British Columbia Hydro & Power Authority

Plan Document Numbers: G0080027, G0080028, G0080029

Plan: C - COPE Union Modular Flex Plan

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: January 01, 2008

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.

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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 British Columbia Hydro & Power Authority. The information in this booklet is a summary of the provisions of the Plan Document. In the event of a discrepancy between this booklet and the Plan Document (available from your employer), the terms of the Plan Document will apply.

The booklet 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.

You or any of your covered dependents have the right to request a copy of any or all of the following items:

- the Group Policy,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

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.

How to Use Your Benefit Booklet

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.

Annual Enrolment Date

the date each year on which you are permitted to make changes to your flexible benefits coverage.

Annual Enrolment Date

Benefit Percentage (Co-insurance)

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

Benefit Percentage (Co-insurance)

Change in Life Event

a change in life event occurs when:

Change in Life Event

- you acquire a dependent;
- you have a change in marital status;
- your spouse's coverage ceases;
- any dependent ceases to qualify as a dependent; or
- any dependent dies.

Covered Expenses

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

Covered Expenses

Deductible

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

Deductible

Dependent

your Spouse or Child who is covered under the Provincial Plan.

Dependent

- Spouse

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

- Child

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

  - unmarried

  - under age 21, or, is a full-time student

  - not employed on a full-time basis, and

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

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

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

  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

the lowest of:

Reasonable and Customary

- 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.

Remote Area

Atlin, Bella Coola, Bums Lake, Chetwynd, Clowhom, Dawson Creek, Dease Lake, Duncan Dam, Falls River, Fort Nelson, Fort St. James, Fort St. John, Fraser Lake, Hazelton, Houston, Hudson's Hope, Kitimat, McBride, McKenzie, Masset, Mica Creek, New Hazelton, Pemberton, Prince Rupert, Queen Charlotte City, Sandspit, Shalath, Smithers, Stewart, Telkwa, Terrace, Tofino, Valemont and Vanderhoof.

Remote Area

Waiting Period

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

Waiting Period

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 Morneau Shepell
Phone Number: 1-888-353-9123

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 complete an enrolment or re-enrolment application form (online or on paper) available from Morneau Shepell. Morneau Shepell 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 Morneau Shepell. 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 Manulife Financial, 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.

Manulife Financial 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, Manulife Financial 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 Manulife Financial.

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 full-time or part-time employee of British Columbia Hydro & Power Authority and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

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

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

Required Number of Hours

Required Number of Hours

Full-time employee - 37.5 hour(s) per week

Part-time employee - as determined by your employer

Applying for Benefits

Applying for Benefits

You may elect one of the Levels outlined under each benefit. If you do not elect a Level at initial enrolment, you will be covered for the following benefits:

- Extended Health Care, Level 2 (single coverage)
- Dental Care, Level 2 (single coverage)

You may elect to move up or down one level for Extended Health Care and Dental Care at the Annual Enrolment Date.

If you do not elect a Level at a subsequent Annual Enrolment, you will be covered at the same Level at which you were covered in the previous plan year.

You may only opt out of coverage only if you have other extended health care coverage in place.

On the Annual Enrolment Date, you may elect to apply for, change or terminate your coverage. You may also elect to do so within 31 days of a change in life event.

Effective Date of Coverage

Effective Date of Coverage

Your Group Benefits will be effective on the date you are eligible.

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

Who Qualifies for Coverage?

Your dependent's coverage becomes effective on the date the dependent becomes eligible.

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 last day of the month in which you cease to be an eligible employee
- the last day of the month in which you cease to be actively at work, unless the Plan Document allows for your coverage to be extended beyond this date
- the last day of the month in which 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 end of the month in which the dependent ceases to be an eligible dependent, whichever is earlier.

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by British Columbia Hydro & Power Authority. 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

You may elect Level 1, Level 2 or Level 3, single, couple or family coverage. You may opt out of coverage only if you have other coverage in place.

Overall Benefit Maximum

Level 1:

$100,000 per lifetime

Level 2:

$500,000 per lifetime

Level 3:

Unlimited

Deductible

Level 1:

$100 Individual, $100 Family, per calendar year
Not applicable to:
Out-of-Province/Canada Emergency Medical Treatment
Out-of-Canada - Referrals

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

Level 2 and Level 3:

Nil

Benefit Percentage (Co-insurance)

Level 1:

80% of the first $1,000 of paid expenses and 100% thereafter for
- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs

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 Emergency Travel Assistance is 100%.

Level 2 and Level 3:

100% for
- Hospital Care
- Medical Services & Supplies
- Professional Services
- Vision
- Drugs

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 Emergency Travel Assistance is 100%.

Termination Age - last day of the month in which the employee retires

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

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

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

Advance Supply Limitation

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 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 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Hospital Care

Extended Health Care - Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private or 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

- private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days

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

Note: Reasonable and Customary limits will not be applied.

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescribed 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, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- charges for smoking cessation aids (including Natural Health Products licensed for sale in Canada by Health Canada)
- diabetic testing
- sclerotherapy
- 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)

The following are not Covered Expenses:

- preventive vaccines and medicines (oral or injected)
- 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. However, drugs administered in a publicly funded cancer clinic in British Columbia will be covered if the patient is being required by the clinic to pay for the drugs.
- Vitamin B6 and B12 injections provided by Dr Bernstein Clinic
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

- Drug Maximums

Fertility drugs - $15,000 per lifetime

Anti-smoking drugs - $150 per calendar year (including Natural Health Products)

Sclerotherapy - $20 per visit

All other covered drug expenses - Unlimited *

* although there is no overall maximum on your drug coverage, the ingredient cost is subject to a maximum mark-up limitation by the pharmacy

- Payment of Covered Expenses

- Payment of Covered Expenses

Covered expenses for any prescribed drug will be reimbursed in accordance with a generic/low cost alternative drug formulary. When a prescription drug with a lower cost equivalent is purchased, only the cost of the lowest cost interchangeable equivalent is covered. The interchangeable equivalent may be either a brand name drug or generic drug containing the same active therapeutic ingredients as the prescribed drug. If there is no generic/low cost equivalent product for the prescribed drug, the amount covered is the cost of the prescribed drug.

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

- 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 and the Co-insurance.

- Payment of Drug Claims

- 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

To receive reimbursement after paying the full cost of the prescription, please submit your pharmacy receipt on an Extended Health Care Claim form.

Vision Care

Extended Health Care - Vision Care

Level 1:

- eye exams, when completed by an ophthalmologist or optometrist, up to $150 per 24 months per family
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $100 per 12 months for persons under age 21

Level 2:

- eye exams, when completed by an ophthalmologist or optometrist, up to $150 per 24 months per family
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $100 per 12 months for persons under age 21 and $250 per 24 calendar months for persons age 21 and over

Level 3:

- eye exams, when completed by an ophthalmologist or optometrist, up to $150 per 24 months per family
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $200 per 12 months for persons under age 21 and $300 per 24 calendar months for persons age 21 and over

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed and registered practitioners:

Level 1 and Level 2:

- Chiropractor - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Osteopath - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Podiatrist/Chiropodist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Massage Therapist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Naturopath - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Speech Therapist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Clinical Psychologist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Physiotherapist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Acupuncturist - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Dietician - $1,450 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

Level 3:

- Chiropractor - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Osteopath - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Podiatrist/Chiropodist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Massage Therapist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician
- Naturopath - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Speech Therapist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Clinical Psychologist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Physiotherapist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Acupuncturist - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

- Dietician - $1,950 per calendar year combined for services of a chiropractor, osteopath, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, clinical psychologist, physiotherapist, acupuncturist and dietician

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.

Note: Reasonable and Customary limits will not be applied.

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.

Medical Exams

- Medical Exams

Medical Exams when required for employment purposes.

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

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 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: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

- Non-Dental Prostheses, Supports and Hearing Aids

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses including myoelectric prosthesis
- surgical stockings
- surgical brassieres
- stump socks
- 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, up to a maximum of 1 pair per calendar year combined for stock-item orthopaedic shoes, custom-made orthopaedic shoes and custom-made orthotics (recommendation of either a physician or a podiatrist is required)

- 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 1 pair per calendar year combined for stock-item orthopaedic shoes, custom-made orthopaedic shoes and custom-made orthotics (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, up to a maximum of 1 pair per calendar year combined for stock-item orthopaedic shoes, custom-made orthopaedic shoes and custom-made orthotics (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 $400 per 5 calendar years

Other Supplies and Services

- Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $500 per calendar year
- viscosupplementation
- 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
- the cost of a Mandibular Repositioning Device provided you have not previously purchased a CPAP

-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 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.

  Expenses are payable up to:

  - for Level 1 $100,000 per lifetime

  - for Level 2 $500,000 per lifetime

  - for Level 3 - Unlimited

- referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar year(s)

  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 year(s).

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 at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided 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 provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

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

Medical Emergency Assistance

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

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

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

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

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

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

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 - Ambulance.

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.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will 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.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed drug; and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

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

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 12 months after the date the expense was incurred. All claims must be submitted within 90 days of the date of termination of coverage.

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, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

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

Exclusions

Extended Health Care - Exclusions

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

- self-inflicted injuries
- 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
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- 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, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- 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 are not permitted by law to be paid
- services or supplies which are required for recreation or sports excluding expenses for orthotics and braces
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic, except sclerotherapy
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Drug Benefit For Persons Who Reside In Quebec

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

Covered Drug Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

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

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

a) **Benefit Percentage**

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

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

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

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

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

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

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

i) deductible amounts, and

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

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

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

c) **Deductible**

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

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.

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by British Columbia Hydro & Power Authority. 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

You may elect Level 1, Level 2 or Level 3, single, couple or family coverage. You may opt out of coverage only if you have other coverage in place.

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 Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment as determined by Manulife Financial.

Benefit Percentage (Co-insurance)

Level 1:

- 90% for Basic Services

- 90% for Supplementary Basic Services

Level 2:

- 95% for Basic Services

- 95% for Supplementary Basic Services

- 65% for Dentures

- 65% for Major Restorative Services

- 50% for Orthodontics

Level 3:

- 100% for Basic Services

- 100% for Supplementary Basic Services

- 80% for Dentures

- 80% for Major Restorative Services

- 50% for Orthodontics

Benefit Maximums

Level 1:

- unlimited for Basic Services and Supplementary Basic Services

Level 2:

- unlimited for Basic Services, Supplementary Basic Services, Dentures and Major Restorative Services

- $2,500 per lifetime for Orthodontics

Level 3:

- unlimited for Basic Services, Supplementary Basic Services, Dentures and Major Restorative Services

- $3,000 per lifetime for Orthodontics

Termination Age - the last day of the month in which the employee retires

Waiting Period

for employees hired on or prior to the Plan Document Effective Date:

12 months for temporary, full-time COPE employees

none for all other employees

for employees hired after the Plan Document Effective Date:

12 months for temporary, full-time COPE employees

none for all other employees

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by your employer or Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Basic Services

Dental Care - Basic Services

- complete oral exam, one per 2 calendar years
- full-mouth x-rays, one per 2 calendar years
- one unit of light scaling and one unit of polishing, twice every calendar year, when the service is performed outside Quebec, or prophylaxis (polishing), twice every calendar year, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, twice every calendar year
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction, plus one recall
- fillings (amalgam, silicate, acrylic, composite and bonded), retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- 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

- onlays and inlays except when performed in conjunction with bridgework, one per tooth in a 60 month period

Supplementary Basic Services

Dental Care - Supplementary Basic Services

- surgical procedures not included in Basic Services (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

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

  - provisional splinting

  - occlusal equilibration, up to a maximum of 8 units per calendar year

- 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

Dentures

Dental Care - 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

- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Major Restorative Services

Dental Care - Major Restorative Services

- crowns and veneers when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- initial provision of fixed bridgework
- onlays and inlays performed in conjunction with 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

- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Orthodontics

Dental Care - Orthodontics

- orthodontic services

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

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

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

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

Submitting a Claim

Dental Care - Submitting a Claim

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

All claims must be submitted within 12 months after the date the expense was incurred. All claims must be submitted within 90 days of the date of termination of coverage.

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, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

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

Exclusions

Dental Care - Exclusions

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

- self-inflicted injuries
- 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
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- 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
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants excluding crowns, bridges and dentures
- 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

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer, at their discretion, may continue the Extended Health Care and Dental Care benefits without requiring any contribution from you, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms)
- the date similar coverage is obtained elsewhere
- the end of the month following your date of death, or
- the date the Plan Document terminates

In-Province Medical Travel Benefit

In-Province Medical Travel Benefit

Your In-Province Medical Travel Benefit is provided directly by British Columbia Hydro & Power Authority. 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 one of your dependents incurs charges for any of the covered expenses specified, your In-Province Medical Travel Benefit can provide financial assistance.

Payment of covered expenses is subject to any maximum amounts shown below under The Benefit.

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

In-Province Medical Travel Benefit - The Benefit

Deductible - Nil

Overall Benefit Maximum - unlimited

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

Termination Age - last day of the month in which the employee retires

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Medical Travel for Remote Areas

Medical Travel for Remote Areas - The Benefit

BC Hydro employees and their dependents may be eligible for this benefit if they:

a) reside in a designated remote community, or

b) are enrolled in Level 3 benefit coverage

When ordered by the attending Physician, Dentist or oral surgeon because, in his or her opinion, adequate medical or dental treatment in not available locally, the following are included as eligible expenses:

a) Charges for transportation to and from the nearest locale within British Columbia or Alberta equipped to provide the required treatment for the Covered Individual by automobile (maximum $0.475 per kilometer) scheduled air, rail, bus, boat or ferry.

b) Charges for transportation of an attendant as follows:

   i) if the patient is the Employee or Spouse - one medical attendant when ordered by the attending physician.

   ii) if the patient is a Dependent Child - one medical attendant or one parent.

   Where transportation has been provided by automobile, gasoline receipts are not required.

   iii) Charges for accommodation, where transportation has been provided under (a) above, in a commercial facility for the Covered Individual and attendant, before and after medical or dental treatment, to a combined maximum of $130 per day for a total of 7 days.

Charges are subject to the following conditions and limitations:

a) Transportation must take place within 1 year of the Physician's or Dentist's referral.

b) The Manager's pre-authorization of each claim form is required for remote location medical travel benefits.

Medical Travel for Cancer Treatment

In-Province Medical Travel Benefit - Medical Travel for Cancer Treatment

Reimbursement for transportation charges by automobile (maximum $0.475 per kilometer), scheduled air, rail, bus or ferry to and from the nearest cancer clinic within British Columbia or Alberta equipped to provide the required treatment. Where transportation has been provided by automobile, the mileage allowance specified in the Schedule applies when the round trip (from the patient's city of residence) exceeds 300 kilometers. Gasoline receipts are not required.

Submitting a Claim

In-Province Medical Travel Benefit - Submitting a Claim

To claim In-Province Medical Travel Expenses, you must complete a Medical Travel Expense form. Claim forms are available from your employer.

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

All claims must be submitted within 12 months after the date the expense was incurred. All claims must be submitted within 90 days of the date of termination of coverage.

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.

Exclusions

In-Province Medical Travel Benefit - Exclusions

No In-Province Medical Travel Benefit benefits will be payable for expenses resulting from:

- self-inflicted injuries
- 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
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- 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, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- 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 are not permitted by law to be paid
- services or supplies which are required for recreation or sports excluding expenses for orthotics and braces
- services or supplies which would have been payable by the Provincial Plan if proper application had been made

- 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 performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

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.