Welcome to the

PULP, PAPER AND WOODWORKERS OF CANADA

Benefit Booklet
for

SELKIRK COLLEGE

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GENERAL POLICY INFORMATION

Manulife Financial Benefits

The following benefits are underwritten by Manulife Financial under:

Group Policy 788016	Life Insurance, Extended Health Care, Emergency Travel Assistance and Long Term Disability
Group Plan 788116	Dental Benefits
Group Plan 788216	Medical Travel Referral Benefit

For claims inquiries, contact Manulife Financial at 1-800-575-2200

Important Notes

<u>What this 'e-booklet' is:</u>

This information has been prepared to help you toward a better understanding of your Group Insurance Coverage. It does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in your collective agreement and the group Master Policy/ies issued by The Manufacturers Life Insurance Company. In the event of any variation between the information provided in this website and the provisions of the collective agreement or insurance policy/ies, the collective agreement and insurance policy/ies shall prevail, in that order.

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SUMMARY OF BENEFITS

This summary section is not a complete booklet. It has been prepared to give you an informal outline of the main features of your group insurance plan.

Please access the other sections of your E-booklet for further details, or contact your Human Resources Department.

WAITING PERIOD: 3 months of continuous service within the past 12 months

EMPLOYEE LIFE INSURANCE:

under age 35	400% of annual earnings
age 35 to 41	375% of annual earnings
age 41 to 46	350% of annual earnings
age 46 to 51	325% of annual earnings
age 51 to 56	300% of annual earnings
age 56 to 61	250% of annual earnings
age 61 & over	200% of annual earnings
Maximum Benefit:	**$350,000**

LONG TERM DISABILITY

Benefit Amount:	60% of monthly earnings to a maximum of $5,000/month
Qualifying Period:	180 days of continuous disability
Maximum Duration:	to age 65

SUMMARY OF BENEFITS

EXTENDED HEALTH

Deductible:	$25 single or family per calendar year
Benefit Percentage:	100%
Lifetime Maximum:	Unlimited
Hospital:	up to private room
Pay-direct Drugs:	prescriptions by law
Paramedical Services:	**$200 maximum per calendar year** per specialty for: Chiropractor, Naturopath or Podiatrist, Speech Therapist, Clinical Psychologist or Christian Science Practitioner **$100 maximum per calendar year** for Acupuncturist **Reasonable and customary charges** for: Physiotherapist or Massage Therapist
Orthopedic Shoes:	one pair per calendar year
Orthotics:	one pair every 12 consecutive months
Private Duty Nursing:	up to the fees for a registered nurse
Hearing Aids:	$300 every 48 consecutive months for adults $400 every 60 consecutive months for dependent children under age 21
Vision Care:	$300 every 24 consecutive months $75 every 24 consecutive months for eye exams (not subject to the deductible)

MEDICAL TRAVEL (MTB)

Deductible:	None
Benefit Percentage:	100%
Lifetime Maximum:	$10,000 per person
Coverage:	$125 per day for a maximum of 50 days for transportation, meals and accommodation

EMERGENCY TRAVEL (ETA)

Deductible:	None
Benefit Percentage:	100%
Lifetime Maximum:	Unlimited

SUMMARY OF BENEFITS

DENTAL EXPENSE

Deductible:	None
Benefit Percentage:	100% Basic Services 60% Major Services 50% Orthodontics
Maximums:	Basic and Major Services: unlimited Orthodontics: $2,000 lifetime
Recall Exams:	once every 6 months
Fluoride/Polishing:	twice per calendar year

GENERAL PROVISIONS

Eligibility

A full-time employee working 35 to 37.5 hours per week or 50% of full-time hours, will become eligible for coverage on the later of the Plan Effective Date or upon completing 3 months of continuous service within the past 12 months.

If the employer is a partnership, a partner shall be considered to be an employee of the employer and eligible for coverage if the partner is engaged full-time (averages 20 or more hours per week) in the business of the employer.

When Your Insurance Starts

Your insurance comes into effect on the latest of the following dates if you are actively at work on that date:

- the date you become eligible;
- the date you apply; or
- if Evidence of Insurability is required the date it is approved by the Insurer.

Evidence of Insurability

Evidence of Insurability is required if:

- you apply for insurance more than 31 days after becoming eligible to apply;
- you reapply after your insurance has terminated due to non-payment of premium; or
- your amount of insurance exceeds or increases beyond the No-Evidence Limit.

When Your Insurance Terminates

Your insurance terminates in the event of:

- non-payment of premium;
- a change in your classification to one not insured;
- termination of your employment;
- termination or amendment of the Master Policy;
- your commencing active duty in any armed forces;
- your attainment of the age specified in the Description of Benefits section; or
- your retirement.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your insurance coverages may continue for a period as outlined in the Master Policy, but only if the required premiums are paid.

Change in Amounts of Insurance

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively-at-work.

GENERAL PROVISIONS

Eligible Dependents

Eligible dependents under this plan shall include:

- Unmarried children who are under age 21, or under age 25 if a full-time student in an accredited school, college, or university. Dependent children must be dependent on you for support and not employed at a regular full-time job.

- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.

- A child of your spouse provided,
  i) he/she is also your biological child; or
  ii) your spouse is living with you and has custody of the child.

- Your spouse, which includes:
  i) a person married to you as a result of a valid civil or religious ceremony; or
  ii) a person whose common law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose, provided the existence of such relationship includes continuous cohabitation and public representation of married status.

If you have been married to more than one person, you can only claim your current spouse or your current common law relationship if you have been cohabiting for more than 12 months.

Co-ordination of Benefits

Payment of Extended Health Care, Vision Care and Dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, Manulife Financial has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

Order of benefit payment will be determined as follows:

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

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 expenses.

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

GENERAL PROVISIONS

Co-ordination of Benefits (Continued)

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.

When parents 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).

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.

Submitting a Claim for Co-ordination of Benefits

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.

GENERAL PROVISIONS

Time Limitations

A claim for disability income benefits must be submitted within 6 months of the end of the qualifying disability period.

A claim for a waiver of premium benefit must be submitted within 12 months of the date disabled.

A claim for any other loss must be submitted within 15 months following the date the loss is incurred. However, in the event of termination of insurance, a claim must be submitted within 90 days following the date of termination of your insurance or the date following termination of a coverage or the policy.

Medical Information Bureau (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

Manulife Financial or its reinsurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. <u>All Information obtained will be treated as confidential</u>.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction. Their address is: MIB, 330 University Ave., Suite 501, Toronto, Ontario, M5G 1R7. Tel: (416) 597-0590.

EMPLOYEE LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time by written notice to your Employer, subject to any policy or legal limitations.

Classification	Benefit Amount
Employees less than age 35	400% of annual earnings
Employees age 35 but less than age 41	375% of annual earnings
Employees age 41 but less than age 46	350% of annual earnings
Employees age 46 but less than age 51	325% of annual earnings
Employees age 51 but less than age 56	300% of annual earnings
Employees age 56 but less than age 61	250% of annual earnings
Employees age 61 and over	200% of annual earnings

(Benefit amounts are rounded to the next higher $1,000, if not already a multiple thereof.)

Overall Maximum Benefit	$350,000
Termination Age	Your benefit terminates on the date you are no longer eligible or the date you retire, whichever is earlier.

Waiver of Premium for Disability:

If you i) qualify for Long Term Disability benefits or ii) become totally disabled for 90 consecutive days before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first.

To qualify, you must be unable to perform the regular duties of your own occupation during the Qualifying Period and the next 2 years. After this period, total disability means you are unable to work at any occupation for which you are or may become qualified by training, education or experience, and for which you are unable to earn more than 75% of your pre-disability earnings adjusted annually by the Consumer Price Index.

Note: In order to qualify for the Waiver of Premium benefit you must notify Manulife Financial of your disability within one (1) year of your last active day at work, and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

Conversion Privilege

If your Group Benefits terminate, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Life Insurance. For information on the conversion privilege, please see your Human Resources Department.

LONG TERM DISABILITY

In the event you become totally disabled for the required period of time known as the Qualifying Period and you are under the continual treatment of a legally qualified physician deemed appropriate by Manulife Financial, you will receive a monthly income benefit.

Benefit Amount	60% of your monthly earnings, rounded to the next higher $1 if not already a multiple thereof, subject to a maximum non-taxable benefit of $5,000 per month.
Qualifying Period	180 days
Maximum Benefit Period	to age 65 or earlier recovery
Termination Age	age 65 less the Qualifying Period, or retirement, whichever is earlier.

Qualifying Period

The qualifying period starts when you first become totally disabled and ends after 180 days, provided your disability is continuous and you are under age 65. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

1) no interruption is longer than 30 days;
2) the disabilities arise from the same or related disease or injury.

Total Disability

You are considered totally disabled due to sickness or injury, if you are unable to perform the regular duties of your own occupation during the Qualifying Period and the next 2 years. After this period, total disability means you are unable to work at any occupation for which you are or may become qualified by training, education or experience, and for which you are unable to earn more than 75% of your pre-disability earnings adjusted annually by the Consumer Price Index.

Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Period unless you have returned to active, full-time employment for a period of 6 consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

Offsets

The amount payable under this benefit for total disability is calculated by deducting from your benefit any other sources of income. These are specified in the Master Policy and include the following:

- any payments on account of your disability from any workers' compensation law or similar law;
- payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children.

LONG TERM DISABILITY

All Source Maximum

Your total monthly income while disabled (Long Term Disability benefit plus any income listed above, CPP/QPP Family benefits, employer wages or retirement benefits and income or benefits payable under any government or provincial automobile insurance act) cannot exceed 85% of net monthly earnings as of the date your disability commenced. If your total income exceeds 85%, your Long Term Disability benefit will be reduced accordingly.

Your monthly benefit will not be reduced due to a government plan or program cost-of-living adjustment occurring after the date on which benefits became payable.

Rehabilitative Employment

If you are receiving disability benefits and enter into a rehabilitation program approved by Manulife Financial, you will still be considered totally disabled during your participation in the program and your benefits will continue.

If you receive income from the rehabilitation program, your benefit payments from Manulife Financial will not be reduced until the total income you receive from all sources exceeds 100% of your net pre-disability earnings.

Waiver of Premium

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

Disability Case Management Program

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. Our disability case management team includes medical consultants, claim adjudicators and a field coordinator. This team will work with you, your employer and your physician to assist you to recover and return to the workplace.

LONG TERM DISABILITY

Exclusions and Limitations

Benefits are not payable for the following:

- for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;
- for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
- for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
- disabilities resulting from self-inflicted injuries or attempted suicide;
- disabilities as a result of active duty in the armed forces, participation in a war, riot, insurrection or criminal act;
- a disability resulting from an accident which occurs while you are operating a motor vehicle and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);
- for the portion of a period of disability during which you are
  a) imprisoned in a penal institution; or
  b) confined in a hospital, or similar institution, as a result of criminal proceedings;
- any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the Definitions section of this booklet, subject to human rights legislation;
- for a disability which commences on or after the date a strike or layoff begins, except as outlined in the Master Policy, subject to applicable labour standards legislation;
- if you refuse to participate in a rehabilitation program which is deemed appropriate by Manulife Financial, the attending physician or on the advice of independent medical opinion.

Canadian Residency Requirement

No benefits are payable if you reside outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period, unless:

i) you have previously notified and received approval in writing from Manulife Financial; and
ii) you remain under the regular care of a licensed physician deemed appropriate by Manulife Financial; and
iii) proof of the ongoing disability can be determined on evidence satisfactory to Manulife Financial in English or French within 30 days of request.

Subrogation

If you recover damages from or reach a settlement with a third party who has caused or contributed to a disability for which you have received benefits under the Long Term Disability Benefit, Manulife Financial has the right to be reimbursed to the extent of the payments under this Benefit.

EXTENDED HEALTH CARE

In the event you incur any of the Eligible Expenses listed below, you will be paid a percentage of such expenses, as outlined below:

Deductible	Nil for Medical Referral Travel expenses; $25 Single per calendar year, or $25 Family per calendar year
Coinsurance	100% of eligible expenses
Lifetime Maximum	Unlimited
Termination Age	Your coverage terminates on the date you are no longer eligible or retirement.

Eligible Expenses

Hospital (in Canada)
Charges, in excess of the hospital's public ward charge, for semi-private or private accommodation.

Vision Care
Lenses and frames for eyeglasses, prescription sunglasses or contact lenses or laser eye surgery, up to a maximum benefit of $300 per person during any 24 consecutive months.

Eye examinations performed by a qualified Optometrist or Ophthalmologist, up to a maximum benefit of $75 per person during any 24 consecutive months (not subject to the deductible).

Ambulance
Licensed ambulance service, including air ambulance, to and from the nearest hospital where adequate treatment is available. Charges for an attendant are covered when medically necessary. (Note: If an ambulance is required outside your province of residence, these charges will be paid for under the *Emergency Travel Assistance* plan).

EXTENDED HEALTH CARE

Professional Services: Charges for treatment (in excess of amounts payable by any Provincial Health Plan when permitted by law) by a practitioner who is registered and legally practising within the scope of his/her license, subject to the following maximums:

Practitioner	Calendar Year Maximum	Maximum per Visit
Chiropractor	$200	* The first 12 visits are covered up to $10 maximum per visit each calendar year.
Podiatrist	$200	* The first 12 visits are covered up to $10 maximum per visit each calendar year.
Naturopath	$200	* The first 12 visits are covered up to $10 maximum per visit each calendar year.
Speech Therapist	$200	Reasonable and customary charges.
Clinical Psychologist	$200	Reasonable and customary charges.
Massage Therapist	Reasonable & Customary	* The first 12 visits are covered up to $10 maximum per visit each calendar year.
Physiotherapist	Reasonable & Customary	* The first 12 visits are covered up to $10 maximum per visit each calendar year.
Christian Science Practitioner	$200	Reasonable and customary charges.
Acupuncturist	$100	Reasonable and customary charges.

Note:

- * After the first 12 visits, eligible expenses for the remainder of that year will be based on reasonable and customary charges.
- X-rays are not covered.
- A physician's referral will be required every 12 months for massage therapy.

Private Duty Nursing

Services (other than custodial care, homemaking services and supervision) provided by a Registered Nurse for an acutely ill bed patient, provided such fees are not covered under the B.C. Hospital Programs Special Nursing Services. If service is performed in a hospital, the nurse providing the service must not be an employee of the hospital.

Charges for the following services are not eligible:

- Service performed by a nursing practitioner who is related to or lives with the patient.
- Service performed while the patient is at home or in a 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.

Accidental Dental

Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing.

Medical Examination

Charges of a physician for a medical examination required by a statute or regulations of government for employment purposes, provided such charges are not payable by your Employer under a collective agreement.

EXTENDED HEALTH CARE

Medical Equipment

Rental or, at the Insurer's option, purchase of a hospital bed, wheelchair, respiratory equipment, oxygen and oxygen equipment, and other durable medical equipment usually found in hospitals.

Orthopedic Shoes and Orthotics

Charges for custom fitted orthopedic shoes and orthotics, including repairs and modifications, which have been specially designed and molded for the patient and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- description of the physical findings from the clinical examination;
- a brief description of the gait abnormality associated with the diagnosis; and
- confirmation that the product has been custom-made.

In order to be eligible for reimbursement, orthopedic shoes must be prescribed, on an annual basis, by providers with the following professional qualifications:

- Medical General Practitioner or Specialist (MD); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M); and

must be dispensed by one of the following provider types:

- Medical General Practitioner or Specialist (MD); or
- Orthotist Co(c) or CPO(c); or
- Pedorthist C Ped (C) or C Ped (MC); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M).

Such charges are limited to the cost of one pair of shoes in any calendar year and one pair of orthotics every 12 consecutive months.

Non-Dental Prostheses, Supports and Hearing Aids

- Artificial eyes and limbs, but excluding myoelectric limbs.
- Braces (excluding foot braces), trusses, collars, walkers, canes, casts and crutches.
- Cost and installation of hearing aids, excluding repairs and maintenance, batteries or recharging devices, when prescribed by a certified ear, nose and throat specialist up to a maximum of:
  - i) $400 per dependent child under age 21 in any 5 year period; and
  - ii) $300 per adult in any 48 month period.
- Wigs and hairpieces when required due to temporary hair loss as a result of a medical condition, up to $500 per lifetime per person.
- Ileostomy and colostomy supplies.

EXTENDED HEALTH CARE

Exclusions

No Extended Health Care benefits are payable for any expense which is directly or indirectly related to:

- surgical procedures or treatment performed primarily for beautification
- self-inflicted injuries
- war, riot, insurrection or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any provincial government plan or workers' compensation
- periodic medical check-ups, third party examinations, physician's travel, broken appointments, communication costs, filing out forms, or physician's supplies
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy
- dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a physician acting within the scope of his licence
- charges for transport or travel, medical treatment or surgical procedure by a physician other than as specifically provided under this plan
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- experimental drugs or supplies and those not approved by Health and Welfare - Canada

PRESCRIPTION DRUGS

(part *of Extended Health Care)*

Deductible	$25 Single per calendar year, or $25 Family per calendar year
Coinsurance	100% of eligible expenses

Eligible Expenses

Reasonable and customary charges for medically necessary drugs and medicines which are dispensed by a licensed pharmacist and are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either

a) drugs which by law require a prescription for purchase, or

b) drugs, medicines , injectable preparations, and allergy serums.

Note: Smoking cessation aids which require a prescription are covered, subject to a lifetime maximum benefit of $500 per individual.

No benefit is payable for

i) oral contraceptives unless prescribed for non-contraceptive purposes; or
ii) oral medications for the treatment of erectile dysfunction

Supply Limits

Drug purchases are limited to a supply which is reasonably used within 90 days.

Purchase Options

Each time you have a drug claim, you have the option to:

(a) Purchase your drugs and submit your receipts as a paper claim for reimbursement, **OR**

(b) Present your ManuScript Drug card to the pharmacist for point of sale assessment and no requirement to submit receipts to the Insurer. If a Brand Name drug is purchased with the ManuScript Card and there is a Generic substitute available, reimbursement will be based on the lowest cost Generic drug.

MEDICAL TRAVEL REFERRAL BENEFIT

In the event you incur any of the Eligible Expenses listed below, you will be paid a percentage of such expenses, as outlined below:

Deductible	Nil
Coinsurance	100% of all eligible expenses
Lifetime Maximum	$10,000 per person
Termination Age	Your coverage terminates on the date you are no longer eligible or retirement.

Coverage Limitation

A benefit up to $125 per day for a maximum of 50 days per calendar year for all expenses combined for the employee. An attendant (if required) will be covered for transportation and accommodation only.

Eligible Expenses

Eligible expenses include the following if you are referred by a licensed doctor (M.D.) to a specialist (or ophthalmologist) for medical or dental treatment that is not available within a 100 kilometre radius from the home campus:

- **Transportation** by scheduled air, rail, bus, taxi or ferry. Expenses for local taxis will only be covered to and from the airport and to and from the medical facility.
- **Automobile Allowance:** If using your personal automobile, you will be reimbursed $0.50 per kilometre, provided expenses do not exceed the equivalent cost of public transportation.
- **Hotel accommodation** (before and after treatment if overnight stay required) or similar institutions such as Easter Seal House, Heather House, Vancouver Lodge, Ronald McDonald House.
- **Attendant:** Transportation and accommodation expenses (excluding meals) for an attendant (i.e., family member or registered nurse) where necessary and at the request of a licensed doctor (M.D.).
- **Meal Allowance:** Reasonable and customary expenses, up to $12.00 for Breakfast, $15.00 for Lunch and $25.00 for Dinner.
- **Dental Specialist:** Travel expenses are only eligible when referred by a licensed doctor (M.D.) and/or when hospitalization for dental treatment is required.

MEDICAL TRAVEL REFERRAL BENEFIT

Exclusions

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

- surgical procedures or treatment performed primarily for beautification
- self-inflicted injuries
- war, riot, insurrection or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any provincial government plan or workers' compensation
- periodic medical check-ups, third party examinations, a licensed doctor’s (M.D.’s) travel, broken appointments, communication costs, filing out forms, or a licensed doctor’s (M.D.’s) supplies
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy
- dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a licensed doctor (M.D.) acting within the scope of his licence
- charges for transport or travel, medical treatment or surgical procedure by a licensed doctor (M.D.) other than as specifically provided under this plan
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- experimental drugs or supplies and those not approved by Health and Welfare - Canada

EMERGENCY TRAVEL ASSISTANCE

Your employer has arranged to provide you and your family with Emergency Travel Assistance coverage. *World Access Canada Inc.*, a multi-service corporation which assists travelers, has contracted with Manulife Financial to provide you with timely, efficient assistance when you travel.

Deductible	Nil
Coinsurance	100% of eligible expenses in addition to eligible services are covered.
Lifetime Maximum	Unlimited
Termination Age	Your coverage terminates on the date you are no longer eligible or retirement.

How to Claim

Dial the number on the back of your identification card and you will be connected with the World Access Operation Centre. Be sure to carry your identification card (supplied by your employer) with you when you travel. The card contains the information you are required to give to World Access in the event you need assistance.

If your claim is for payment of $200 or less, you will be asked to make the payment and keep the receipts. Your provincial health plan and the Insurer will reimburse you for the eligible expenses upon your return.

Services

The following services are covered in the event of an emergency which occurs while you or your dependents are traveling for non-medical reasons outside your province of residence:

- Multilingual assistance by toll-free telephone, 24 hours a day, 365 days a year, for insured individuals and providers of medical services to obtain aid and assistance;
- Referral to a legally qualified physician, dentist, legal advisor or an appropriate medical care facility;
- Assistance in arranging a cash advance from credit cards or family and friends to post bail and pay legal fees;
- Assistance in replacement (but not cost) of necessary travel documents or tickets in the event of theft or loss;
- Multilingual telephone interpretation services in the event of an emergency;
- A centre for communication of messages between you and your family, friends or business associates. Messages are held for 15 days;
- Medical consultation and monitoring of medical care and services if you or your dependents are hospitalized, and arrangement for contact with the patient, the attending physician and the patient's personal physician and family if necessary.

EMERGENCY TRAVEL ASSISTANCE

Eligible Expenses

- Medical Services - Charges incurred for medical and surgical fees, semi-private hospital accommodations to a maximum of 90 days and prescribed drugs;

- Emergency Transportation - Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in Canada. Upon written recommendation of a physician, such charges shall include a medical attendant if necessary who is neither a resident in the employee's home nor a relative of the employee or the employee's spouse;

- Return of Deceased - Charges incurred for the return of a deceased employee or dependent to the place of former residence in Canada, subject to a maximum benefit of $5,000 per individual;

- Return of Dependent Children - Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary;

- Return Trip Delay - Transportation - Charges incurred for delay of the return trip of an insured individual due to the hospitalization of that individual or another insured individual with whom the individual is traveling, limited to the cost of one way economy class transportation;

- Visit of Family Member - Charges incurred for transportation of an immediate family member to visit a hospitalized insured individual. Such individual must have been traveling alone and confined to a hospital for more than 7 days. The cost of transportation is limited to return economy fare for one family member. An immediate family member is defined as a spouse, parent, child, brother or sister or a person with whom the insured individual normally resides;

** Charges for these expenses are subject to a combined maximum benefit of $5,000 per emergency.*

- Return of Vehicle - Charges incurred in connection with the return of an insured's vehicle in the event the insured is unable to return it due to illness, injury or death, subject to a maximum benefit of $500 per trip. The vehicle will be returned to the insured's residence or nearest appropriate rental agency. Such charges shall not include commercial transport vehicles;

- Return Trip Delay - Accommodation - Charges incurred for commercial accommodation and meals for insured individuals while staying with a hospitalized insured family member when their return trip is delayed due to an illness or accident. Such charges are subject to a maximum benefit of $700 per family;

- Convalescent Benefit - Charges incurred for accommodation for insured individuals requiring convalescence following hospitalization, subject to a maximum benefit of $75 per day for not more than 5 days for each insured individual.

EMERGENCY TRAVEL ASSISTANCE

Exclusions

The foregoing list of services shall not include any of the following:

- charges for surgical procedures or treatment performed primarily for beautification;
- charges for services or supplies resulting from self-inflicted injuries;
- charges for bodily injury resulting from war (whether declared or undeclared), riot, insurrection or civil commotion;
- charges for an illness or injury for which benefits are payable under any provincial government plan;
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy
- charges for dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a physician acting within the scope of his licence
- charges for transport or travel, other than as specifically provided under this plan;
- charges for medical treatment which is not usual or customary, or is experimental or investigational in nature;
- charges for experimental drugs or supplies and those not approved by Health and Welfare - Canada;
- charges which are not incurred as a result of an emergency while travelling;
- charges in connection with childbirth and medical complications resulting from childbirth when the delivery takes place after the beginning of the 32nd week of pregnancy.

Liability

The Insurer is not responsible for the availability, quantity, quality or results of any medical treatment received by an insured individual, or for the failure of an insured individual to receive Medical treatment for any reason.

Travel to Countries in Civil Distress

If you or your dependents plan on traveling to a country that may be under distress or in strife, you should be aware that there may be difficulty obtaining Emergency Travel Assistance while in that country.

The Department of Foreign Affairs and International Trade publishes and updates a list of countries that are currently affected. This list can be obtained from World Access Canada Inc. by calling one of the telephone numbers on the back of your Emergency Travel Assistance identification card.

If you have further concerns, please contact your Plan Administrator.

DENTAL EXPENSE BENEFIT

In the event you incur any of the eligible expenses listed below, you will be paid a percentage of such expenses as outlined below:

Deductible	Nil
Coinsurance	100% for Plan A - Basic Services 60% for Plan B - Major Restorative Services 50% for Plan C - Orthodontics
Benefit Maximums	Unlimited for Basic and Major Services $2,000 per lifetime for Orthodontic Services
Termination Age	Your coverage terminates on the date you are no longer eligible or retirement

Dental Fee Guide

The fee guide established for the B.C. Colleges/University Colleges in effect on the date the charge is incurred.

Submission of Treatment Plan

As a service to you, Manulife Financial will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your employer, including pretreatment x-rays if the proposed treatment involves crowns, dentures or bridgework.

DENTAL EXPENSE BENEFIT

Eligible Expenses

Plan A - Basic Services

Diagnostics: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- Recall examinations: once every 6 months.
- Consultations and complete oral examinations: once every 3 years.
- X-rays: as required by the dentist, subject to a full mouth series not more than once every 36 months.

Preventive Services: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- Fluoride treatment: two applications in any calendar year.
- Polishing: 2 units in any calendar year.
- Scaling.
- Space maintainers when placed primarily to maintain space and not for orthodontic purposes.

(One unit of time = 15 minutes)

Restorative Services: All the necessary procedures to restore the natural teeth to their normal function including amalgam, silicate, acrylic, composite and stainless steel crowns. In addition:

- Gold may be used only where no other material is adequate and restoration of the tooth surface is covered only once regardless of the number of restorations.
- Inlays and onlays for repair of badly broken-down teeth where other restorative material could not be used satisfactorily.
- Gold foils where other restorative material would not be adequate.

Surgical Services:

- Extractions.
- Other routine oral surgical procedures (surgical removal of impacted teeth, residual roots and associated post-operative care).

Endodontics:

- Treatment of diseases of the pulp chamber and pulp canal (root canal): once per tooth per lifetime of patient.
- Root amputation.

Periodontics: Treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth, but not bone or tissue grafts.

- Acute infections, occlusal adjustment.
- Gingival curettage, gingivoplasty, gingivectomy or osseous surgery.
- Special periodontal appliances.

Prosthetic Repairs:

Repair, relining and rebasing of dentures and repair to bridgework.

DENTAL EXPENSE BENEFIT

Eligible Expenses (Continued)

Plan B - Major Services

Those services required for major reconstruction of teeth that have deteriorated and for replacement of teeth that are missing.

Major Restorative: Crowns for rebuilding natural teeth where other restorative material cannot be used satisfactorily.

Removable and Fixed Prosthetic Devices
Initial provision of full or partial removable dentures and fixed bridgework (including the addition of teeth to bridgework).

Replacement of an existing appliance is not covered except if:

(a) replacement is required because of extraction, loss or fracture of one or more sound natural teeth; or
(b) the existing appliance is at least 5 years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

Plan C - Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

Exclusions

No Extended Health Care benefits are payable for any expense which is directly or indirectly related to:

- surgical procedures or treatment performed primarily for beautification
- self-inflicted injuries
- war, riot, insurrection or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any provincial government plan or workers' compensation
- periodic medical check-ups, third party examinations, physician's travel, broken appointments, communication costs, filing out forms, or physician's supplies
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services or supplies which are not permitted by law to be paid
- care and treatment of any existing or suspected injury, disease or pregnancy
- dental work where a third party is responsible for payment
- services or supplies furnished without the recommendation or approval of a physician acting within the scope of his licence
- charges for transport or travel, medical treatment or surgical procedure by a physician other than as specifically provided under this plan
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- experimental drugs or supplies and those not approved by Health and Welfare - Canada