

Selkirk College

Plan Document Number: G0083247

Plan: CA - Retiring SCFA

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: December 01, 2009

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your employer can answer any questions you may have about your benefits, or how to submit a claim.

Table of Contents

Benefit Summary	3
How to Use Your Benefit Booklet	8
Explanation of Commonly Used Terms	10
Why Group Benefits?	14
Your Employer's Representative.....	14
Applying for Group Benefits.	14
Making Changes.	14
The Claims Process	15
How to Submit a Claim.....	15
Co-ordination of Extended Health Care and Dental Care Benefits.	15
Who Qualifies for Coverage?	18
Eligibility.	18
Medical Evidence.	18
Late Application.....	18
Late Dental Application.	18
Effective Date of Coverage.	19
Termination of Coverage.....	19
Your Group Benefits	20
Extended Health Care.	20
Dental Care.	40
Notes	46

Benefit Summary

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

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$50 Individual, \$50 Family, per calendar year(s)

Not applicable to:

- Eye Exams under the Vision Care benefit
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Benefit Percentage (Co-insurance)

100% for

- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Termination Age - none, coverage continues until 90 days following the employee's retirement or until coverage begins under the college pension plan, whichever occurs first.

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 prescribed for non-contraceptive reasons, intrauterine devices and diaphragms

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

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

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

*Extended Health Care
Extended Health Care -
The Benefit*

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

Benefit Summary

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

Charges for the following expenses are not covered:

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

drugs determined to be ineligible as a result of due diligence

fertility drugs

oral drugs used in the treatment of a sexual dysfunction

oral contraceptives prescribed for contraceptive reasons

- Drug Maximums

- Drug Maximums

Anti-smoking drugs - \$500 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

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

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

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.

Benefit Summary

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

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

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

Vision Care

eye exams, up to \$125 per 24 months

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

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$200 per 24 consecutive months

visual training, to a maximum of \$200 per lifetime

*Extended Health Care -
Vision Care*

Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year

Podiatrist/Chiropodist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year

*Extended Health Care -
Professional Services*

Benefit Summary

Massage Therapist - \$20 per visit for the first 5 visits in any calendar year, thereafter unlimited

Naturopath - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year. For naturopath, lab fees are not subject to the per visit maximum.

Speech Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Physiotherapist - \$20 per visit for the first 5 visits in any calendar year, thereafter unlimited

Psychologist - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

Acupuncturist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Athletic Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Audiologist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Dietitian - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Occupational Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Social Worker - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

Clinical Counselor - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

Christian Science Practitioner - \$200 per calendar year

Benefit Summary

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current British Columbia Dental Association Approved Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services
- 100% for Level II - Supplementary Basic Services
- 80% for Level III - Dentures
- 80% for Level IV - Major Restorative Services
- 50% for Level V - Orthodontics

Benefit Maximums

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

Termination Age - none, coverage continues until 90 days following the employee's retirement or until coverage begins under the college pension plan, whichever occurs first.

*Dental Care
Dental Care - The
Benefit*

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 Plan Document must be in effect and you must satisfy all the requirements of the Plan.

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

the Group Policy and/or Plan Document,

your application for group benefits, and

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

How to Use Your Benefit Booklet

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

Manulife Financial reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

Your Group Benefit Card

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

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

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

***Your Group Benefit
Card***

Explanation of Commonly Used Terms

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

Addiction Facility	Addiction Facility a licensed facility that specializes in the evaluation and treatment of drug addiction, alcoholism and associated disorders
Adherence	Adherence use drug, service or supply in accordance with the terms for which it was prescribed.
Administrator	Administrator Manulife Financial
Advisory Body	Advisory Body Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.
Benefit Percentage (Co-insurance)	Benefit Percentage (Co-insurance) the percentage of Covered Expenses which is payable by the administrator, acting on behalf of your employer.
Covered Expenses	Covered Expenses expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.
Deductible	Deductible the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by the administrator, acting on behalf of your employer.
Dependent	Dependent your Spouse or Child who, for Extended Health Care benefits only, is covered under the Provincial Plan. - Spouse your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months. - Child your natural or adopted child, or stepchild, who is: <ul style="list-style-type: none">- 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

Explanation of Commonly Used Terms

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

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

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

a stepchild must be living with you to be eligible

Disease Management Programs

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

Disease Management Programs

Drug

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

Drug

Due Diligence

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

Due Diligence

Exclusive Distribution

Manulife Financial approved vendors.

Exclusive Distribution

Experimental or Investigational

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

Experimental or Investigational

Immediate Family Member

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

Immediate Family Member

Explanation of Commonly Used Terms

Interchangeable Drug

Interchangeable Drug

includes but is not limited to:

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

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

Licensed, Certified, Registered

Licensed, Certified, Registered

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

Life-Sustaining Drugs

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Lower Cost Alternative

Lower Cost Alternative

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

Medically Necessary

Medically Necessary

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

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.

Explanation of Commonly Used Terms

Provincial Plan

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

Provincial Plan

Reasonable and Customary

the lowest of:

the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,

the amount shown in the applicable professional association fee guide, or

the maximum price established by law.

Reasonable and Customary

Retirement

the period in which you are retired by your employer. The normal retirement age for all employees is 65 years, subject to the provisions of any applicable collective agreement or statute. Employees shall normally retire on June 30th next following their 65th birthday. However, a retiring employee may, at the sole discretion of the board, be re-appointed for a term(s) not exceeding one year.

Retirement

Ward

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

Ward

Why Group Benefits?

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Employer's Representative

Your Employer's Representative

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

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

Your Employer's Representative is _____ Phone Number: (_____) _____ - _____
--

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

Applying for Group Benefits

Applying for Group Benefits

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

Making Changes

Making Changes

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

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

The Claims Process

How to Submit a Claim

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

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!

Payment of Extended Health Care and Dental Claims

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

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

How to Submit a Claim

Claim Payment

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

The Claims Process

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 Claims Process

- 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.

***Submitting a Claim for
Co-ordination of
Benefits***

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you:

- are a retiree of Selkirk College,
 - have elected to defer receipt of pension income from the University pension plan,
 - are a member of an eligible class,
 - are eligible to continue coverage under the college pension plan upon retirement
 - are younger than the Termination Age,
- for Extended Health Care benefits, are covered under the Provincial plan, and
- are residing in Canada.

The Termination Age 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.

Note: Where used in this Benefit Booklet, the term employee shall mean retiree.

Medical Evidence

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person.

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.

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

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan; or

- apply for benefits, and benefits under your spouse's plan have not terminated.

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

Late Dental Application

Late Dental Application

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to \$300 for each covered person for the first 12 months of coverage.

Who Qualifies for 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.

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.

Effective Date of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

the date you cease to be an eligible employee

the date your employer terminates coverage

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

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

the date you reach the Termination Age

the date of your death

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

Termination of Coverage

Your Group Benefits

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by Selkirk 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:

- Eye Exams under the Vision Care benefit
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Benefit Percentage (Co-insurance)

100% for

- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs
- Out-of-Province/Canada Emergency Medical Treatment
- Emergency Travel Assistance

Termination Age - none, coverage continues until 90 days following the employee's retirement or until coverage begins under the college pension plan, whichever occurs first.

Your Group Benefits

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.

Your Group Benefits

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 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.

Extended Health Care - Hospital 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

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

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

Your Group Benefits

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

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

oral contraceptives prescribed for non-contraceptive reasons, intrauterine devices and diaphragms

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

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

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

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

Charges for the following expenses are not covered:

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

drugs determined to be ineligible as a result of due diligence

fertility drugs

oral drugs used in the treatment of a sexual dysfunction

oral contraceptives prescribed for contraceptive reasons

- Drug Maximums

Anti-smoking drugs - \$500 per lifetime

All other covered drug expenses - Unlimited

- Drug Maximums

- Payment of Covered Expenses

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

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

***- Payment of Covered
Expenses***

Your Group Benefits

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

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

- No Substitution Prescriptions

- No Substitution Prescriptions

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

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

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

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

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

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

you cannot locate a participating Pay Direct Drug pharmacy

you do not have your Pay Direct Drug Card with you at that time

the prescription is not payable through the Pay Direct Drug Card system

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

Vision Care

eye exams, up to \$125 per 24 months

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

Extended Health Care - Vision Care

Your Group Benefits

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$200 per 24 consecutive months

visual training, to a maximum of \$200 per lifetime

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year.

Podiatrist/Chiropodist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year.

Massage Therapist - \$20 per visit for the first 5 visits in any calendar year, thereafter unlimited

Naturopath - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist limited to \$20 per visit for the first 5 visits in any calendar year. For naturopath, lab fees are not subject to the per visit maximum.

Speech Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Physiotherapist - \$20 per visit for the first 5 visits in any calendar year, thereafter unlimited

Psychologist - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

Acupuncturist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Christian Science Practitioner - \$200 per calendar year

Athletic Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Audiologist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Dietitian - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Your Group Benefits

Occupational Therapist - \$1,000 per calendar year, combined with chiropractor, podiatrist, chiropodist, naturopath, speech therapist, acupuncturist, athletic therapist, audiologist, dietitian, and occupational therapist.

Social Worker - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

Clinical Counselor - \$1,500 per calendar year, combined with psychologist, social worker, and clinical counselor

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, except for services of a massage therapist, which requires a referral once every 12 months.

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 \$15,000 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

Your Group Benefits

Pre-Determination of Benefits

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

Ambulance

- Ambulance

licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available

emergency transportation provided in the covered person's province of residence, including rail, boat, airline or public transportation, to transfer the patient to the nearest hospital where adequate treatment is available

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: electric 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 4 pairs per calendar year

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

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

stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of 1 pair per calendar year

casted, custom-made orthotics, up to a maximum of 1 pair in any 12 month period (recommendation of either a physician or a podiatrist is required)

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

Your Group Benefits

Other Supplies and Services

- Other Supplies and Services

ileostomy, colostomy and incontinence supplies

for employees only, medical exams performed by a physician for employment purposes, provided such charges are not payable by your employer under a collective agreement

medicated dressings and burn garments

viscosupplementation, to a maximum of 9 injections every 12 months

wigs and hairpieces for patients with temporary hair loss as a result of medical treatment. For hair loss as a result of non-medical treatment (such as alopecia), charges are limited to \$500 per lifetime.

oxygen

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

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

- Fertility Treatment

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

- Gender Affirmation Treatment

Gender Affirmation Treatment

Charges for feminization procedures as follows:

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

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

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

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

Your Group Benefits

Charges for the following expenses are not covered:

expenses related to travel or accommodation under this benefit

services obtained outside of Canada

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

expenses related to the reversal of gender affirmation treatments

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

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

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

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

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

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

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

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

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

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.

Your Group Benefits

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.

Your Group Benefits

Charges for the following are payable under this expense:

physician's services

hospital room and board up to the hospital maximum under this Benefit Program

the cost of special hospital services

hospital charges for out-patient treatment

licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available

medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

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

Your Group Benefits

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

been admitted to the hospital for treatment of the condition

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

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

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

a) **24-Hour Access**

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

b) **Medical Referral**

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

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

Your Group Benefits

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 l) of this provision.

Your Group Benefits

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.

Your Group Benefits

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Exceptions

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

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

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

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

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

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

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your employer.

**Extended Health Care -
Submitting a Claim**

Your Group Benefits

All applicable receipts must be attached to the completed claim form when submitting it to Manulife Financial. 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. It will only take you a few minutes to answer the necessary questions and create your own electronic claim submission.

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:

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

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

any illness or injury for which benefits are payable under any government plan or legally mandated program

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

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

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

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

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

Your Group Benefits

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

medical or surgical care which is cosmetic

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

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:

Your Group Benefits

- 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:

Your Group Benefits

- 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.

Your Group Benefits

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

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

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by Selkirk 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 - Current British Columbia Dental Association Approved Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services
- 100% for Level II - Supplementary Basic Services
- 80% for Level III - Dentures
- 80% for Level IV - Major Restorative Services
- 50% for Level V - Orthodontics

Benefit Maximums

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

Termination Age - none, coverage continues until 90 days following the employee's retirement or until coverage begins under the college pension plan, whichever occurs first.

Your Group Benefits

Covered Expenses

The following expenses are covered if they:

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

are incurred for services provided by a dentist, a dental hygienist working 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

Dental Care - Covered Expenses

Alternate Treatment

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

Dental Care - Alternate Treatment

Level I - Basic Services

complete oral exam, one per 36 months

complete series x-rays, one per 36 months combined with panoramic x-rays

panoramic x-rays, one per 36 months combined with complete series x-rays

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

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

routine diagnostic and laboratory procedures

initial oral hygiene instruction, plus one recall per lifetime

fillings, retentive pins and pit and fissure sealants. Gold foil fillings are not eligible. Bonded fillings are not subject to alternate treatment. Replacement fillings are covered provided:

Dental Care - Level I - Basic Services

Your Group Benefits

- 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)

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

denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

nervous/muscular disorders

Level II - Supplementary Basic Services

Dental Care - Level II - Supplementary Basic Services

surgical procedures not included in Level I (excluding implant surgery)

periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

- scaling not covered under Level I
- 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

Your Group Benefits

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 60 months old and cannot be made serviceable, or

- the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

crowns when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay. Replacement of crowns are eligible once every 5 years.

inlays, covering at least 3 surfaces, provided the tooth cusp is missing

initial provision of fixed bridgework

replacement of bridgework, provided the new bridgework is required because:

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

- the existing appliance is at least 60 months old and cannot be made serviceable, or

- the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

implants, or any services rendered in conjunction with implants

Level V - Orthodontics

Dental Care - Level V - Orthodontics

orthodontic services

Late Entrant Limitation

Dental Care - Late Entrant Limitation

If you or your dependents become covered for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to \$300 for each covered person.

Your Group Benefits

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:

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

committing or attempting to commit an assault or criminal offence

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

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

services which are payable by any government plan

Your Group Benefits

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

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

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

laboratory fees which exceed reasonable and customary charges

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

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

