Camosun College

Plan Document Numbers: G0083707, G0083708

Group Policy Number: G0039942

Plan: A - CCFA

Employee Name:

Certificate Number:

Welcome to Your Group Benefit Program

Plan Documents Effective Date: February 01, 2010

Group Policy Effective Date: February 01, 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.

Table of Contents

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

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

Benefit Amount - 3 times your annual earnings, to a maximum of $800,000

Benefit Reduction:

Employees Age 65 - 2.7 times your annual earnings, subject to a maximum of $800,000

Employees Age 66 - 2.4 times your annual earnings, subject to a maximum of $800,000

Employees Age 67 - 2.1 times your annual earnings, subject to a maximum of $800,000

Employees Age 68 - 1.8 times your annual earnings, subject to a maximum of $800,000

Employees Age 69 - 1.5 times your annual earnings, subject to a maximum of $800,000

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

Employee Optional Life Insurance

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

Benefit Amount - increments of $10,000 to a maximum of $200,000

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier.

Dependent Optional Life Insurance

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $200,000

Termination Age - employee's or spouse's age 65 or employee's retirement, whichever is earlier

Benefit Summary

Accidental Death and Dismemberment

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0039942.

Benefit Amount - 3 x your annual earnings, to a maximum of $800,000.

Benefit Reduction:

Employees Age 65 - 2.7 times your annual earnings, subject to a maximum of $800,000

Employees Age 66 - 2.4 times your annual earnings, subject to a maximum of $800,000

Employees Age 67 - 2.1 times your annual earnings, subject to a maximum of $800,000

Employees Age 68 - 1.8 times your annual earnings, subject to a maximum of $800,000

Employees Age 69 - 1.5 times your annual earnings, subject to a maximum of $800,000

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

Extended Health Care

Extended Health Care
Extended Health Care - The Benefit

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $50 Individual, $50 Family, per calendar year(s)
Not applicable to:
Vision
Professional Services (Psychologist/Clinical Counsellor only)
Out-of-Province/Canada Emergency Medical Treatment

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

Benefit Percentage (Co-insurance)

100% for
- Vision

95% of the first $1,000 of paid expenses and 100% thereafter for
- Hospital Care
- Medical Services & Supplies
- Professional Services (other than Psychologist/Clinical Counsellor)
- Drugs

90% for
- Professional Services (Psychologist/Clinical Counsellor)

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 - employee's retirement. On retirement your coverage may continue for up to 90 calendar days provided you have applied for health and welfare benefits under the college pension plan.

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 not prescribed for birth control

injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

life-sustaining drugs

standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

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

drugs determined to be ineligible as a result of due diligence

anti-smoking drugs

drugs used in the treatment of a sexual dysfunction

oral contraceptives prescribed for birth control, intrauterine devices and diaphragms

injectable vitamins

preventive vaccines and medicines (oral or injected)

- Drug Maximums

- Drug Maximums

Fertility drugs - $2,500 per lifetime

All other covered drug expenses - Unlimited

Benefit Summary

- 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.

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, $100 every 2 years

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $650 combined every 2 calendar years

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $400 per calendar year combined with athletic therapist. X-rays are not covered.

Podiatrist/Chiropodist - $400 per calendar year. X-rays are not covered.

Massage Therapist - unlimited

Naturopath - $400 per calendar year, X-rays are not covered.

Speech Therapist - $1,000 per calendar year

Physiotherapist - unlimited. X-rays are not covered.

Psychologist/Clinical Counsellor - $3,000 per family per calendar year

Acupuncturist - $300 per calendar year

Athletic Therapist - $400 per calendar year, combined with chiropractor. X-rays are not covered.

Medical Travel Referral (MTB)

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

The Benefit

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

Deductible- Nil

Benefit Percentage (Co-insurance)- 100%

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

Termination Age - employee's retirement

Benefit Summary

Dental Care

Dental Care
Dental Care - The Benefit

The Benefit

Deductible - Nil

Dental Fee Guide - 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

- 75% for Level III - Dentures

- 75% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $2,000 per lifetime for Level V

Termination Age - employee's retirement. On retirement your coverage may continue for up to 90 calendar days provided you have applied for health and welfare benefits under the college pension plan.

Weekly Income (Short Term Disability)

Weekly Income

The Weekly Income (Short Term Disability) Benefit is insured under Manulife Financial's Policy G0039942.

Benefit Amount - 70% of weekly earnings, to a maximum benefit of $1,385

Qualifying Period - 30 calendar days, if the disability is due to an accident; 30 calendar days, if the disability is due to a sickness

Maximum Benefit Period - For Total and Partial Disability - 21 weeks

Termination Age - age 70 or retirement, whichever is earlier. However, if you attain age 70 while receiving benefits, benefit payments will continue until you have received a total of 21 weeks of benefits.

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 dependents are covered. The Group Policy and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

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

the Group Policy and/or Plan Document,

your application for group benefits, and

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

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

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

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

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

Explanation of Commonly Used Terms

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

Addiction Facility

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

Addiction Facility

Adherence

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

Adherence

Administrator

Manulife Financial

Administrator

Advisory Body

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

Advisory Body

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

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

Covered Expenses

Deductible

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

Deductible

Dependent

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

Dependent

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner 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

- not employed on a full-time basis, and

- not eligible for coverage as an employee under this or any other Group Benefit Program

a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

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

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

a stepchild must be living with you to be eligible

a newborn child shall become eligible from the moment of birth

Disease Management Programs

Disease Management Programs

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

Drug

Drug

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

Due Diligence

Due Diligence

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

Earnings

Earnings

your regular rate of pay including regular bonuses and regular overtime

For Weekly Income

Gross weekly earnings refer to your normal earnings on the last day of work or sick leave. The gross weekly earnings applicable on the last day of work or sick leave shall be adjusted due to salary increases negotiated retroactively.

If you working less than full-time or if your regular employment includes a period of layoff with a predetermined recall date of less than nine months, the gross weekly earnings refers to your hours normally worked per week, as determined by averaging the number of hours you actually worked over the 52 week period immediately preceding the date of Disability or illness, times your regular hourly rate, or the hourly equivalent, which are rates in effect at the date of Disability.

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

the amount reported on your claim form, or

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

Exclusive Distribution

Manulife Financial approved vendors.

Exclusive Distribution

Experimental or Investigational

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

Experimental or Investigational

Immediate Family Member

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

Immediate Family Member

Interchangeable Drug

includes but is not limited to:

Interchangeable Drug

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

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

Licensed, Certified, Registered

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

Licensed, Certified, Registered

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Life-Sustaining Drugs

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.

Lower Cost Alternative

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.

Medically Necessary

Explanation of Commonly Used Terms

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.

Pharmacoeconomics

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

Prior Authorization

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

Provincial Plan

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

Qualifying Period

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

Reasonable and Customary

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

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

Ward

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

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 inputs the applicable information into the Manulife website.

Making Changes

Making Changes

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

change in Dependent Coverage

change in Beneficiary

applying for coverage previously waived

change in Name

The Claims Process

Naming a Beneficiary

Naming a Beneficiary

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

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

How to Submit a Claim

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.

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.

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!

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

Claim Payment

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

other Group Benefit Programs;

any other arrangement of coverage for individuals in a group; and

individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

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

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

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

– For Claims incurred by you or your Dependent Spouse:

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

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

  ° The Plan where the person is covered as an active full-time employee, then

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

– 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

Eligibility

You are eligible for Group Benefits if you:

are an employee of Camosun College, and

are a member of the Faculty Association who is working on an active, continuing or probationary basis, or

are a phased retiree employee of Camosun College and work at least 50% of a full-time workload,

are a member of an eligible class,

are younger than the Termination Age,

for Extended Health Care and Medical Travel Referral (MTB) benefits, are covered under the Provincial plan,

Dental Care benefits, is either a continuing Full-time or continuing Part-time employee with an appointment of at least 50% or Term employee with an appointment of at least 50% for 16 weeks,

for Short Term Disability Insurance, either a continuing full time or continuing part time employee or term employee who is on contract for 4 months or more with an appointment of at least 50%,

for Group Life Insurance and Accidental Death & Dismemberment, either a continuing full time or continuing part time employee or term employee who is on contract for 4 months or more with an appointment of 100%,

for Extended Health Care benefits and Psychological Services Plan, are a continuing full time or continuing part time employee or term employee on contract for more than one month,

are residing in Canada, and

have completed the Waiting Period.

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

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

Medical Evidence

Medical Evidence

Medical evidence is required for all non-mandatory benefits 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.

Who Qualifies for Coverage?

Late Application

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.

Effective Date of Coverage

Effective Date of Coverage

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

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

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

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

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

Termination of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

the date you cease to be an eligible employee, for reasons other than retirement

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

the date your employer terminates coverage

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

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

the date you reach the Termination Age

the date of your death

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

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

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

The Benefit

Employee Life - The Benefit

Benefit Amount - 3 times your annual earnings, to a maximum of $800,000

Non-Evidence Limit - $800,000

Qualifying Period for Waiver of Premium - 180 days of Disability or expiration of benefits under the Weekly Income benefit, whichever is earlier

Benefit Reduction:

Employees Age 65 - 2.7 times your annual earnings, subject to a maximum of $800,000

Employees Age 66 - 2.4 times your annual earnings, subject to a maximum of $800,000

Employees Age 67 - 2.1 times your annual earnings, subject to a maximum of $800,000

Employees Age 68 - 1.8 times your annual earnings, subject to a maximum of $800,000

Employees Age 69 - 1.5 times your annual earnings, subject to a maximum of $800,000

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

Waiting Period

First of the month coincident with or next following date of hire

Naming a Beneficiary

Employee Life Insurance - Naming a Beneficiary

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

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

Submitting a Claim

Employee Life Insurance - Submitting a Claim

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

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

A completed claim form must be submitted within 15 months from the date of the loss.

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

A completed claim form must be submitted within 6 months following the first month after the end of the Qualifying Period.

Waiver of Premium

Employee Life Insurance - Waiver of Premium

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

Definition of Totally Disabled

Employee Life Insurance - Totally Disabled

Totally Disabled means your complete inability because of an accident or sickness to perform 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 current 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 Premium, you must meet the following criteria:

you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 2 weeks due to the same or related cause, 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 complete inability, 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
  - the current monthly earnings are 75% or more of the current 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 Premium

Employee Life Insurance - Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

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

the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes complete inability, 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
  - the current monthly earnings are 75% or more of the current 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

Recurrent Disability

Employee Life Insurance - Recurrent Disability

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

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

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

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

Conversion Privilege

Employee Life Insurance - Conversion Privilege

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

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

Employee Optional Life Insurance

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

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

The Benefit

Employee Optional Life Insurance - The Benefit

Benefit Amount - increments of $10,000 to a maximum of $200,000

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

Qualifying Period for Waiver of Premium - 180 days of Disability or expiration of benefits under the Weekly Income benefit, whichever is earlier

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier.

Waiting Period

First of the month coincident with or next following date of hire

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

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

Waiver of Premium

Employee Optional Life Insurance - Waiver of Premium

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

Exclusions

Employee Optional Life Insurance - Exclusions

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

Dependent Optional Life Insurance

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under Manulife Financial's Policy G0039942.

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

The Benefit

Dependent Optional Life Insurance - The Benefit

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $200,000

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

Qualifying Period for Waiver of Premium - 180 days of Disability or expiration of benefits under the Weekly Income benefit, whichever is earlier

Termination Age - employee's or spouse's age 65 or employee's retirement, whichever is earlier

Waiting Period

First of the month coincident with or next following date of hire

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

Submitting a Claim

Dependent Optional Life Insurance - Submitting a Claim

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

A completed claim form must be submitted within 15 months from the date of loss.

Waiver of Premium

Dependent Optional Life Insurance - Waiver of Premium

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

Conversion Privilege

Dependent Optional Life Insurance - Conversion Privilege

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

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

Exclusions

Dependent Optional Life Insurance - Exclusions

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

Accidental Death and Dismemberment

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy G0039942.

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

The Benefit

AD& D - The Benefit

Aggregate Limit - $5,000,000

Benefit Amount - 3 x your annual earnings, to a maximum of $800,000.

Benefit Reduction:

Employees Age 65 - 2.7 times your annual earnings, subject to a maximum of $800,000

Employees Age 66 - 2.4 times your annual earnings, subject to a maximum of $800,000

Employees Age 67 - 2.1 times your annual earnings, subject to a maximum of $800,000

Employees Age 68 - 1.8 times your annual earnings, subject to a maximum of $800,000

Employees Age 69 - 1.5 times your annual earnings, subject to a maximum of $800,000

Qualifying Period for Waiver of Premium - 180 days of Disability or expiration of benefits under the Weekly Income benefit, whichever is earlier

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

Waiting Period

First of the month coincident with or next following date of hire

Schedule of Losses

AD& D - Schedule of Losses

A loss shown in this schedule is covered provided it:

is a direct result of the accidental injury

occurs within 365 days from the date of the accidental injury

is total and irreversible or irrecoverable

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

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

Loss of Life - 100%

Loss of or Loss of Use of Both Hands or Both Feet - 100%

Loss of Sight of Both Eyes - 100%

Loss of One Hand and One Foot - 100%

Loss of One Hand and Sight of One Eye - 100%

Loss of One Foot and Sight of One Eye - 100%

Loss of Hearing in Both Ears and Speech - 100%

Loss of or Loss of Use of One Arm or One Leg - 75%

Loss of or Loss of Use of One Hand or One Foot - 75%

Loss of Sight of One Eye - 75%

Loss of Speech or Hearing in Both Ears - 75%

Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33.33%

Loss of All Toes of One Foot - 25%

Loss of Hearing in One Ear - 25%

Hemiplegia, Paraplegia or Quadriplegia - 200%

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

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

Exposure and Disappearance

AD& D - Exposure and Disappearance

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

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

Aggregate Limit

AD& D - Aggregate Limit

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

Rehabilitation Expenses

AD& D - Rehabilitation Expenses

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

reasonable and necessary, as determined by Manulife Financial

incurred within a period of 3 years from the date of the accidental injury

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

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

Repatriation Expenses

AD& D - Repatriation Expenses

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

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

Family Transportation Expenses

AD& D - Family Transportation Expenses

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

reasonable and necessary, as determined by Manulife Financial

for hotel accommodations in the vicinity of the hospital

for transportation by the most direct route to the hospital, including return fare

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

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

Dependent Education Expenses

AD& D - Dependent Education Expenses

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

in a school for higher learning above the secondary school level, or

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

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

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

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

$5,000

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

No payment will be made for:

tuition expenses incurred prior to your death

room and board expenses, or other living, travelling or clothing expenses

Spousal Occupational Training Expenses

AD& D - Spousal Occupational Training Expenses

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

reasonable and necessary, as determined by Manulife Financial

incurred within a period of 3 years from the date of the accidental injury

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

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

Seat Belt Benefit

AD& D - Seat Belt Benefit

If you die as a direct result of an accidental injury sustained while driving or riding in an automobile, Manulife Financial will pay an additional amount equal to 10% of your Accidental Death and Dismemberment benefit, to a maximum of $25,000, provided you were wearing your seat belt and it was properly fastened at the time of the accidental injury.

Day-Care Expenses

AD& D - Day-Care Expenses

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

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

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

$10,000

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

No payment will be made for:

expenses incurred prior to your death

room and board expenses, or other living, travelling or clothing expenses

Home Alteration and Vehicle Modification Expenses

AD& D - Home Alteration and Vehicle Modification Expenses

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

suffer a loss of, or loss of use of, both feet or both legs, or

become a hemiplegic, paraplegic, or quadriplegic

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

reasonable and necessary, as determined by Manulife Financial

incurred within 3 years from the date of the accidental injury

for alterations to your home for the purpose of making it wheelchair accessible

for modifications to one motor vehicle for the purpose of making it wheelchair accessible

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

Non-Duplication of Expenses

AD& D - Non-Duplication of Expenses

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

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

Naming a Beneficiary

AD&D - Naming a Beneficiary

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

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

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

Submitting a Claim

AD& D - Submitting a Claim

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

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

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

A completed claim form must be submitted within 15 months from the date of the loss.

Waiver of Premium

AD& D - Waiver of Premium

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

Exclusions

AD& D - Exclusions

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

suicide or self-inflicted injuries

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

riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew

riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by Camosun 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 dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

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

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

Drug Benefit and Pharmacy Services for Quebec Residents

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $50 Individual, $50 Family, per calendar year(s)
Not applicable to:
- Vision
- Professional Services (Psychologist/Clinical Counsellor only)
- Out-of-Province/Canada Emergency Medical Treatment

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

Benefit Percentage (Co-insurance)

100% for
- Vision

95% of the first $1,000 of paid expenses and 100% thereafter for
- Hospital Care
- Medical Services & Supplies
- Professional Services (other than Psychologist/Clinical Counsellor)
- Drugs

90% for
- Professional Services (Psychologist/Clinical Counsellor)

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 - employee's retirement. On retirement your coverage may continue for up to 90 calendar days provided you have applied for health and welfare benefits under the college pension plan.

Waiting Period

First of the month coincident with or next following date of hire

Covered Expenses

Extended Health Care - Covered Expenses

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

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

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

reasonable taking all factors into account

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

legally insurable

used as prescribed or recommended by a physician

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

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

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

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

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

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

Adherence

Adherence

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

Patient Assistance Programs

Patient Assistance Programs

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

Disease Management Programs

Disease Management Programs

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

Extended Health Care - Advance Supply Limitation

Advance Supply Limitation

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

- Drug Expenses

- Drug Expenses

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

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

b) a 90 day supply.

Hospital Care

Extended Health Care - Hospital Care

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

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

- the accommodation was specifically elected in writing by the patient

Extended Health Care - Addiction Facility

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

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

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

drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist

oral contraceptives not prescribed for birth control

injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

life-sustaining drugs

standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

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

drugs determined to be ineligible as a result of due diligence

anti-smoking drugs

drugs used in the treatment of a sexual dysfunction

oral contraceptives prescribed for birth control, intrauterine devices and diaphragms

injectable vitamins

preventive vaccines and medicines (oral or injected)

- Drug Maximums

- Drug Maximums

Fertility drugs - $2,500 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.

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, $100 every 2 years

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $650 combined every 2 calendar years

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $400 per calendar year combined with athletic therapist. X-rays are not covered.

Podiatrist/Chiropodist - $400 per calendar year. X-rays are not covered.

Massage Therapist - unlimited

Naturopath - $400 per calendar year. X-rays are not covered.

Speech Therapist - $1,000 per calendar year

Physiotherapist - unlimited. X-rays are not covered.

Psychologist/Clinical Counsellor - $3,000 per family per calendar year

Acupuncturist - $300 per calendar year

Athletic Therapist - $400 per calendar year, combined with chiropractor. X-rays are not covered.

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

Extended Health Care - 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

- 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 $25,000 per lifetime.

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 covered person'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 within the covered person's province of residence by boat, rail, airline, or, in an acute emergency, air ambulance to the nearest hospital where adequate treatment is available are also covered.

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

surgical stockings/support hose, up to a maximum of 2 pairs per calendar year

surgical brassieres, up to a maximum of 4 per calendar year

braces (other than foot braces), trusses, collars, leg orthosis, casts and splints

stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of $300 per calendar year for dependent children under age 21 and $500 per calendar year for any other person, combined with custom-made orthotics

casted, custom-made orthotics, up to a maximum of $300 per calendar year for dependent children under age 21 and $500 per calendar year for any other person, combined with orthopaedic shoes (recommendation of either a physician or a podiatrist is required)

cost and installation of hearing aids, to a maximum of $1,000 every 3 years. Charges for batteries, maintenance and repairs are not covered.

Other Supplies and Services

- Other Supplies and Services

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

for yourself only, physician's charges for medical examinations required by law for employment purposes, when not covered by your employer under a collective agreement

synvisc, to a maximum of 9 injections every 12 months

wigs and hairpieces for patients with permanent or temporary hair loss as a result of medical treatment or condition and for hair loss as a result of non-medical condition (such as alopecia), up to a maximum of $500 per lifetime

oxygen

microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec

charges for the treatment of accidental injuries to natural teeth or jaw, to a maximum of $5,000 per accident, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

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

Charges for masculinization procedures as follows:

breast/chest surgery - mastectomy, chest masculinization

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

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

Charges for the following expenses are not covered:

expenses related to travel or accommodation under this benefit

services obtained outside of Canada

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

expenses related to the reversal of gender affirmation treatments

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Province/Out-of-Canada

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

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

A Medical Emergency is

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

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

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

- been treated or tested for any new symptoms or conditions

- had an increase or worsening of any existing symptoms

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

- been admitted to the hospital for treatment of the condition

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

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

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

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.

Emergency Travel Assistance

Extended Health Care - 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

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

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/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 I) 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.

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 a Emergency Travel Assistance Card, please contact your employer.

Submitting a Claim

Extended Health Care - 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. Claim forms may also be obtained from the Plan Member website at www.manulife.com/groupbenefits.

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

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

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)

Subrogation (Third Party Liability)

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

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

Exclusions

Extended Health Care - Exclusions

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

any illness or injury arising out of or in the course of employment when the person is insured 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 of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind

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

charges for supplies and services:

- when there would have been no charge at all in the absence of plan benefit coverage
- when reimbursement would have been made under a government-sponsored plan in the absence of plan benefit coverage
- which are received from a medical or dental department maintained by an employer, association or trade union
- which are required for recreation or sports but which are not medically necessary for regular activities
- which would have been payable by the Provincial Government if proper application had been made
- which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- which are not specified as a covered expense under this benefit

medical or surgical care which is cosmetic

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

charges which were considered an insured service of any provincial government plan at the time this plan document was issued and subsequently were modified, suspended or discontinued

charges for general health examinations, and examinations required for use of a third party, other than, for you, the employee, examinations required for employment purposes

charges for eye examinations, except where included as an eligible expense

charges for transport or travel, other than as specifically provided under Extended Health Care expenses

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

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

Covered Expenses

The following expenses are covered:

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

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

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

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

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

a) **Benefit Percentage**

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

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

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

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

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

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

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

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

i) deductible amounts, and

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

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

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

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

c) **Deductible**

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

d) **Lifetime Maximums**

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

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

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

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

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

- 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.

Medical Travel Referral (MTB)

Medical Travel Referral (MTB)

Your Medical Travel Referral (MTB) Benefit is provided directly by Camosun 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.

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

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

The Benefit

Medical Travel Referral (MTB) - The Benefit

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

Deductible - Nil

Benefit Percentage (Co-insurance) - 100%

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

Termination Age - employee's retirement

Waiting Period

First of the month following date of hire

Covered Expenses

Medical Travel Referral (MTB) - Covered Expenses

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

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

Eligible Expenses

-Eligible Expenses

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

charges for transportation to and from the nearest locale equipped to provide the required treatment for the covered person by automobile (to a maximum of $0.48 per kilometre), scheduled air, rail, bus, taxi or ferry

charges for accommodation, where transportation has been provided under one of the conveyances as described above, in a commercial facility or hotel, Easter Seal House, Heather House, Vancouver Lodge, Ronald McDonald House, or other similar institution approved by Manulife Financial, acting on behalf of your employer, before and after medical treatment

charges for meals, limited to:

– $10.00 for breakfast
– $13.00 for lunch
– $21.50 for dinner

Charges for transportation of a family member or a medical attendant if medically necessary and requested by a licensed physician, combined with the transportation and accommodation charges listed above

Charges are subject to the following conditions and limitations:

referral treatment must be performed by a licensed medical specialist or ophthalmologist;

charges for travel and eligible expenses incurred outside the covered person's province or residence are not covered, unless such expenses are lesser than those incurred in the covered person's province of residence

the benefit does not apply to dental treatment unless:

– such services are required by a licensed physician and/or when hospitalization for treatment is required
– such treatment is performed by an oral surgeon, except in the case of emergency dental assessment or treatment, in which case treatment may be performed by a specialist in the field of dentistry

Submitting a Claim

Medical Travel Referral (MTB) - Submitting a Claim

To submit a Medical Travel Referral (MTB) claim, you must complete an Extended Health Care Claim form. Claim forms are available from your employer.

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

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

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

Exclusions

Medical Travel Referral (MTB) - Exclusions

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

charges which are considered an insured service of any provincial government plan

charges which were considered an insured service under the extended health plan, or any other group insurance plan

charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment

charges for medical treatment, transport or travel, other than as specifically provided under eligible expenses

charges not included in the list of eligible expenses

charges for services or supplies which are furnished without recommendation and approval of a licensed physician acting within the scope of his or her license

charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy

charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation

charges which would not normally have been incurred but for the presence of this coverage or for which you or your dependent are not legally allowed to pay

charges which Manulife Financial is not permitted, by any law or regulation, to cover

charges for dental work where a third party is responsible for payment of such charges

charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind

for Out-of-Province only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness

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

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

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by Camosun 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 dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

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

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

The Benefit

Dental Care - The Benefit

Deductible - Nil

Dental Fee Guide - 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

- 75% for Level III - Dentures

- 75% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $2,000 per lifetime for Level V

Termination Age - employee's retirement. On retirement your coverage may continue for up to 90 calendar days provided you have applied for health and welfare benefits under the college pension plan.

Waiting Period

First of the month coincident with or next following date of hire

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

are incurred for the necessary dental care of a covered person while covered under this benefit

are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license

are reasonable as determined by your employer or Manulife Financial, taking all factors into account

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

Level I - Basic Services

Dental Care - Level I - Basic Services

complete oral exam, one per 36 months

full-mouth x-rays, one per 2 calendar years

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

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

routine diagnostic and laboratory procedures

initial oral hygiene instruction, plus one recall

fillings, retentive pins and pit and fissure sealants. Gold may be used where no other material is adequate. Bonded amalgam fillings are eligible. 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

onlays (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay)

inlays

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

extractions (including impacted and residual roots)

consultations, anaesthesia, and conscious sedation

prosthetic repairs, relines and rebases. Denture relines are eligible once per 24 consecutive months.

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 16 units per calendar year

- provisional splinting

- occlusal equilibration

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

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

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

Level III - Dentures

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

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

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

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

Level V - Orthodontics

Dental Care - Level V - Orthodontics

orthodontic services

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.

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:

a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program

charges which were considered an insured service of any provincial government plan at the time this Plan Document was issued and subsequently were modified, suspended or discontinued

services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind

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

charges for services or supplies:

- when there would have been no charge at all in the absence of plan benefit coverage
- which are received from a medical or dental department maintained by an employer, association or trade union
- which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- which are not specified as a covered expense under this Benefit

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

cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan

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 the employer or the administrator

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.

charges related to dental surgery which require hospitalization

services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease

Health Care Spending Account

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

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, for all benefits other than Psychologist

the date which is 12 months from your death, for Psychologist benefits, or

the date the Plan Document terminates

Wellness Spending Account

Wellness Spending Account

Your plan includes a Wellness Spending Account.

Wellness Spending Account (WSA) plan number is **G0142464**.

Be sure to use your WSA number on all WSA 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.

Wellness Spending Account money may also be used to subsidize personal/lifestyle choices or requirements (such as Fitness Club Memberships), but only if your plan sponsor has pre-defined these uses. You should check with your plan sponsor for a complete list of eligible expenditures for your Wellness Spending Account.

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

The Benefit

Wellness Spending Account - 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 - Your retirement. On retirement, coverage may continue for 30 days only if you have applied for health and welfare benefits under the municipal pension plan.

Waiting Period

First of the month following date of hire

Covered Expenses

Wellness Spending Account - Covered Expenses

Covered Expenses are expenses which are:

incurred by the person while covered under this Plan;

not covered under a Provincial/Territorial 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 addictions programs;

Classes/courses for health/wellness enhancement or for personal or professional development

Fitness Instruction/ Personal Trainers

Admission fees for personal races and fitness activities

Fitness trackers and app subscription, such as Fitbit or MyFitnessPal, or other technology

Consultation session(s) with a Registered Dietitian or Nutritionist

Meditation/Mindfulness classes or programs

Sports equipment

HEALTHCARE EXPENSES i.e.

Any unpaid amounts for health procedure codes not covered under core benefits or Health Care Spending Account

- Stress management programs counselling, books, CDs
- Smoking cessation programs, counselling, books, CDs
- Lifeline monitoring system
- Medic Alert bracelet
- Vitamins/supplements
- Massage tables/supplies
- Bed mattresses (Sealy Posturepedic, etc.)
- Beds other than hospital beds (Craftmatic, etc.)
- Heating pad
- Electric blankets

- Thermometer
- Prenatal classes, Midwife
- Virtual Healthcare/Executive Health Clinics Administration/Membership fees
- Traditional Medicines (i.e. sweetgrass, sage, cedar, ceremonial tobacco, smudge kits)
- Fees and supplies for Indigenous ceremonies (i.e. sweat lodge, healing circles, smudging)

Dental EXPENSES i.e.

- Any unpaid amounts for dental procedure codes not covered under core benefits or Health Care Spending Account
- Prefabricated mouth guards
- Water flosser / WaterPik

FITNESS AND RECREATION EXPENSES

- Dance lessons
- Equipment required to participate in a sporting event
- Fishing - fishing rod, lures, waders, fishing license, etc.
- Fitness equipment (treadmill, Bowflex, exercise bike, etc.), FitBit, Apple Watch etc.
- Fitness/exercise videos, CDs, books
- Golf - green fees, lessons
- Health club membership, fitness programs, gym memberships/classes (yoga, Pilates, aerobics, Curves, GoodLife, etc.)
- Hiking, jogging, running - club fees, race entry fees, shoes
- Horseback riding - lessons and equipment (saddle, helmet, boots, etc.)
- Hunting license and equipment
- Personal trainer
- Racket sports - court fees, lessons, equipment
- Recreational club membership (sailing, skiing, etc.)
- Self-defence courses - registration fees
- Skiing and snowboarding - passes, equipment, membership
- Sports such as baseball, curling, hockey, etc. (registration, equipment, team fees, lessons)
- Water sports equipment - paddle board, canoe, kayak, surf board, life jacket, etc

Expenses Not Covered

Wellness Spending Account - 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.

Submitting a Claim

Wellness Spending Account - Submitting a Claim

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

All claims must be submitted within 31 days from 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 number of days specified above from the end of the plan year in which the expense was incurred; and

31 days from the date of termination of plan benefits.

Weekly Income (Short Term Disability)

Weekly Income

The Weekly Income (Short Term Disability) Benefit is insured under Manulife Financial's Policy G0039942.

If you become Totally Disabled while covered and meet the Entitlement Criteria for this benefit, your employer will pay a disability benefit.

Definition of Totally Disabled

Weekly Income - Definition of Totally Disabled

Totally Disabled means your inability because of accident or sickness to perform the regular duties of your own occupation.

The Benefit

Weekly Income - The Benefit

Benefit Amount- 70% of weekly earnings, to a maximum benefit of $1,385

Qualifying Period - 30 calendar days, if the disability is due to an accident; 30 calendar days, if the disability is due to a sickness

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

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period. Otherwise, benefits are not payable until the date you are first treated by your physician.

Maximum Benefit Period - For Total and Partial Disability - 21 weeks

Termination Age - age 70 or retirement, whichever is earlier. However, if you attain age 70 while receiving benefits, benefit payments will continue until you have received a total of 21 weeks of benefits.

Waiting Period

First day of the month coincident with or next following date of hire

Entitlement Criteria

Weekly Income - Entitlement Criteria

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

you must be continuously Totally Disabled throughout the Qualifying Period

Manulife Financial must receive medical evidence documenting how your illness or injury causes incapacitation, such that you are prevented from performing the regular duties of your own occupation

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.

Subject to the aforementioned criteria, you may elect to use banked sick leave in replacement of weekly income benefits for all or a portion of the 21 week disability benefit period provided the application for weekly income is approved by Manulife Financial.

In no event will the maximum benefit be less than the maximum required for the highest salary scale.

Periods for Which You are Not Entitled to Benefits

Weekly Income - Periods for Which You are Not Entitled to Benefits

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

not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

residing outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period unless:

– you remain under the regular care of a licensed Physician deemed appropriate by Manulife Financial;

- you have previously notified and received approval in writing from Manulife Financial, and
- proof of the ongoing Disability can be determined on evidence satisfactory to Manulife Financial in English or French within 30 days of request

imprisoned in a penal institution for the portion of a period of disability

Amount of Disability Benefit Payable

Weekly Income - Amount of Disability Benefit Payable

In the event you are entitled to any other disability income from your employer as a result of the same accident or sickness that caused you to be eligible to receive benefits from this plan, the benefits from this plan will be reduced by 100% of such other disability income as well as:

primary disability benefits to which the person is entitled on his own behalf under the Canada Pension Plan or Quebec Pension Plan, or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan; except for increases that take effect after the benefit period starts

benefits under any Workers' Compensation Act or similar law except for:

- permanent partial disability awards related to the disability for which you are receiving weekly disability income benefit; and
- Benefits related to any other employment with another employer.

If you receive earnings during the weekly income period, and if such earnings are derived from employment which has not been approved as rehabilitative employment, then the regular monthly benefit from the plan will be reduced by 100% of such earnings.

Subrogation

Weekly Income - Subrogation

Manulife Financial shall have full rights of subrogation with respect to the full or partial amount of any weekly income benefits paid or payable to a claimant where the disability of the claimant is caused or contributed to by the action of any third party.

With respect to Insurance Corporation of British Columbia (ICBC) weekly indemnity payments, integration will apply to the extent that the combination of benefits payable under this Policy and ICBC weekly indemnity payments exceeds either:

100% of your gross weekly Earnings; or

the applicable benefit percentage of your average total monthly income in the 12 month period immediately preceding commencement of the disability, whichever is greater.

Where this provision is to apply, you will be required to provide satisfactory evidence of your total monthly income.

Where you make a successful wage loss claim against a third party for an injury for which you received or would receive weekly income benefits, Manulife Financial will be entitled to recover or decrease plan benefits by an amount equal to the amount that plan benefits in combination with the wage loss claim paid exceed 100% of pay subject to the following:

the amount of plan benefit recovered or decreased will be reduced or limited to the legal fees attributed to Manulife Financial's share of total claim recovery

the existence of an action commenced by or on your behalf does not preclude Manulife Financial from joining your action or commencing an action on its own behalf respecting the benefits paid

where either Manulife Financial or yourself intends to commence or join such an action, they shall advise the other in writing of that intention

The above does not apply to a war disability pension paid under an Act of Government of Canada or other Commonwealth countries.

Tax Status of Benefits

Weekly Income - Tax Status

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

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

Payment of Disability Benefits

Weekly Income - Payment of Disability Benefits

Disability benefit payments will be made bi-weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.

Rehabilitation Assistance

Weekly Income - Rehabilitation Assistance

Manulife Financial acknowledges and supports the efforts of the Joint Rehabilitation Committees, made up of representatives of the Employer and Employees established at each of the institutions party to this Policy.

It is the intent of Manulife Financial to provide support and expertise to such Committees.

Manulife Financial, however, reserves the right to approve a program of rehabilitation being offered by such a Committee and to recommend a program of rehabilitation for an employee eligible for weekly income benefits, where no such program exists and where Manulife Financial deems appropriate.

When Manulife Financial becomes involved, Manulife Financial will notify you in writing of its approval of the program with a copy to the Committee, and the extent, if any, of its support during such program.

Manulife Financial will reimburse reasonable and customary expenses incurred by yourself in connection with an approved program. Manulife Financial shall not reimburse expenses that are payable through government programs or a third party Insurer.

If, while receiving weekly income benefits you engage in rehabilitative employment, your earnings from rehabilitative employment plus the weekly income benefit and income from other sources specified in the Amount of Disability Benefit Payable section cannot exceed 100% of your gross Earnings. If total income exceeds 100%, the weekly income benefit will be reduced by the amount of such excess.

"Rehabilitative employment" shall mean any occupation or employment for wage or profit or any course or training that entitles you to an allowance, provided such rehabilitative employment has the approval of your doctor, your employer and Manulife Financial.

Partial Disability Benefit

Weekly Income - Partial Disability Benefit

If you become Partially Disabled, Manulife Financial will pay a Partial Disability Benefit, as outlined below.

Partial Disability Definition

Disability due to an accidental injury or sickness to the extent that you are able to perform only a portion of your normal workload.

In order to qualify to receive Partial Disability Benefits, the following conditions must be satisfied:

you must be under the care of a legally qualified doctor of medicine for treatment of the condition that causes you to be disabled

your inability to perform a portion of your normal instructional and non-instructional workload must be confirmed by Manulife Financial for your employer

your employer must agree that your inability to perform a portion of your normal workload due to your disability conforms with the standards your employer has established to determine what a normal workload is, for all areas of activity and function mandated by your job category

if you qualify for a partial sick-leave absence as established under your employer's human resources practices, then you are able to work no more than 80% of your normal workload full-time hours.

If you are determined to be partially Disabled and are entitled to employer paid sick leave on a pro-rated basis, you will be deemed to have satisfied the Qualifying Period for short-term disability benefits when the pro-rated days of partial disability add up to a total of thirty complete calendar days. In any event, to qualify for short-term disability benefits you must complete the Qualifying Period within six (6) months of the date you commenced part-time sick leave

the disability which entitles you to receive partial disability benefits must commence while you are insured under this coverage by Manulife Financial

the other provisions and conditions of the Weekly Income Benefit, including but not limited to the Periods for which You are not Entitled to Benefits and Disabilities Not Covered provisions, the Amount of Disability Benefit provision and the Subrogation provision will apply during any period in which you receive partial disability Benefits.

Your employer and Manulife Financial agree that the standards established by your employer regarding the parameters of a normal workload will comply with any law or regulation governing employment standards and conditions of work and with the requirements of any collective bargaining agreement or similar agreement governing your employment. Any such standard applied under the partial disability benefit provision will be deemed to be automatically amended to comply with the requirements of such laws and regulations and with any collective bargaining agreement or similar agreement entered into by your employer and later modified.

The application of the provisions under the partial disability benefit will not exempt your employer for its legal obligation to accommodate a disabled Employee to continue working.

The benefit amount becomes payable once you have satisfied the Qualifying Period. However, in order to qualify for Partial Disability Benefits, within six months of the commencement of disability, you need only be absent from work due to your disability for an accumulated total number of hours that would be equivalent to the number of full days of continuous disability that would qualify you to receive benefits due to being disabled as defined by the Definition of Disability and Qualifying Period for Weekly Income benefits.

Amount of Partial Disability Benefit

Benefits will be 70% of your pre-disability gross weekly earnings from Manulife for the time that you are not working due to partial disability; and 100% of gross earnings from your employer for the time you are working.

The amount of the gross weekly benefit payable to an employee who qualifies for Partial Disability Benefits will be calculated as follows:

Regular work schedule less proportionate share currently worked under partial disability program equals Percentage of Time Loss, and

Percentage Time Loss multiplied by gross pre-disability weekly earnings x 70% = benefit payable.

The amount determined by the above formula is the amount payable before any reductions are applied. Partial Disability Benefits will be reduced by other disability benefits and by other income you are entitled to receive as described under the Amount of Disability Benefit provision.

In addition to the other circumstances in which your entitlement to receive benefits under the terms and conditions of this Policy terminates, under the Partial Disability Benefits provision your entitlement to receive Partial Disability Benefits also ceases:

when you meet the requirements to be deemed Totally Disabled as defined within this policy

when you recover from your disability and return to work on a full-time basis

Termination of Benefit Payments

Weekly Income - Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

the date you cease to be Totally Disabled, as defined under this benefit, except as provided for under the Partial Disability Benefit provision

the date you fail to participate or co-operate in an approved rehabilitation program

the date on which benefits have been paid up to the Maximum Benefit Period for this benefit

the end of the month following the date you retire

the end of the month following the date of your death

If a repayment is owed to Manulife Financial, you shall make immediate repayment or repayment in a schedule approved by Manulife Financial.

Recurrent Disability

Weekly Income - Recurrent Disability

If you are completing the Qualifying Period or are receiving weekly income benefits and become Totally Disabled from the same or related Disability within 14 consecutive days after returning to active work, provided it is not considered rehabilitative employment, you will be considered to be within the original Qualifying Period or within the original weekly income benefit period. If you have returned to active work for one full day and becomes Disabled from a new illness or injury unrelated to the illness or injury that caused the previous absence, it will be considered a new period of Disability.

If the Policy or weekly income benefit terminates and you become Disabled prior to such termination, Manulife Financial continues to be liable as though the provision remained in force.

Submitting a Claim

Weekly Income - Submitting a Claim

To submit a claim, you must complete the Weekly Income Claim form which is available from your employer. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 6 months following the first month after the end of the Qualifying Period.

Exclusions

Weekly Income - Exclusions

No benefits are payable for any disability related to:

participation in the commission of a criminal offence

war, insurrection, rebellion, or service in the Armed Forces of any country after the commencement of this Policy

voluntary participation in a riot or civil commotion except while you are in the course of performing the duties of your regular occupation.