

British Columbia Institute of Technology

Plan Document Numbers: G0083238A, G0143814, G0158464A

Plan: AB - Faculty & Staff Association - Flexible Learning

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: June 01, 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.

This booklet produced: July17, 2026

Table of Contents

Benefit Summary	3
How to Use Your Benefit Booklet	7
Explanation of Commonly Used Terms.....	8
Why Group Benefits?	10
Your Employer's Representative	10
Please record the name of your representative and the contact number in the space provided.	10
Applying for Group Benefits	10
Making Changes	10
The Claims Process.....	11
How to Submit a Claim	11
Co-ordination of Extended Health Care and Dental Care Benefits.....	11
Who Qualifies for Coverage?	14
Eligibility	14
Medical Evidence	14
Late Application.....	14
Effective Date of Coverage	15
Termination of Coverage	15
Your Group Benefits.....	16
Extended Health Care	16
Dental Care	31
Health Care Spending Account	36
Survivor Extended Benefit.....	36
Lifestyle and Wellness Spending Account.....	36
Notes	39

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

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

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

Not applicable to:

Out-of-Province/Canada Emergency Medical Treatment

Note: *The deductible is not applicable to Emergency Travel Assistance.*

Benefit Percentage (Co-insurance)

95% of the first \$1,000 of paid expenses and 100% thereafter in any calendar year for
Hospital Care
Drugs
Vision
Professional Services
Medical Services and Supplies

Note:

The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%

The Benefit Percentage for Emergency Travel Assistance is 100%

Termination Age - Coverage continues until the employee's retirement and as outlined under Termination of Coverage.

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
- injectable medications, including vitamin B12 for the treatment of pernicious anaemia (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- shingles vaccine
- insulin preparations and supplies, 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)

Dispensing fees for Drugs purchased with the Pay Direct Drug Card, other than compounds, will not be subject to Reasonable and Customary limitations.

Benefit Summary

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
- vaccines, other than shingles vaccine
- anti-smoking drugs
- drugs used in the treatment of a sexual dysfunction
- non-oral contraceptives, intrauterine devices and diaphragms

- Drug Maximums

Sclerotherapy - \$20 per day

Fertility drugs - \$2,500 per lifetime per certificate

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.

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.

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

- eye exams, up to \$100 per 24 consecutive months
- purchase and fitting of prescription glasses (excluding prescription sunglasses or safety goggles) or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$750 per 24 months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$150 per lifetime

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$350 per calendar year, including one x-ray per calendar year
- Podiatrist/Chiropodist - \$350 per calendar year, including one x-ray per calendar year
- Massage Therapist - \$750 per calendar year combined with physiotherapist
- Naturopath - \$250 per calendar year
- Speech Therapist - \$200 per calendar year
- Physiotherapist - \$750 per calendar year combined with massage therapist
- Psychologist - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Clinical Counsellor - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Social Worker - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Acupuncturist - \$250 per calendar year

Benefit Summary

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current British Columbia 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

60% 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 - Coverage continues until the employee's retirement and as outlined under Termination of Coverage.

Designed with Your Needs in Mind

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

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

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of British Columbia Institute of Technology. The information in this booklet is a summary of the provisions of the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Plan Document (available from your employer), the terms of the Plan Document will apply.

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 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 Plan Document has the right to request a copy of any or all of the following items:

- the 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 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 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 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.

Administrator

Manulife Financial

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by your employer.

Covered Expenses

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

Deductible

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

Dependent

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

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your natural or adopted child, or stepchild, who is:
 - unmarried
 - under age 21, or under age 25 if a full-time student at an accredited school, college or university
 - not employed on a full-time basis, and
 - not eligible for coverage as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

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

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

Explanation of Commonly Used Terms

Drug

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

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

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister. An immediate family member is not eligible for benefits unless the family member also meets the definition of dependent. An immediate family member as defined here is used for the purposes of administering certain provisions of the Extended Health Care or Dental Care benefits and not for defining who is eligible for coverage.

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

drugs which are necessary for the survival of the patient.

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.

Provincial Plan

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

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.

Waiting Period

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

Ward

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

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

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

Your Employer's representative is _____
Phone Number: _____

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

Applying for Group Benefits

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

Making Changes

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

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

How to Submit a Claim

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim. You can also submit claims online at www.manulife.com.

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

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

Payment of Extended Health Care and Dental Claims

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

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

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

Plan does not include school insurance or Provincial Plans.

The Claims Process

Order of Benefit Payment

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

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:

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

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

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

- For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

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

- The Plan of the parent with custody of the child, then
- The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).
- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

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

Submitting a Claim for Co-ordination of Benefits

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

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a part-time employee of British Columbia Institute of Technology, or
- are a part-time employee of the BCIT Faculty and Staff Association, and
- work at least the Required Number of Hours,
- are a member of an eligible class,
- for Extended Health Care benefits, are covered under the Provincial Plan,
- are younger than the Termination Age,
- are residing in Canada,
- have completed the Waiting Period, and
- for Extended Health Care and Dental Care benefits, if you have worked 250 contract hours in the first calendar year of employment (June 1 - May 31) and at least 150 contract hours in subsequent calendar years.

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

Part-time employee - normal work schedule of at least 150 contract hours per calendar year

Medical Evidence

Medical evidence is required for Extended Health Care benefits, when you make a Late Application for coverage on any person.

Late Application

An application is considered late when you:

- apply for contributory 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.

If you apply for Dental benefits more than 31 days after first being eligible, you may become covered upon submission of proof satisfactory to Manulife Financial that eligibility for comparable or more comprehensive coverage under another group plan, under which you or your dependents were covered, ceased not more than 31 days before you applied for replacing coverage under this Plan.

Who Qualifies for Coverage?

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.

If you opt out of coverage under this plan, you will not be eligible to re-enroll in the plan for a period of two years.

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.

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 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 Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date you opt out of coverage under this plan, in which case, you will not be eligible to re-enroll in the plan for a period of two years
- the date you have less than 150 contract hours in a subsequent calendar year
- the date you have no contract hours credited for five (5) consecutive months
- the date of your retirement

Your dependents' coverage terminates on the date your coverage terminates, the date the dependent ceases to be an eligible dependent, or the date your dependent commences active duty in the armed forces of any country, state or international organization, whichever is earliest.

Your Group Benefits

Extended Health Care

Your Extended Health Care Benefit is provided directly by British Columbia Institute of Technology. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

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

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

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

Drug Benefit 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

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

Not applicable to:

Out-of-Province/Canada Emergency Medical Treatment

Note: *The deductible is not applicable to Emergency Travel Assistance.*

- 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)

95% of the first \$1,000 of paid expenses and 100% thereafter in any calendar year for

Hospital Care

Drugs

Vision

Professional Services

Medical Services and Supplies

Note:

The Benefit Percentage for Out-of-Province/Out-of-Canada Emergency Medical Treatment is 100%.

The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - Coverage continues until the employee's retirement and as outlined under Termination of Coverage.

Waiting Period

once qualification of coverage has been met, coverage begins July 1st or the first day of the month following the date of application, whichever is later

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 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

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

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

- Drug Expenses

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

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

Hospital Care

- charges, in excess of the hospital's public ward charge, for private accommodation, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges, in excess of the hospital's semi-private room, for private accommodation, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Your Group Benefits

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
- injectable medications, including vitamin B12 for the treatment of pernicious anaemia (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- shingles vaccine
- insulin preparations and supplies, 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)

Dispensing fees for Drugs purchased with the Pay Direct Drug Card, other than compounds, will not be subject to Reasonable and Customary limitations.

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
- vaccines, other than shingles vaccine
- anti-smoking drugs
- drugs used in the treatment of a sexual dysfunction
- non-oral contraceptives, intrauterine devices and diaphragms

- Drug Maximums

Sclerotherapy - \$20 per day

Fertility drugs - \$2,500 per lifetime per certificate

All other covered drug expenses - Unlimited, subject to overall Plan maximum

- 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.

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.

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

- eye exams, up to \$100 per 24 consecutive months
- purchase and fitting of prescription glasses (excluding prescription sunglasses or safety goggles) or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$750 per 24 months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$150 per lifetime

Your Group Benefits

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$350 per calendar year, including one x-ray per calendar year
- Podiatrist/Chiropodist - \$350 per calendar year, including one x-ray per calendar year
- Massage Therapist - \$750 per calendar year combined with physiotherapist
- Naturopath - \$250 per calendar year
- Speech Therapist - \$200 per calendar year
- Physiotherapist - \$750 per calendar year combined with massage therapist
- Psychologist - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Clinical Counsellor - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Social Worker - \$2,000 per calendar year combined with psychologist, clinical counsellor and social worker
- Acupuncturist - \$250 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.

- 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 3 calendar years. If during the accumulation period, the maximum has been reached, benefits will be payable to a maximum of \$50 per day.

Charges for the following services are not covered:

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

Pre-Determination of Benefits

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

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available. Charges for emergency transportation by railroad, boat or airline, or for emergency transportation from one hospital to another as a result of inadequate facilities are also covered.

Medical Equipment

- rental or, when approved by Manulife Financial or your employer, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs
 - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses Charges for replacement of a prosthesis are eligible when the device can no longer be repaired or no longer meets the patient's medical needs.
- surgical stockings/support hose, up to a maximum of \$80 per calendar year
- surgical brassieres, up to a maximum of \$150 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 a dependent child and \$400 per calendar year for any other person
- casted, custom-made orthotics, up to a maximum of \$300 per calendar year (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

Your Group Benefits

Other Supplies and Services

- blood and blood plasma
- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- stump socks, to a maximum of \$200 per calendar year
- viscosupplementation, 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 \$1,500 per 3 years
- 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

The cost of eligible non-drug fertility expenses provided directly or indirectly by a Canadian fertility clinic, as permitted under the Canada Revenue Agency's (CRA's) Medical Expense Tax Credit (METC), up to a maximum of \$10,000 per certificate, per lifetime.

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs during the first 365 days while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

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.

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
- prescribed Drugs
- 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.

Emergency Travel Assistance

Emergency Travel Assistance is a travel assistance program available for you and your covered dependents. The assistance services are delivered through an international organization, specializing in travel assistance. The following services are provided, when required as a result of a medical emergency during the first 365 days while travelling outside your province of residence.

Details on your Emergency Travel Assistance benefit are provided below, as well as in your Emergency Travel Assistance brochure.

Medical Emergency Assistance

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

Your Group Benefits

- 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.

a) **24-Hour Access**

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

b) **Medical Referral**

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

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

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

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

g) Trip Interruption/Delay

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

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

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

h) After Hospital Convalescence

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) Visit of Family Member

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

j) Vehicle Return

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

k) Identification of Deceased

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

l) Meals and Accommodation

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of \$2,000 (Canadian) per medical emergency.

Your Group Benefits

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

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

b) **Lost Document and Ticket Replacement**

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

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Exceptions

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

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

How to Access Emergency Travel Assistance - Your Emergency Travel Assistance Card

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

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

If you do not have an Emergency Travel Assistance Card, please contact your employer.

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.

All claims must be submitted within 12 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, acting on behalf of your employer those amounts you recover which, when added to the payments you received from the administrator, acting on behalf of your employer, exceed 100% of your incurred expenses.

Exclusions

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

- any illness or injury arising out of or in the course of employment when the person is covered by or is eligible for coverage by workers' compensation
- any illness or injury for which benefits are payable under any government plan or legally mandated program
- for Out-of-Province/Out-of-Canada and Emergency Travel Assistance 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 or war (whether declared or undeclared), insurrection or riot, or hostilities of any kind
- charges for periodic check-ups, broken appointments, travel for health purposes or completion of claim forms
- charges for general health examinations and examinations required for use by a third party
- charges for eye examinations, except where included as an eligible expense

Your Group Benefits

- 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 required for recreation or sports but which are not Medically Necessary for regular activities,
 - which are received from a medical or dental department maintained by an employer, association or trade union,
 - 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 provided while confined in a hospital on an in-patient basis,
 - which are not specified as a covered expense under this benefit,
- medical or surgical care which is cosmetic, other than for sclerotherapy
- medical treatment which is not usual and customary, or which is Experimental or Investigational in nature
- charges which were considered an insured service of any Provincial government plan at the time this policy was issued and subsequently were modified, suspended or discontinued
- charges for transport or travel, other than as specifically provided under this benefit
- charges for services or supplies which are furnished without the recommendation and approval of a Physician acting within the scope of his license
- charges which Manulife Financial is not permitted, by any law or regulation, to cover
- charges for medical treatment or surgical procedures by a physician other than as specifically provided for under the Out-of-Province or Out-of-Canada 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%.

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.

Your Group Benefits

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.

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:

- 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

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.

Dental Care

Your Dental Care Benefit is provided directly by British Columbia Institute of Technology. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

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

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

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

The Benefit

Deductible - Nil

Dental Fee Guide - Current British Columbia 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

60% 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 - Coverage continues until the employee's retirement and as outlined under Termination of Coverage.

Waiting Period

once qualification of coverage has been met, coverage begins July 1st or the first day of the month following the date of application, whichever is later

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

Your Group Benefits

- are reasonable as determined by your employer or Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

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

Level I - Basic Services

- complete oral exam, one per every 9 months and one per every 6 months for children under 19
- complete x-rays series or equivalent, one per 3 years
- full-mouth x-rays, one per 2 calendar years
- panoramic x-rays, one per 60 months
- specific exams, 2 per calendar year
- cephalometric x-rays, 2 per 6 months
- study casts, 2 per calendar year
- one unit of light scaling and one unit of polishing twice per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing) twice per calendar year, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year
- routine diagnostic and laboratory procedures
- fillings and retentive pins. Composite fillings on molar teeth are not covered. 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
- pit and fissure sealants, one per tooth per 2 calendar years
- pre-fabricated full coverage restorations (metal and plastic) Stainless steel crowns are limited to once per tooth in a 60 month period.
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care

- extractions (including impacted and residual roots)
- consultations, 2 units of time 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
- metal onlay, composite onlay, porcelain/ceramic onlay (after fillings or the pre-formed crowns). Replacement crowns are covered once every 60 months.

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery) Charges for gingival curettage are not covered.
- 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 per lifetime
 - re-treatment is not covered

Level III - Dentures

Note: Only one of the below services is eligible on the same tooth in any 60 month period, combined with all services under Level IV

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

Your Group Benefits

Level IV - Major Restorative Services

Note: Only one of the below services is eligible on the same tooth in any 60 month period, combined with all services under Level III

- crowns when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- onlays not included in Level I, when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay Replacement crowns are covered once every 60 months. Temporary crowns are not covered.
- porcelain staining
- 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 60 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

Level V - Orthodontics

- orthodontic services

Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

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

Submitting a Claim

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

All claims must be submitted within 12 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.

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

Exclusions

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

- a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program
- charges which were considered an insured service of any Provincial government plan at the time this Policy was issued and subsequently were modified, suspended or discontinued
- services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- charges for broken appointments, third party examinations, travel to and from appointments, or completion of claim forms
- charges for services or supplies:
 - when there would have been no charge at all in the absence of plan benefit coverage
 - which are received from a medical or dental department maintained by an employer, association or trade union
 - which are performed or provided by the covered person, an Immediate Family Member or a person who lives with the covered person
 - which are not specified as a covered expense under this benefit
- 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 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.
- any hospital charges for board and room and related services and supplies
- 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 Manulife Financial
- services or supplies which are not medically necessary to the care of any existing or suspected injury or disease

Your Group Benefits

Health Care Spending Account

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

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue 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 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 the end of the month following the month of your death, or
- the date the Plan Document terminates

Lifestyle and Wellness Spending Account

Your plan includes a Lifestyle and Wellness Spending Account.

Your Lifestyle and Wellness Spending Account (LWSA) plan number is G0158464A.

Be sure to use your LWSA number on all LWSA claims.

You can use the money in this account to cover the remaining portion of, or even the full cost of a treatment or service that your plan does not include as part of the base coverage.

Lifestyle and Wellness Spending Account money may also be used to subsidize personal/lifestyle choices or requirements (such as Childcare or Fitness Club Memberships), but only if your plan sponsor has pre-defined these uses.

Any amounts paid from your Lifestyle and Wellness Spending Account will be reflected on your T4 as taxable income.

The Benefit

Your employer will pay the Benefit Percentage of all Covered Expenses incurred for the care of a covered person. The total payment for all Covered Expenses incurred during the plan year will not exceed the maximum benefit as set by your employer.

Any unused portion of your maximum benefit remaining at the end of the plan year will be carried forward to be used in the following plan year. However, if the amount carried forward is not used by the end of that plan year, it will be forfeited.

Overall Benefit Maximum - the amount reported by the employer to Manulife

Deductible - Nil

Benefit Percentage (Co-insurance) - 100% of eligible expenses

Termination Age - employee's retirement

Waiting Period

once qualification of coverage has been met, coverage begins July 1st or the first day of the month following the date of application, whichever is later

Covered Expenses

Covered Expenses are expenses which are:

- incurred by the person while covered under this Plan;
- not covered under a Provincial Plan or any other government-sponsored program; and
- not prohibited by law from being covered.

Covered Expenses shall include:

- membership and/or admission to fitness facilities;
- textbooks and/or related media on health and/or wellness related topics;
- smoking cessation, weight loss or addiction programs;
- classes/courses for health/wellness enhancement or for personal or professional development;
- fitness instruction/personal trainers;
- admission fees for races and fitness activities;
- fitness trackers and app subscription, such as Fitbit or MyFitness Pal, and other technology;
- consultation session(s) with a Registered Dietitian or Nutritionist;
- meditation/mindfulness classes or programs;
- active wear and sports equipment;
- for other lifestyle or wellness purposes, as agreed by the Employer and Union.

Expenses Not Covered

No benefit is payable for any expense which is not directly or indirectly related to the Employee's wellness, as determined by the Employer and the Administrator from time to time.

Your Group Benefits

Submitting a Claim

To submit a claim, you must complete a Lifestyle Spending Account form, available from your employer.

All claims must be submitted by the end of the plan year in which the expense was incurred.

Upon termination of a person's benefits under this Plan, proof that benefits are payable must be submitted within the earlier of:

- the end of the plan year in which the expense was incurred; and
- 90 days from the date of termination of plan benefits.

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

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.