanation of Commonly Used Terms

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

Drug

Drug

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

Earnings

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.

Experimental or Investigational

***Experimental or
Investigational***

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Immediate Family Member

***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.

Explanation of Commonly Used Terms

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.

***Licensed, Certified,
Registered***

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Life-Sustaining Drugs

Medically Necessary

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

Medically Necessary

Non-Evidence Limit

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

Non-Evidence Limit

Provincial Plan

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

Provincial Plan

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.

Qualifying Period

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.

***Reasonable and
Customary***

Waiting Period

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

Waiting Period

Ward

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

Ward

Why Group Benefits?

Why Group Benefits?

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'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

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

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.

Naming a Beneficiary

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.

How to Submit a 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.

Claim Payment

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.

***Co-ordination of
Extended Health Care
and Dental Care
Benefits***

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.

The Claims Process

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

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (ie., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (ie., 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.

The Claims Process

- 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.

*Submitting a Claim for
Co-ordination of
Benefits*

The Claims Process

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.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a permanent, full-time or sessional faculty 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,
- are residing in Canada, and
- have completed the Waiting Period.

Eligibility

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

Sessional employee - normal work schedule not exceeding 10 calendar months in duration

Required Number of Hours

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.

Medical Evidence

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.

Late Application

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.

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.

Late Dental Application

Who Qualifies for Coverage?

Effective Date 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. For Plan D, 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

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.

Your Group Benefits

Employee Life Insurance

For Plan D and Plan DD

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

Employee Life - The Benefit

Benefit Amount - 3 times your annual earnings, to a maximum of \$500,000

Non-Evidence Limit - \$500,000

Qualifying Period for Waiver of Premium - proof of acceptance under your employer's Long Term Disability program or 90 consecutive days prior to reaching age 65

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

Termination Age - age 70 or retirement, whichever is earlier.

Waiting Period - first day of the month coincident with or next following 3 months of continuous, active employment

Naming a Beneficiary

Employee Life Insurance - 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

Employee Life Insurance - 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.

Your Group Benefits

Employee Life Insurance - Waiver of Premium

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

Employee Life Insurance - Totally Disabled

Totally Disabled means that you are completely unable because of an accident or sickness to perform all the duties of:

- your own occupation, during the first 24 months of Total Disability; and
- any occupation for which:
 - you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified in part a) of this provision, and
 - the current monthly earnings are 75% or more of the current monthly earnings for your own occupation at the date of your disability.

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

Entitlement Criteria

Employee Life Insurance - 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 either:

- proof of acceptance for benefit payments under your employer's long term disability benefits, or
- medical evidence documenting how your sickness or accident causes an inability to perform all the duties of:
 - your own occupation, during the first 24 months of Total Disability, and
 - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
 - the current monthly earnings are 75% or more of the current monthly earnings for your own occupation at the date of your disability

Your Group Benefits

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

Employee Life Insurance - 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:

- benefit payments cease under the Employer's long term disability plan; or
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your sickness or accident causes an inability to perform all the duties of:
 - your own occupation, during the first 24 months of Total Disability, and
 - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above and
 - the current monthly earnings are 75% or more of the current monthly earnings for your own occupation at the date of your disability

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

Employee Life Insurance - 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.

Your Group Benefits

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

Employee Life Insurance - 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

Employee Optional Life Insurance

For Plan D only

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

Employee Optional Life Insurance - 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 - proof of acceptance under your employer's Long Term Disability program or 90 consecutive days prior to reaching age 65

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

Waiting Period - first day of the month coincident with or next following 3 months of continuous, active employment

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

Your Group Benefits

For details on Submitting a Claim and Conversion Privilege, please refer to Employee Life Insurance.

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).

Employee Optional 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.

Employee Optional Life Insurance - Exclusions

Spousal Optional Life Insurance

For Plan D only

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

Spousal Optional Life Insurance

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

Spousal Optional Life Insurance - The Benefit

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

Qualifying Period for Waiver of Premium - proof of acceptance under your employer's Long Term Disability program or 90 consecutive days prior to reaching age 65

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

Waiting Period - first day of the month coincident with or next following 3 months of continuous, active employment

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

Your Group Benefits

Submitting a Claim

Spousal Optional Life Insurance - 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

Spousal Optional Life Insurance - 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

Spousal Optional Life Insurance - 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

Spousal Optional Life Insurance - 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.

Your Group Benefits

Accidental Death and Dismemberment

For Plans D and DD

***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

AD&D - The Benefit

Benefit Amount - 3 times your annual earnings, to a maximum of \$500,000

Qualifying Period for Waiver of Premium - proof of acceptance under your employer's Long Term Disability program or 90 consecutive days prior to reaching age 65

Termination Age - age 70 or retirement, whichever is earlier

Waiting Period - first day of the month coincident with or next following 3 months of continuous, active employment

Schedule of Losses

***AD&D - 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%

Your Group Benefits

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

AD& D - 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

AD& D - Aggregate Limit

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

Rehabilitation Expenses

AD& D - 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.

Your Group Benefits

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.

AD& D - Repatriation Expenses

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 within 150 kilometres from your normal 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.

AD& D - Family Transportation Expenses

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 enrolls 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 professionnel (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.

AD& D - Dependent Education Expenses

Your Group Benefits

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, to a maximum of \$25,000, 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

***AD&D - Spousal
Occupational Training
Expenses***

***AD&D - Seat Belt
Benefit***

***AD&D - Day-Care
Expenses***

Your Group Benefits

Home Alteration and Vehicle Modification Expenses

**AD&D - 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

**AD&D -
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

**AD&D - 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

**AD&D - 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.

Your Group Benefits

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 the loss.

Waiver of Premium

AD& D - 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

AD& D - 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

Extended Health Care

For Plan D and Plan DD

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.

Your Group Benefits

Drug Benefit for Quebec Residents

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

The Benefit

Overall Benefit Maximum - Unlimited

***Extended Health Care -
The Benefit***

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

- Medical Services & Supplies

- Professional Services

- Vision (other than Eye Exams)

- Drugs

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

Waiting Period - first of the month coincident with or next following date of hire

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

***Extended Health Care -
Covered Expenses***

Your Group Benefits

reasonable taking all factors into account

not covered under the Provincial Plan or any other government-sponsored program

legally insurable

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

Advance Supply Limitation

Extended Health Care - 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

- 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

Extended Health Care - 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

Extended Health Care - Addiction Facility

charges for room and board made by an addiction treatment facility, provided the treatment is not covered by a provincial medical plan, up to \$25,000 per lifetime.

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

Extended Health Care - 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

Your Group Benefits

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 intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

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 and the Co-insurance.

For Pay Direct drug card submissions only, covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug, the amount covered is the cost of the prescribed product.

- 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.

- Drug Maximums

- Payment of Covered Expenses

- No Substitution Prescriptions

Your Group Benefits

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

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

Extended Health Care - Vision Care

eye exams, \$75 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 \$500 per 24 consecutive months for persons age 18 and over

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year

Podiatrist/Chiropodist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year

Massage Therapist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year

Naturopath - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year. Lab fees are not subject to the per visit maximum.

Your Group Benefits

Speech Therapist - \$500 per calendar year

Physiotherapist - \$250 per calendar year, limited to \$10 per visit for the first 5 visits in any calendar year

Psychologist - \$500 per calendar year

Acupuncturist - \$100 per calendar year

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.

***Extended Health Care -
Medical Services and
Supplies***

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

- Private Duty Nursing

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.

Your Group Benefits

- Ambulance

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

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

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)

costs for installation of hearing aids, (including charges for batteries) to a maximum of \$1,000 per 3 calendar years. Charges for maintenance and repair are not covered.

- Other Supplies and Services

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

Your Group Benefits

medicated dressings and burn garments

synvisc, to a maximum of 9 injections per 12 months

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.

Your Group Benefits

Out-of-Province/Out-of-Canada

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

Your Group Benefits

- 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, 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.

***Extended Health Care -
Submitting a Claim***

***Subrogation (Third
Party Liability)***

Your Group Benefits

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

Extended Health Care - 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

Your Group Benefits

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 For Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

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

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

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

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

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 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%.

Your Group Benefits

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

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

- 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%.

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 paid for your dependent children.

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

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

- i) only drugs that are on the RAMQ List are covered, and
- ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

Your Group Benefits

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 provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

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

f) Termination Age

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) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation
- iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation
- iv) 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.

Your Group Benefits

Medical Travel Referral Benefit (MTB)

Medical Travel Referral Benefit (MTB)

For Plan D and Plan DD

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

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

Waiting Period - first of the month coincident with date of hire

Covered Expenses

Medical Travel Referral (MTB) - 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

Your Group Benefits

Eligible Expenses

-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

Medical Travel Referral (MTB) - 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.

Your Group Benefits

Subrogation (Third Party Liability)

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

Medical Travel Referral (MTB) - 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

Your Group Benefits

Dental Care

For Plan D and Plan DD

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

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

Waiting Period - first day of the month coincident with or next following 3 months of continuous active employment

Your Group Benefits

Covered Expenses

Dental Care - 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

Dental Care - Alternate Treatment

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

Level I - Basic Services

Dental Care - Level I - Basic Services

complete oral exam, one per 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 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

recall exams, bitewing x-rays, and fluoride treatments, once every 6 months for dependent children under age 19 and once every 9 months for any other person

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

Your Group Benefits

- 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

**Dental Care - Level II -
Supplementary Basic
Services**

**Dental Care - Level III -
Dentures**

Your Group Benefits

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

Dental Care - 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

Dental Care - Level V - Orthodontics

orthodontic services

Late Entrant Limitation

Dental Care - 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

Dental Care - 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.

Your Group Benefits

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.

Dental Care - Work in Progress When Coverage Terminates

Submitting a Claim

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

Dental Care - Submitting a Claim

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, 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.

Subrogation (Third Party Liability)

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 Dental Care benefits will be payable for expenses resulting from:

Dental Care - Exclusions

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

Your Group Benefits

- 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

the replacement of removable appliances which are 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

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Extended Health Care benefit 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