

Douglas College

Plan Document Number: G0083239

Group Policy Number: G0039945

Plan: F - Contract Faculty

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: January 1, 2010

Group Policy Effective Date: January 1, 2010

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.

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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

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039945.

Employee Life Insurance

If you elect the Employee Life Insurance Benefit, you will automatically be covered for the Extended Health Care and Dental Care Benefit as a package.

Benefit Amount - \$10,000

Termination Age - your benefit amount terminates at age 71 or retirement, whichever is earlier.

Extended Health Care

The Benefit

Extended Health Care

If you elect the Extended Health Care Benefit, you will automatically be covered for the Dental Care and Employee Life Insurance Benefit as a package.

Overall Benefit Maximum - Unlimited

Extended Health Care - The Benefit

Deductible - \$50 Individual, \$50 Family, per calendar year

Not applicable to:

- Hospital Care
- Vision (Eye Exams)

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Vision

95% for
- Medical Services & Supplies
- Professional Services
- Drugs

Note:

The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 95%.

Termination Age - the end of the month in which the employee attains age 71 or the last day of the month following the month in which the employee retires, whichever is earlier

Benefit Summary

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

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)

standard syringes, needles and diagnostic aids, required for the treatment of diabetes

Note Dispensing fees for drugs purchased with the Pay Direct Drug card, other than compounds, will not be subject to Reasonable and Customary limitations

The following are not Covered Expenses:

charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment

drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis

drugs determined to be ineligible as a result of due diligence

oral drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Fertility drugs - \$2,500 per lifetime

Anti-smoking drugs - \$500 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

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

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

**- Payment of Covered
Expenses**

- Drug Maximums

Benefit Summary

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

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

- No Substitution Prescriptions

**- No Substitution
Prescriptions**

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

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

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

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

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

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

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

Vision Care

**Extended Health Care -
Vision Care**

- eye exams, up to \$125 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a combined maximum of \$650 per 24 consecutive months

Benefit Summary

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be 1 pair of eyeglasses or contact lenses per lifetime

non-prescription reading glasses, to a maximum of \$40 per 24 consecutive months

Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$300 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Osteopath - \$275 per calendar year

Podiatrist/Chiropodist - \$275 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Massage Therapist - \$500 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Naturopath - \$275 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year. Lab fees are not subject to the per visit maximum.

Speech Therapist - \$275 per calendar year

Physiotherapist - \$500 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Mental Health Practitioners* - \$1,500 per calendar year

*Mental Health Practitioners include Clinical Counsellors, Psychologists and Social Workers only

Dental Care

The Benefit

If you elect the Dental Care Benefit, you will automatically be covered for the Extended Health Care and Employee Life Insurance Benefit as a package.

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
- 70% for Level III - Dentures

**Extended Health Care -
Professional Services**

Dental Care

**Dental Care - The
Benefit**

Benefit Summary

- 70% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- \$3,500 per lifetime for Level V

Termination Age - the end of the month in which the employee attains age 71 or the last day of the month following the month in which the employee retires, whichever is earlier

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:

Your Benefit Booklet includes...

a detailed Table of Contents, allowing quick access to the information you are searching for,

Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,

a clear, concise explanation of your Group Benefits,

information you need, and simple instructions, on how to submit a claim.

Important Note

Important Note

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

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

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

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

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

the Group Policy and/or Plan Document,

your application for group benefits, and

any Evidence of Insurability you submitted as part of your application for benefits.

How to Use Your Benefit Booklet

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 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.

***Your Group Benefit
Card***

Explanation of Commonly Used Terms

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

Addiction Facility	Addiction Facility a licensed facility that specializes in the evaluation and treatment of drug addiction, alcoholism and associated disorders
Adherence	Adherence use drug, service or supply in accordance with the terms for which it was prescribed.
Administrator	Administrator Manulife Financial
Advisory Body	Advisory Body Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.
Benefit Percentage (Co-insurance)	Benefit Percentage (Co-insurance) the percentage of Covered Expenses which is payable by the administrator, acting on behalf of your employer.
Covered Expenses	Covered Expenses expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.
Deductible	Deductible the amount of Covered Expenses that must be incurred and paid by you or your Dependants before benefits are payable by the administrator, acting on behalf of your employer.
Dependant	Dependant your Spouse or Child who, for Extended Health Care benefits only, is covered under the Provincial Plan. - Spouse your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months. Only one spouse will be eligible for benefits under this plan and will be indicated by you on your application for benefits under this plan. Where this information is not contained in your application, the person who qualifies last under this plan's definition of spouse will be the eligible spouse.

Explanation of Commonly Used Terms

- Child

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

- unmarried
- under age 21, or under age 25 if a full-time student
- not employed on a full-time basis, and
- not eligible for coverage as an employee under this or any other Group Benefit Program

a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible Dependant. 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 Dependant on the employee for support, maintenance and care, due to a mental or physical handicap.

The administrator, acting on behalf of your employer, may require written proof of the child's condition as often as may reasonably be necessary.

a stepchild must be living with you to be eligible

a newborn child shall become eligible from the moment of birth

Disease Management Programs

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

Disease Management Programs

Drug

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

Drug

Due Diligence

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

Due Diligence

Exclusive Distribution

Manulife Financial approved vendors.

Exclusive Distribution

Explanation of Commonly Used Terms

Experimental or Investigational

***Experimental or
Investigational***

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

Immediate Family Member

***Immediate Family
Member***

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Interchangeable Drug

Interchangeable Drug

includes but is not limited to:

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

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

Licensed, Certified, Registered

***Licensed, Certified,
Registered***

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

Life-Sustaining Drugs

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

Lower Cost Alternative

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

Medically Necessary

Medically Necessary

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

Non-Evidence Limit

Non-Evidence Limit

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

Patient Assistance Program

***Patient Assistance
Program***

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

Explanation of Commonly Used Terms

Pharmacoeconomics

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

Pharmacoeconomics

Prior Authorization

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

Prior Authorization

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

within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Reasonable and Customary

Waiting Period

the period of continuous 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 Dependant 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.

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 your employer, 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.

Sign up to use Manulife's Plan Member Secure Site at www.manulife.ca/groupbenefits.

When combined with your health care service provider's electronic transmission of your claim, in some cases you can go to your appointment in the morning and see a record of your claim processing on the site in the afternoon!

If your health care service provider cannot send Manulife electronic claim transmissions, you may still be able to submit your claim electronically to us online, right from the Plan Member Secure Site. If your plan sponsor has selected this service for your plan, it will only take you a few minutes to answer the necessary questions and create your own electronic claim submission.

Even if you send us paper claim forms by letter mail, we encourage you to choose to have your claim money deposited directly into your bank account when you set up your access on the Plan Member Secure Site. We will send you an e-mail telling you when your claim has been processed. You will receive your claim payment up to 70% faster than by waiting for a paper cheque!

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.

The Claims Process

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

- other Group Insurance 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 Dependant Spouse:

The Plan covering you or your Dependant Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a Dependant.

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 Claims Process

- The Plan where the person is covered as a retiree.
- For Claims incurred by your Dependant 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 Dependant 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 Dependant 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.

The Claims Process

Submitting a Claim for Co-ordination of Benefits

Submitting a Claim for Co-ordination of Benefits

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

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

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

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

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

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a contract faculty employee of Douglas College,
- have a contract of quarter-time or more work for at least 90 days duration
- are a member of an eligible class,
- are younger than the Termination Age,
- for Extended Health Care 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 Dependants are eligible for coverage on the date you become eligible or the date you first acquire a Dependand, whichever is later. You must apply for coverage for yourself in order for your Dependants to be eligible.

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

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days; or
- re-apply for coverage on any person whose coverage had earlier been cancelled.

Late Application

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

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

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

Late Dental Application

If you apply for coverage for Dental for yourself or your Dependants 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 Dependant's coverage becomes effective on the date the Dependant becomes eligible, or the date any required medical evidence on the Dependant is approved by Manulife Financial, whichever is later.

Your Dependant's coverage will not be effective prior to the date your coverage becomes effective.

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 Dependant ceases to be an eligible Dependant, whichever is earlier.

Your Group Benefits

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039945.

Employee Life Insurance

If you elect the Employee Life Insurance Benefit, you will automatically be covered for the Extended Health Care and Dental Care Benefit as a package.

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

The Benefit

Benefit Amount - \$10,000

Employee Life - The Benefit

Non-Evidence Limit - \$10,000

Qualifying Period for Waiver of Premium - 180 days

Termination Age - your benefit amount terminates at age 71 or retirement, whichever is earlier.

Waiting Period

none

Naming a Beneficiary

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

Employee Life Insurance - Naming a Beneficiary

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.

Employee Life Insurance - Submitting a Claim

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

A completed claim form must be submitted within the earlier of:

15 months following the date of loss

90 days following the date of termination of your insurance

90 days following the date of termination of this Policy or a benefit therein

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

Your Group Benefits

A completed claim form must be submitted within 18 months following the day you were last actively at work, provided notification is submitted to Manulife Financial within 12 months of the date you were last actively at work.

Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it is not reasonable possible to furnish such proof within the required time, and if proof is given as soon as is reasonably possible.

Waiver of Premiums

***Employee Life
Insurance - Waiver of
Premiums***

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 a restriction or lack of ability due to an illness or injury which prevents you from performing all the duties of:

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

any occupation for which

- you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above
- the current monthly earnings are 75% or more of the monthly earnings for your own occupation at the date of Disability

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

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

Entitlement Criteria

***Employee Life
Insurance - Entitlement
Criteria***

To be entitled to Waiver of Premiums, 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 30 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled

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

Your Group Benefits

- your own occupation, during the Qualifying Period and the following 24 months, and
- any occupation for which
 - you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
 - the current monthly earnings are 75% or more of the monthly earnings for your own occupation at the date of Disability

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 Premiums

Employee Life Insurance - Termination of Waiver of Premiums

Your Waiver of Premiums will cease on the earliest of:

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

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

- your own occupation, during the Qualifying Period and the following 24 months, and
- any occupation for which
 - you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
 - the current monthly earnings are 75% or more of the monthly earnings for your own occupation at the date of 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

Your Group Benefits

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 Premiums benefit, Manulife Financial will waive the Qualifying Period.

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

If the same disability recurs more than 6 months after cessation of your Waiver of Premiums 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.

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by Douglas College. 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 Dependants 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 and Pharmacy Services for Quebec Residents

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

The Benefit

If you elect the Extended Health Care Benefit, you will automatically be covered for the Dental Care and Employee Life Insurance Benefit as a package.

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

Overall Benefit Maximum - Unlimited

Deductible - \$50 Individual, \$50 Family, per calendar year

Not applicable to:

- Hospital Care
- Vision (Eye Exams)

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Vision

95% for
- Medical Services & Supplies
- Professional Services
- Drugs

Note:

The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 95%.

Termination Age - the end of the month in which the employee attains age 71 or the last day of the month following the month in which the employee retires, whichever is earlier

Waiting Period

date of hire

Your Group Benefits

Covered Expenses

Extended Health Care - Covered Expenses

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

- medically necessary for the treatment of an illness or injury and recommended by a physician

- incurred for the care of a person while covered under this Group Benefit Program

- reasonable taking all factors into account

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

- legally insurable

- used as prescribed or recommended by a physician

- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

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

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

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

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

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

Your Group Benefits

Adherence

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

Adherence

Patient Assistance Programs

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

Patient Assistance Programs

Disease Management Programs

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

Disease Management Programs

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.

Extended Health Care - Advance Supply Limitation

- Drug Expenses

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

- Drug Expenses

- a) the quantity prescribed by your physician or dentist, or
- b) a 90 day supply.

Hospital Care

charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:

Extended Health Care - Hospital Care

- the person was confined to hospital on an in-patient basis, and
- the accommodation was specifically elected in writing by the patient

charges for room and board made by an addiction treatment facility, provided the treatment has been recommended and approved in writing by a physician, up to a maximum of \$25,000 per lifetime

Extended Health Care - Addiction Facility

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

Your Group Benefits

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

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)

standard syringes, needles and diagnostic aids, required for the treatment of diabetes

Note Dispensing fees for drugs purchased with the Pay Direct Drug card, other than compounds, will not be subject to Reasonable and Customary limitations

The following are not Covered Expenses:

charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment

drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis

drugs determined to be ineligible as a result of due diligence

oral drugs used in the treatment of a sexual dysfunction

- Drug Maximums

- Drug Maximums

Fertility drugs - \$2,500 per lifetime

Anti-smoking drugs - \$500 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

**- Payment of Covered
Expenses**

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

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

Your Group Benefits

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

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

- No Substitution Prescriptions

**- No Substitution
Prescriptions**

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

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

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

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

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

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

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

Vision Care

**Extended Health Care -
Vision Care**

- eye exams, up to \$125 per 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a combined maximum of \$650 per 24 consecutive months

Your Group Benefits

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be 1 pair of eyeglasses or contact lenses per lifetime

non-prescription reading glasses, to a maximum of \$40 per 24 consecutive months

Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$300 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Osteopath - \$275 per calendar year

Podiatrist/Chiropodist - \$275 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Massage Therapist - \$500 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Naturopath - \$275 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year. Lab fees are not subject to the per visit maximum.

Speech Therapist - \$275 per calendar year

Physiotherapist - \$500 per calendar year, limited to \$25 per visit for the first 3 visits in any calendar year

Mental Health Practitioners* - \$1,500 per calendar year

*Mental Health Practitioners include Clinical Counsellors, Psychologists and Social Workers only

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

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

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

**Extended Health Care -
Professional Services**

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

Your Group Benefits

Private Duty Nursing

- Private Duty Nursing

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

a registered nurse, or

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

Covered Expenses are subject to a maximum of \$5,000 per 36 months.

Charges for the following services are not covered:

service provided primarily for custodial care, homemaking duties, or supervision

service performed by a nursing practitioner who is an immediate family member or who lives with the patient

service performed while the patient is confined in a hospital, nursing home, or similar institution

service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

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

Ambulance

- 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, to a maximum of \$300 per calendar year

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. Breast prostheses are limited to post-mastectomy only, to a maximum of 1 per calendar year.

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

Your Group Benefits

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, provided such footwear forms an integral part of a brace (recommendation of either a physician or a podiatrist is required)

casted, custom-made orthotics, up to a maximum of 1 pair per calendar year, to a maximum of \$450 per pair (recommendation of either a physician or a podiatrist is required)

cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of \$1,500 per 3 calendar years

Other Supplies and Services

- Other Supplies and Services

eneuretic devices

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

synvisc, to a maximum of 9 injections every 12 months

wigs and hairpieces for patients with temporary hair loss as a result of medical treatment

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

Fertility Treatment

- Fertility Treatment

The cost of eligible non-drug fertility expenses based on the list from the Canada Revenue Agency (CRA) Medical Expense Tax Credit (METC), up to a maximum of \$10,000, per certificate, per lifetime.

Gender Affirmation Treatment

- Gender Affirmation Treatment

Charges for feminization procedures as follows:

breast/chest surgery - augmentation mammoplasty (implants/lipofilling)

genital surgery - penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, scrotectomy, labiaplasty

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

Your Group Benefits

Charges for masculinization procedures as follows:

breast/chest surgery - mastectomy, chest masculinization

genital surgery - hysterectomy, salpingo-oophorectomy, metoidioplasty or phalloplasty, urethroplasty, vaginectomy, glansplasty, scrotoplasty and insertion of testicular implants; and insertion of an erectile device

non-genital, non-breast interventions - facial masculinization surgery such as facial bone reconstruction, rhinoplasty and blepharoplasty, abdominoplasty, liposuction, lipofilling, pectoral implants, electrolysis or laser hair removal of skin graft and laryngoplasty/vocal cord surgery

Charges for the following expenses are not covered:

expenses related to travel or accommodation under this benefit

services obtained outside of Canada

services that are considered cosmetic, except as otherwise provided under the list of eligible expenses as outlined in the feminization and masculinization procedures mentioned above

expenses related to the reversal of gender affirmation treatments

expenses related to sperm preservation and/or cryopreservation of fertilized embryos and expenses related to infertility

any services/expenses payable under any Provincial/Territorial Plan.

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

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

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

proof of approval from the province/territory that has accepted coverage under their gender affirmation program, where provincial/territorial coverage exists, OR

proof of completing a recognized program at a specialized gender identity treatment centre (such as the CAMH Gender Identity Clinic), OR

proof that the covered person has met the clinical eligibility for gender affirming surgery as determined by the World Professional Association for Transgender Health (WPATH) Standards of Care (SoC) criteria and have been assessed by a physician, specialist, nurse practitioner (NP) and/or a health care professional (HCP) trained in the WPATH SoC.

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

Your Group Benefits

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

Manulife is responsible for determining a covered person's eligibility for coverage under the gender affirmation benefit. Before incurring an expense, the covered person must contact the Administrator to predetermine the eligibility of their claim. The Administrator reserves the right to request details of the services, along with provincial/territorial approval with respect to the assessment/approval for coverage under the provincial/territorial gender affirmation program. The Administrator will assess all medical expenses based on the terms of this plan and considering WPATH's standards of care for Gender Identity Dysphoria. Covered Expenses are subject to a maximum of \$30,000 per lifetime.

Out-of-Province/Out-of-Canada

*-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.

A Medical Emergency is

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your Dependant) 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 Dependant) 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.

Your Group Benefits

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, 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. Certain claims may be submitted electronically. Please visit Manulife's Group Benefits website at www.manulife.ca/groupbenefits for details.

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.

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.

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

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

Your Group Benefits

Exclusions

Extended Health Care - Exclusions

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

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

war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion

an illness or injury for which benefits are payable under any government plan or workers' compensation

charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms

services or supplies provided by an association, trade union or your employer's medical or dental department

services or supplies for which no charge would normally be made in the absence of group benefit coverage

services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage

services or supplies which are not permitted by law to be paid

services or supplies which would have been payable by the Provincial Plan if proper application had been made

medical treatment which is not usual or customary, or is experimental or investigational in nature

medical or surgical care which is cosmetic

services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person

services or supplies which are not specified as a covered expense under this benefit

Continuation of Coverage

Extended Health Care - Continuation of Coverage

If a Dependant is Disabled when coverage under this Benefit terminates, Covered Expenses related to the treatment of the Disability will continue to be payable by Manulife Financial, acting on behalf of your Employer.

Coverage will be continued for up to 90 days after coverage would otherwise have terminated while the Dependant remains Disabled. However, coverage will terminate if either this Benefit, or Plan Document should terminate.

Your Group Benefits

A Dependant shall be considered wholly Disabled when he/she is confined to a hospital or incapacitated to the extent that the Dependant is not able to perform all of the usual and customary duties or activities of a person in good health and of the same age.

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

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

covered pharmacy services that are to be paid when the drug is on the RAMQ List, and

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

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

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

a) Benefit Percentage

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

- i) for any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation.
- ii) for any Legislated pharmacy services which are not otherwise covered under the terms of this Benefit, the percentage payable is as set out by the then applicable Legislation.
- iii) for any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:
 - the benefit percentage stated under The Benefit; and
 - the percentage as set out by the then applicable Legislation.

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

Your Group Benefits

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

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

- i) deductible amounts, and
- ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%, and
- iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

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

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

c) **Deductible**

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

d) **Lifetime Maximums**

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

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

e) **Eligible Dependent Children**

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

Your Group Benefits

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms); and
- ii) age 26.

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

- only drugs that are on the RAMQ List are covered, and
- only covered pharmacy services performed for a drug in 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 for Covered Drug and Pharmacy Service Expenses**

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

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services related to a drug on the RAMQ List are covered,
- iii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,
- iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and
- v) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

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

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

Your Group Benefits

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by Douglas College. 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 Dependants 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

If you elect the Dental Care Benefit, you will automatically be covered for the Extended Health Care and Employee Life Insurance Benefit as a package.

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
- 70% for Level III - Dentures
- 70% for Level IV - Major Restorative Services
- 50% for Level V - Orthodontics

Benefit Maximums

- unlimited for Level I, Level II, Level III and Level IV
- \$3,500 per lifetime for Level V

Termination Age - the end of the month in which the employee attains age 71 or the last day of the month following the month in which the employee retires, whichever is earlier

Waiting Period

date of hire

Your Group Benefits

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 under the supervision of a dentist, 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

Dental Care - Covered Expenses

Level I - Basic Services

complete oral exam, one per 24 months

complete series x-rays, one per 24 months

panoramic x-rays, one per 24 months

one unit of light scaling and one unit of polishing once every 6 months for Dependant children under age 19 and once every 9 months for any other person when the service is performed outside Quebec, or prophylaxis (light scaling and polishing) once every 6 months for Dependant 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 Dependant children under age 19 and once every 9 months for any other person

routine diagnostic and laboratory procedures

oral hygiene instruction, limited to one per 24 months for the initial instruction. Recall instructions are eligible twice per calendar year

fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:

- the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
- the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

pre-fabricated full coverage restorations (metal and plastic)

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

minor surgical procedures and post surgical care, other than surgical procedures covered under Level IV

extractions (including impacted and residual roots)

Dental Care - Level I - Basic Services

Your Group Benefits

consultation with patient or other professionals, twice per calendar year

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

nervous/muscular disorders

Level II - Supplementary Basic Services

Dental Care - 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 8 units per calendar year

- provisional splinting

- occlusal equilibration

endodontic services which include root canals and therapy, root amputation, apexifications, periapical services and the bleaching of endodontically-treated teeth

- 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

Dental Care - Level III - Dentures

initial provision of full or partial removable dentures

replacement of removable dentures, provided the dentures are required because:

- a natural tooth is extracted and the existing appliance cannot be made serviceable

- the existing appliance is at least 5 years old and cannot be made serviceable, or

- the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

Your Group Benefits

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

crowns, veneers and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay

inlays

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 5 years old and cannot be made serviceable, or

- the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.

surgical incision and drainage

stomatoplasty, frenectomy and sialolithotomy

soft tissue biopsy, oral pathology, cytological tests and bacteriological exams

post-surgical treatment

excision of torus palatinus, unilateral and bilateral excision of torus mandibularis

implants, or any services rendered in conjunction with implants

Level V - Orthodontics

Dental Care - Level V - Orthodontics

orthodontic services

Late Entrant Limitation

Dental Care - Late Entrant Limitation

If you or your Dependants 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

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

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

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

Subrogation (Third Party Liability)

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.

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

Dental Care - Exclusions

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

war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion

committing or attempting to commit an assault or criminal offence

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

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

services which are payable by any government plan

services or supplies provided by an association, trade union or your employer's medical or dental department

services or supplies for which no charge would normally be made in the absence of group benefit coverage

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

Your Group Benefits

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

laboratory fees which exceed reasonable and customary charges

services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person

implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, the plan will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge

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

services or supplies which are not specified as a covered expense under this benefit

Health Care Spending Account

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

*Health Care Spending
Account*

Survivor Extended Benefit

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

the date your Dependant is no longer a Dependant, according to the definition of Dependant (see Explanation of Commonly Used Terms)

the date similar coverage is obtained elsewhere

the date which is one year from your death, for Extended Health Care benefits

the date which is 90 days from your death, for Dental Care benefits, or

the date the Plan Document terminates

*Survivor Extended
Benefit*

