Thompson Rivers University

Plan Document Numbers: G0081006, G0081007

Plan: FD - Retired Faculty Employees

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Documents Effective Date: March 01, 2010

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

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

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

Table of Contents

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

This version of the Benefit Summary drafted: November 25, 2010

Extended Health Care

The Benefit

Extended Health Care
Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $25 Individual, $25 Family, per calendar year(s)
Not applicable to:
- Vision
- Medical Services & Supplies (Ambulance)
- Professional Services (Naturopath supplements)
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

Note: *The deductible is not applicable to ManuAssist.*

Benefit Percentage (Co-insurance)

100% for
- Professional Services (Naturopath supplements)
- Vision (other than Visual Training)

95% of the first $1,000 of paid expenses and 100% thereafter for
- Hospital Care
- Medical Services & Supplies (other than Glucose Monitor)
- Professional Services (other than Naturopath supplements)
- Drugs

50% for
- Medical Services & Supplies (Glucose Monitor)
- Vision (Visual Training)

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for ManuAssist is 100%.

Termination Age - the end of the month following the employee's retirement

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

oral contraceptives

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

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

sclerotherapy

iron supplements as determined by Manulife Financial which are licensed for sale in Canada by Health Canada as a Natural Health Product

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

Charges for the following expenses are not covered:

drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

fertility drugs

anti-smoking drugs

drugs used in the treatment of a sexual dysfunction

intrauterine devices and diaphragms

- Drug Maximums

- Drug Maximums

All 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 and the Co-insurance.

For Pay-Direct Drug card submissions only, covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- No Substitution Prescriptions

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

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

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

you cannot locate a participating Pay Direct Drug pharmacy

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

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

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

Vision Care

Extended Health Care - Vision Care

eye exams, once per 12 months for persons under age 21 and once per 24 months for any other person

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $225 per 24 months

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

visual training (not subject to Reasonable and Customary charges)

Benefit Summary

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Osteopath - $200 per calendar year

Podiatrist/Chiropodist - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Massage Therapist - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Naturopath - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year. In addition, naturopath supplements, to a maximum of $200 per calendar year

Speech Therapist - $200 per calendar year

Physiotherapist - $10 per visit for the first 12 visits in any calendar year, thereafter unlimited

Psychologist - $200 per calendar year

Christian Science - $200 per calendar year

Medical Travel Referral (MTB)

Medical Travel Referral (MTB)

Medical Travel Referral (MTB) - The Benefit

The Benefit

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

Deductible- Nil

Benefit Percentage (Co-insurance)- 100%

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

For example, where the expenses claimed in a given calendar year are $150 day 1, $125 day 2 and $160 day 3, a total of $375 will be paid. Where the expenses claimed in a given calendar year are $150 day 1, $75 day 2 and $300 day 3, a total of $375 will be paid.

Termination Age - the end of the month following the employee's retirement

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners and Specialists for the Province in which the services are rendered

If the services are rendered in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by Manulife Financial.

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services

- 100% for Level II - Supplementary Basic Services

- 70% for Level III - Dentures

- 70% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $2,000 per lifetime for Level V

Termination Age - the end of the month following the employee's retirement

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

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of Thompson Rivers University. In the event of a discrepancy between this booklet and the Plan Document (both available from your employer), the terms of the Plan Document will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

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

Your Group Benefit Card

Your Group Benefit Card

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

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

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

Explanation of Commonly Used Terms

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

Administrator

Manulife Financial

Administrator

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 is covered under the Provincial Plan.

- Spouse

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

- Child

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

- unmarried

- under age 21, or under age 25 if a full-time student

- not employed on a full-time basis, and

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

A student whose normal residence is Canada will be considered a dependent while attending school outside of Canada

Your spouse's child shall be considered a dependent only if the child is also your child and your spouse is living with you and has custody of the child.

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

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

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

a stepchild must be living with you to be eligible

a newborn child shall become eligible from the moment of birth

Drug

Drug

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

Experimental or Investigational

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Immediate Family Member

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.

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

drugs which are necessary for the survival of the patient.

Medically Necessary

Medically Necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Natural Health Products

Natural Health Products

products licensed for sale in Canada by Health Canada as a Natural Health Product

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

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

Reasonable and Customary

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

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.

Payment of Extended Health Care and Dental Claims

Claim Payment

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

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

Plan means:

other Group Benefit Programs;

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

individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

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

The Claims Process

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

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

– For Claims incurred by you or your Dependent Spouse:

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

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

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

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

  ° The Plan where the person is covered as a retiree.

– For Claims incurred by your Dependent Child:

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

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

  ° The Plan of the parent with custody of the child, then

  ° The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then

  ° The Plan of the parent not having custody of the child, then

  ° The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

Submitting a Claim for Co-ordination of Benefits

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

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

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

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

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

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you:

are a retired employee of Thompson Rivers University,

are a member of an eligible class,

are younger than the Termination Age,

are covered under the Provincial plan, and

are residing in Canada.

The Termination Age and 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 $200 for each covered person for the first 12 months of coverage for levels I, II, III and IV combined. No coverage for level V is eligible for the first 12 consecutive months of coverage.

Who Qualifies for Coverage?

Effective Date of Coverage

Effective Date of Coverage

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

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

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

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

Termination of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

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

the date 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 the date the dependent ceases to be an eligible dependent, whichever is earlier.

Your Group Benefits

Extended Health Care

Extended Health Care

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

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

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

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

Drug Benefit for Quebec Residents

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

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $25 Individual, $25 Family, per calendar year(s)
Not applicable to:
- Vision
- Medical Services & Supplies (Ambulance)
- Professional Services (Naturopath supplements)
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

Note: *The deductible is not applicable to ManuAssist.*

- Deductible Carry-Forward

Covered Expenses used to satisfy the deductible in the last 3 months of the calendar year may also be used to satisfy the deductible in the following calendar year.

Benefit Percentage (Co-insurance)

100% for
- Professional Services (Naturopath supplements)
- Vision (other than Visual Training)

95% of the first $1,000 of paid expenses and 100% thereafter for
- Hospital Care
- Medical Services & Supplies (other than Glucose Monitor)
- Professional Services (other than Naturopath supplements)
- Drugs

50% for
- Medical Services & Supplies (Glucose Monitor)
- Vision (Visual Training)

Note:

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

The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

The Benefit Percentage for ManuAssist is 100%.

Termination Age - the end of the month following the employee's retirement

Covered Expenses

Extended Health Care - Covered Expenses

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

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

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

reasonable taking all factors into account

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

legally insurable

Advance Supply Limitation

Extended Health Care - Advance Supply Limitation

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

- Drug Expenses

- Drug Expenses

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

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

b) a 90 day supply.

Hospital Care

Extended Health Care - Hospital Care

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

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

- the accommodation was specifically elected in writing by the patient

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

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

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

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

oral contraceptives

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

life-sustaining drugs

preventive vaccines and medicines (oral or injected)

sclerotherapy

iron supplements as determined by Manulife Financial which are licensed for sale in Canada by Health Canada as a Natural Health Product

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

Charges for the following expenses are not covered:

drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

fertility drugs

anti-smoking drugs

drugs used in the treatment of a sexual dysfunction

intrauterine devices and diaphragms

- Drug Maximums

- Drug Maximums

All 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 and the Co-insurance.

For Pay-Direct Drug card submissions only, covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

- No Substitution Prescriptions

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

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

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance.

Payment of Drug Claims

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

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

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

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

you cannot locate a participating Pay Direct Drug pharmacy

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

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

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

Your Group Benefits

Vision Care

Extended Health Care - Vision Care

eye exams, once per 12 months for persons under age 21 and once per 24 months for any other person

purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $225 per 24 months

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

visual training (not subject to Reasonable and Customary charges)

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Osteopath - $200 per calendar year

Podiatrist/Chiropodist - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Massage Therapist - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year

Naturopath - $200 per calendar year, limited to $10 per visit for the first 12 visits in any calendar year. In addition, naturopath supplements, to a maximum of $200 per calendar year

Speech Therapist - $200 per calendar year

Physiotherapist - $10 per visit for the first 12 visits in any calendar year, thereafter unlimited

Psychologist - $200 per calendar year

Christian Science - $200 per calendar year

Expenses for some of these Professional Services may be payable in part by Provincial Plans. 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

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

a member of the Victoria Order of Nurses

Covered Expenses are subject to a maximum of $5,000 per 3 calendar years.

Charges for the following services are not covered:

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

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

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

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

Pre-Determination of Benefits

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

Ambulance

- Ambulance

licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to and from 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. Covered Expenses are subject to a maximum of $2,000 per calendar years. Insulin pumps are not subject to the overall maximum.

- 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 $25 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

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, up to a maximum of $300 per 2 consecutive calendar years combined with custom-made orthotics (must be constructed by a certified orthopaedic footwear specialist)

casted, custom-made orthotics, up to a maximum of $300 per 2 consecutive calendar years combined with custom-made shoes (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 $600 per 5 calendar years

- Other Supplies and Services

Other Supplies and Services

glucose monitors, up to a maximum of $500 per lifetime

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

physician’s fees for medically necessary procedures, where permitted by law. Charges for notes, letters or the cost of shipping such documentation are not covered.

sleep apnea oral devices

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, up to a maximum of $500 per lifetime

oxygen

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

charges for the treatment of accidental injuries to natural teeth or jaw, excluding injuries due to biting or chewing, provided the treatment is rendered within 3 years of the accident, to a maximum of $500 per accident

Out-of-Province/Out-of-Canada

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

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

A medical emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while a covered person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician and supporting medical evidence, the covered person is stable enough to return to his province of residence.

expenses are not subject to an overall maximum

referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar years

If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar years.

For all non-emergency medical treatment out of Canada:

the treatment must be recommended by a physician practicing in Canada, and

it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

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.

ManuAssist

Extended Health Care - ManuAssist

ManuAssist 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 while travelling outside your province of residence.

Details on your ManuAssist benefit are provided below, as well as in your ManuAssist brochure.

Medical Emergency Assistance

A Medical Emergency is a sudden, unexpected injury which occurs or an unforeseen illness which begins while a covered person is travelling outside his province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the covered person is able to return to his province of residence.

a) **24-Hour Access**

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

b) **Medical Referral**

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

c) **Claims Payment Service**

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

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

d) **Medical Care Monitoring**

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

e) **Medical Transportation**

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

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

f) **Return of Dependent Children**

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

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

g) **Trip Interruption/Delay**

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

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

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

h) **After Hospital Convalescence**

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

i) **Visit of Family Member**

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

j) **Vehicle Return**

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

k) **Identification of Deceased**

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

l) **Meals and Accommodation**

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

Non-Medical Assistance

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

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

b) **Lost Document and Ticket Replacement**

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

c) **Legal Referral**

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

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

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

f) **Pre-trip Assistance Service**

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

Exceptions

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

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

How to Access ManuAssist - Your ManuAssist Card

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

If you do not have a ManuAssist Card, please contact your employer.

Submitting a Claim

Extended Health Care - Submitting a Claim

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

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

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

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Extended Health Care - Exclusions

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

any illness or injury arising out of or in the course of employment when the person is covered by or is eligible for coverage by workers' compensation

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

self-inflicted injuries or illnesses

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

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

charges for services or supplies:

- when there would have been no charge at all in the absence of plan benefit coverage
- when reimbursement would have been made under a government-sponsored plan in the absence of plan benefit coverage
- which would have been payable by the Provincial Plan if proper application had been made
- which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- which are not specified as a Covered Expense under this Benefit

medical or surgical care which is cosmetic, other than for sclerotherapy

medical treatment which is not usual and customary, or which is Experimental or Investigational in nature

charges for medical treatment or surgical procedure by a physician other than as specifically provided under Out-of-Canada or Out-of-Province expenses

charges which the Administrator is not permitted, by law or regulation, to cover

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

charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an in-patient or out-patient basis, except as provided for under the Out-of-Province or Out-of-Canada provision

charges which are not Medically Necessary to the care and treatment of any suspected injury, disease or pregnancy

Drug Benefit For Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

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

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

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

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

a) **Benefit Percentage**

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

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

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

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

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

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

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

i) deductible amounts, and

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

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for your dependent children.

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

c) **Deductible**

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

d) **Lifetime Maximums**

Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

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

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

e) **Eligible Dependent Children**

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

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

ii) age 26.

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

- only drugs that are on 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**

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

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

ii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation

iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation

iv) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

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

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

Medical Travel Referral Benefit (MTB)

Medical Travel Referral Benefit (MTB)

Your Medical Travel Referral Benefit is provided directly by Thompson Rivers University. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

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

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

The Benefit

Medical Travel Referral (MTB) - The Benefit

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

Deductible - Nil

Benefit Percentage (Co-insurance) - 100%

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

For example, where the expenses claimed in a given calendar year are $150 day 1, $125 day 2 and $160 day 3, a total of $375 will be paid. Where the expenses claimed in a given calendar year are $150 day 1, $75 day 2 and $300 day 3, a total of $375 will be paid.

Termination Age - the end of the month following the employee's retirement

Covered Expenses

Medical Travel Referral (MTB) - Covered Expenses

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

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

Eligible Expenses

-Eligible Expenses

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

charges for transportation to and from the nearest locale equipped to provide the required treatment for the covered person by automobile (to a maximum of $0.40 per kilometre), scheduled air, rail, bus, taxi or ferry

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

charges for meals (submission of receipts not required), limited to:

- $8.00 for breakfast
- $12.00 for lunch
- $20.00 for dinner

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

Charges are subject to the following conditions and limitations:

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

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

the benefit does not apply to dental treatment unless:

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

Submitting a Claim

Medical Travel Referral (MTB) - Submitting a Claim

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

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

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

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, 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

Medical Travel Referral (MTB) - Exclusions

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

charges which are considered an insured service of any provincial government

charges which are considered a covered service under the Extended Health Care plan, or any other group plan in force at the time

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

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

charges not specified in the foregoing list of eligible expenses

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

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

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

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

charges which the administrator is not permitted, by any law or regulation, to cover

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

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

charges for services or supplies resulting from any intentionally self-inflicted wound

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

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

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by Thompson Rivers University. 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 Fee Guide for General Practitioners and Specialists for the Province in which the services are rendered

If the services are rendered in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by Manulife Financial.

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services

- 100% for Level II - Supplementary Basic Services

- 70% for Level III - Dentures

- 70% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

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

- $2,000 per lifetime for Level V

Termination Age - the end of the month following the employee's retirement

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

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

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

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

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

Alternate Treatment

Dental Care - 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.

Level I - Basic Services

Dental Care - Level I - Basic Services

complete oral exam, once every 6 months

full-mouth x-rays, one per 36 months

panoramic x-rays, one per 36 months

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 (light scaling and 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

oral hygiene instruction, one per 6 months

fillings, retentive pins and pit and fissure sealants. Bonded amalgam fillings are not subject to alternate treatment.

onlays

pre-fabricated full coverage restorations (metal and plastic)

space maintainers (appliances placed for orthodontic purposes are not covered), limited to dependent children only

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

Level II - Supplementary Basic Services

Dental Care - Level II - Supplementary Basic Services

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

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

- scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year

- provisional splinting

- occlusal equilibration

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

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

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

Level III - Dentures

Dental Care - Level III - Dentures

initial provision of full or partial removable dentures

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

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

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

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

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

crowns when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay. Charges for temporary crowns are not eligible.

inlays

initial provision of fixed bridgework

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

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

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

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

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 benefit will be limited to $200 for each covered person for the first 12 months of coverage for levels I, II, III and IV combined. No coverage for level V is eligible for the first 12 consecutive months of coverage.

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

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

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

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Exclusions

Dental Care - Exclusions

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

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

self-inflicted injuries or illnesses

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

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

charges for services or supplies:

- when there would have been no charge at all in the absence of plan benefit coverage
- which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- which are not specified as a covered expense under this benefit

treatment rendered for a full mouth reconstruction or for a vertical dimension

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

implants, or any services rendered in conjunction with implants

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

the replacement of removable appliances which are lost, mislaid or stolen (considered on a case by case basis)

laboratory fees which exceed reasonable and customary charges, as determined by the employer or the administrator

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Dental Care benefit without requiring any contribution from you, until the earliest of:

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

the date similar coverage is obtained elsewhere

the date which is 90 days from your death, or

the date the Plan Document terminates

Notes

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