

Vancouver Island University

Plan Document Numbers: G0083719, G0083720

Group Policy Number: G0039957

Plan: D - Members of BCGEU Local 702

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: July 1, 2009

Group Policy Effective Date: July 1, 2009

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

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

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

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Benefit Summary

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 provided electronically: February 7, 2011

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039957.

*Employee Life
Insurance*

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

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

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$25 Individual, \$25 Family, per calendar year(s)

Not applicable to:

Vision

Out-of-Province/Canada Emergency Medical Treatment

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

*Extended Health Care
Extended Health Care -
The Benefit*

Benefit Percentage (Co-insurance)

100% for

- Vision

95% of the first \$1,000 of paid expenses and 100% thereafter for

- Hospital Care

- Medical Services & Supplies

- Professional Services

- Drugs

Note:

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

The Benefit Percentage for ManuAssist is 100%.

Termination Age - the last day of the month following the month of the employee's retirement. However, if you apply for coverage under the health and welfare benefits of the college pension plan, coverage will be extended beyond your retirement date for a maximum of 90 days or until the date coverage begins under the college pension plan, whichever occurs first.

Benefit Summary

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

life-sustaining drugs

injectable medications

non-prescription iron supplements

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)

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

oral contraceptives, intrauterine devices and diaphragms

preventative vaccines and medications (oral or injected)

- Drug Maximums

Sclerotherapy - \$20 per visit

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Applicable to Pay Direct Drug Card submissions only

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

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.

- Drug Maximums

**- Payment of Covered
Expenses**

Benefit Summary

- 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, \$75 per 24 consecutive months
- purchase and fitting of prescription glasses (excluding prescription sunglasses or safety goggles) or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$500 per 24 consecutive months
- if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$150 per lifetime

Benefit Summary

Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$200 per calendar year, limited to a maximum of \$10 per visit for the first 12 visits during any calendar year, combined with naturopath, subject to an overall maximum of \$500 per family per calendar year, combined with naturopath. Charges for x-rays are not eligible.

Podiatrist/Chiropodist - \$10 per visit for the first 12 visits during any calendar year, thereafter unlimited. Charges for x-rays are not eligible.

Massage Therapist - \$10 per visit for the first 12 visits during any calendar year, thereafter unlimited

Naturopath - \$200 per calendar year, limited to a maximum of \$10 per visit for the first 12 visits during any calendar year, combined with chiropractor, subject to an overall maximum of \$500 per family per calendar year, combined with chiropractor. Lab fees are not subject to the per visit maximum.

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

Medical Travel Referral (MTB)

The Benefit

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

Deductible- Nil

Benefit Percentage (Co-insurance)- 100%

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

Termination Age - the last day of the month following the month of the employee's retirement

Dental Care

The Benefit

Deductible - Nil

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

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services

- 100% for Level II - Supplementary Basic Services

*Extended Health Care -
Professional Services*

*Medical Travel Referral
(MTB)*

*Medical Travel Referral
(MTB) - The Benefit*

*Dental Care
Dental Care - The
Benefit*

Benefit Summary

- 60% for Level III - Dentures
- 60% 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 last day of the month following the month of the employee's retirement. However, if you apply for coverage under the health and welfare benefits of the college pension plan, coverage will be extended beyond your retirement date for a maximum of 90 days or until the date coverage begins under the college pension plan, whichever occurs first.

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

Your Benefit Booklet includes...

a detailed Table of Contents, allowing quick access to the information you are searching for,

Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,

a clear, concise explanation of your Group Benefits,

information you need, and simple instructions, on how to submit a claim.

Important Note

Important Note

This information has been prepared to help you towards a better understanding of your Group Benefits coverage. It does not create or confer any contractual or other rights. The terms and conditions governing the coverage are set out in your collective agreement and the Group Policy/ies and Plan Document(s) issued by The Manufacturers Life Insurance Company. In the event of any variation between the information provided in this booklet and the provisions of the collective agreement or Group Policy/ies and Plan Document(s), the provisions of the collective agreement or Group Policy/ies and Plan Document(s) shall prevail, in that order.

The information on all benefits insured or administered by Manulife Financial is up to date as at July 1, 2009.

The Basic Accidental Death and Dismemberment benefit described in this booklet is insured by Industrial-Alliance Pacific Life Insurance Company. Your Plan Sponsor has provided this wording for use in this booklet and is responsible for ensuring it is accurate, up to date and consistent with the governing policy. Manulife Financial is not responsible for any claims in connection with the booklet wording relating to this benefit. In the event of a discrepancy between this booklet and the policy, the terms of the group policy will apply. Manulife Financial shall not be responsible for any detrimental reliance that you may place on this information whatsoever.

All other benefits are insured or administered by Manulife Financial.

Your employer reserves the right to amend or discontinue any of the benefit programs referred to in this booklet at any time without notice, subject only to the terms of the collective bargaining agreement. If government legislation changes or if benefits or subsidies under government benefit plans are reduced or eliminated, your benefit programs do not automatically replace or supplement such reductions or eliminations. Your employer takes no responsibility for any changes in federal or provincial income or other taxes or levies or the impact of these changes on the taxation of any of the benefit programs. This booklet describes benefit programs for active employees and does not describe any retiree or post-employment benefit programs.

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How to Use Your Benefit Booklet

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

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

Your Group Benefit Card

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

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

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

***Your Group Benefit
Card***

Explanation of Commonly Used Terms

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

Administrator

Administrator

Manulife Financial

Benefit Percentage (Co-insurance)

**Benefit Percentage
(Co-insurance)**

the percentage of Covered Expenses which is payable by Manulife Financial, 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 Manulife Financial, on behalf of your employer.

Dependent

Dependent

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

- Spouse

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

- Child

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

- unmarried
- under age 21, or under age 25 if a full-time student
- not employed on a full-time basis, and
- not eligible for coverage as an employee under this or any other Group Benefit Program

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

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

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

Explanation of Commonly Used Terms

a stepchild must be living with you to be eligible

a newborn child shall become eligible from the moment of birth

Drug

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

Drug

Earnings

your regular rate of pay from your employer (prior to deductions), excluding regular bonuses, regular overtime pay, regular commissions, retroactive adjustments or other additional compensation.

Earnings

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

the amount reported on your claim form, or

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

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.

Experimental or Investigational

Immediate Family Member

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

Immediate Family Member

Licensed, Certified, Registered

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

Licensed, Certified, Registered

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Life-Sustaining Drugs

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.

Medically Necessary

Non-Evidence Limit

you must submit satisfactory medical evidence to Manulife Financial for Benefit Amounts greater than this amount.

Non-Evidence Limit

Explanation of Commonly Used Terms

<i>Provincial Plan</i>	<i>Provincial Plan</i> any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.
<i>Qualifying Period</i>	<i>Qualifying Period</i> a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.
<i>Reasonable and Customary</i>	<i>Reasonable and Customary</i> 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.
<i>Waiting Period</i>	<i>Waiting Period</i> the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.
<i>Ward</i>	<i>Ward</i> a hospital room with 3 or more beds which provides standard accommodation for patients.

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 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

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

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

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

Why Group Benefits?

Your Employer's Representative

Applying for Group Benefits

Making Changes

The Claims Process

How to Submit a Claim

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

Your employer can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

Payment of Extended Health Care and Dental Claims

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

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

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

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).

How to Submit a Claim

Claim Payment

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

*Order of Benefit
Payment*

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.

The Claims Process

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

You are eligible for Group Benefits if you:

Eligibility

- are a regular or term employee of Vancouver Island University,
- are a member of BCGEU Local 702,
- have an appointment of at least ten months per year for Employee Life and at least five months per year for all other benefits,
- for Employee Life, have a minimum workload of 20 instructional contact hours per week or 40 hours bi-weekly,
- for all other benefits, have a minimum workload of 14 instructional contact hours per week or 28 hours bi-weekly,
- for Extended Health Care and Medical Travel Referral (MTB) benefits, are covered under the Provincial Plan,
- 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.

Medical Evidence

Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Medical Evidence

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.

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.

Effective Date of Coverage

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 date you cease to be an eligible employee

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

the date your employer terminates coverage

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

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

the date you reach the Termination Age

the date of your death

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

Your Group Benefits

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy G0039957.

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

The Benefit

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

Non-Evidence Limit - \$800,000

Qualifying Period for Waiver of Premium - 180 days prior to attainment of age 65 or expiration of benefits under your employer's weekly income benefit, whichever is earlier

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

Waiting Period

first day of the month coincident with or next following one month for employees hired on or prior to the Group Policy Effective Date

first day of the month coincident with or next following one month for all other employees

Submitting a Claim

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

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

A completed claim form must be submitted within 90 days from the date of the loss.

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

A completed claim form must be submitted within 180 days from the end of the Qualifying Period.

Waiver of Premium

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

Employee Life Insurance

Employee Life - The Benefit

Employee Life Insurance - Submitting a Claim

Employee Life Insurance - Waiver of Premium

Your Group Benefits

Definition of Totally Disabled

Employee Life Insurance - Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

your own occupation, during the Qualifying Period and the 24 months immediately following the Qualifying Period, and

any occupation for which

- you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
- the current monthly Earnings are 75% or more of the current monthly Earnings for your own occupation.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

Employee Life Insurance - Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled

Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 24 months, and
- any occupation for which:
 - you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
 - the current monthly Earnings are 75% or more than the current monthly Earnings for your own occupation

you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Your Group Benefits

Termination of Waiver of Premium

Employee Life Insurance - Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

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

the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 24 months, and
- any occupation for which:
 - you are qualified, or may reasonably become qualified by training, education or experience, after the 24 months specified above, and
 - the current monthly Earnings are 75% or more than the current monthly Earnings for your own occupation

the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial

the date you do not attend an examination by an examiner selected by Manulife Financial

the date of your death

the date of your 65th birthday

Recurrent Disability

Employee Life Insurance - Recurrent Disability

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

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

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

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

Your Group Benefits

Conversion Privilege

Employee Life Insurance - Conversion Privilege

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

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

Extended Health Care

Extended Health Care

Your Extended Health Care Benefit is provided directly by Vancouver Island 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.

Your Group Benefits

The Benefit

**Extended Health Care -
The Benefit**

Overall Benefit Maximum - Unlimited

Deductible - \$25 Individual, \$25 Family, per calendar year(s)

Not applicable to:

Vision

Out-of-Province/Canada Emergency Medical Treatment

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

- Vision

95% of the first \$1,000 of paid expenses and 100% thereafter for

- Hospital Care

- Medical Services & Supplies

- Professional Services

- Drugs

Note:

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

The Benefit Percentage for ManuAssist is 100%.

Termination Age - the last day of the month following the month of the Employee's retirement. However, if you apply for coverage under the health and welfare benefits of the college pension plan, coverage will be extended beyond your retirement date for a maximum of 90 days or until the date coverage begins under the college pension plan, whichever occurs first

Waiting Period

first day of the month following date of hire for employees hired on or prior to the Plan Document Effective Date

first day of the month following date of hire 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

Your Group Benefits

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

life-sustaining drugs

injectable medications

non-prescription iron supplements

sclerotherapy

Your Group Benefits

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

oral contraceptives, intrauterine devices and diaphragms

preventative vaccines and medications (oral or injected)

- Drug Maximums

Sclerotherapy - \$20 per visit

All other covered drug expenses - Unlimited

- Drug Maximums

- Payment of Covered Expenses

Applicable to Pay Direct Drug Card submissions only

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

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.

- Payment of Covered Expenses

- 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.

- No Substitution Prescriptions

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

Your Group Benefits

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, \$75 per 24 consecutive months

purchase and fitting of prescription glasses (excluding prescription sunglasses or safety goggles) or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$500 per 24 consecutive months

if contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be \$150 per lifetime

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

Chiropractor - \$200 per calendar year, limited to a maximum of \$10 per visit for the first 12 visits during any calendar year, combined with naturopath, subject to an overall maximum of \$500 per family per calendar year, combined with naturopath. Charges for x-rays are not eligible.

Podiatrist/Chiropodist - \$10 per visit for the first 12 visits during any calendar year, thereafter unlimited. Charges for x-rays are not eligible.

Massage Therapist - \$10 per visit for the first 12 visits during any calendar year, thereafter unlimited

Your Group Benefits

Naturopath - \$200 per calendar year, limited to a maximum of \$10 per visit for the first 12 visits during any calendar year, combined with chiropractor, subject to an overall maximum of \$500 per family per calendar year, combined with chiropractor. Lab fees are not subject to the per visit maximum.

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

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Recommendation by a physician for Professional Services is not required, except for services of a massage therapist, which requires a recommendation once every 6 months.

Medical Services and Supplies

Note: All expenses listed below are also subject to Reasonable and Customary limitations.

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

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

a registered nurse, or

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

Covered Expenses are subject to a maximum of \$25,000 per lifetime.

Charges for the following services are not covered:

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

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

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

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

***Extended Health Care -
Medical Services and
Supplies***

- Private Duty Nursing

Your Group Benefits

Pre-Determination of Benefits

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

Ambulance

- Ambulance

licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to 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

surgical stockings/support hose, up to a maximum of \$80 per calendar year

surgical brassieres, up to a maximum of \$150 per calendar year

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

stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of 2 pairs per calendar year. A recommendation annually by one of the following is required: physician, podiatrist (DPM), chiropodist (D CH or D Pod M) or Dr B.D. Mitchell (Prosthetist, Orthotist, Pedorthist). In addition, the shoes must be dispensed by a physician, podiatrist (DPM), chiropodist (D CH or D Pod M), Dr B.D. Mitchell (Prosthetist, Orthotist, Pedorthist), Orthotist (Co(c) or CPO (c)) or Pedorthist (C Ped (C) or C Ped (MC))

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 (must be constructed by a certified orthopaedic footwear specialist)

casted, custom-made orthotics, up to a maximum of 1 pair per calendar year, to a maximum of \$500 per 3 calendar years. A recommendation annually by one of the following is required: physician, podiatrist (DPM), chiropodist (D CH or D Pod M) or Dr B.D. Mitchell (Prosthetist, Orthotist, Pedorthist). In addition, the orthotics must be dispensed by a physician, podiatrist (DPM), chiropodist (D CH or D Pod M), Dr B.D. Mitchell (Prosthetist, Orthotist, Pedorthist), Orthotist (Co(c) or CPO (c)) or Pedorthist (C Ped (C) or C Ped (MC))

Your Group Benefits

cost, installation, repair and maintenance of hearing aids, (excluding charges for batteries) to a maximum of \$600 in any 5 consecutive years

Other Supplies and Services

- Other Supplies and Services

ileostomy, colostomy and incontinence supplies

medicated dressings and burn garments

stump socks, to a maximum of \$200 per calendar year

synvisc, to a maximum of 9 injections per 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, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

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

treatment required as a result of a medical emergency which occurs during the first 365 days while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

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

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

Your Group Benefits

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 during the first 365 days 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 and supporting medical evidence, 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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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.

Your Group Benefits

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

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.

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)

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

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

Extended Health Care - Submitting a Claim

Subrogation (Third Party Liability)

Your Group Benefits

Exclusions

Extended Health Care - Exclusions

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

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

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

charge for general health examinations, and examinations required for use of a third party

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

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

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

charges for transport or travel, other than as specifically provided under this benefit

charge 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 law or similar legislation

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

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

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

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

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

charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare Canada or are experimental or limited in use whether or not so approved

Your Group Benefits

charges for experimental medical 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

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%.

Your Group Benefits

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

Your Group Benefits

- 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 (MTB)

Medical Travel Referral (MTB)

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

Your Group Benefits

The Benefit

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

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

Deductible - Nil

Benefit Percentage (Co-insurance) - 100%

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

Termination Age - the last day of the month following the month of the employee's retirement

Waiting Period

first day of the month following date of hire for employees hired on or prior to the Plan Document Effective Date

first day of the month following date of hire for all other employees

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 \$0.45 per kilometre), scheduled air, rail, bus, taxi or ferry

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

Your Group Benefits

charges for meals, subject to a maximum benefit of \$40 per day, limited to:

- \$10.00 for breakfast
- \$12.00 for lunch
- \$21.00 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 for incidental expenses, to a maximum of \$7.00 per day (receipts not required)

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 12 months after the date the expense was incurred.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

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

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

Your Group Benefits

Exclusions

**Medical Travel Referral
(MTB) - Exclusions**

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

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

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

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

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

charges not included in the list of eligible expenses

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

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

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

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

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

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

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

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

Your Group Benefits

Dental Care

Dental Care

Your Dental Care Benefit is provided directly by Vancouver Island 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 British Columbia Fee Guide for General Practitioners and Specialists

Benefit Percentage (Co-insurance)

- 100% for Level I - Basic Services
- 100% for Level II - Supplementary Basic Services
- 60% for Level III - Dentures
- 60% 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 last day of the month following the month of the Employee's retirement. However, if you apply for coverage under the health and welfare benefits of the college pension plan, coverage will be extended beyond your retirement date for a maximum of 90 days or until the date coverage begins under the college pension plan, whichever occurs first

Waiting Period

first day of the month following one month for employees hired on or prior to the Plan Document Effective Date
first day of the month following one month for all other employees

Your Group Benefits

Covered Expenses

The following expenses are covered if they:

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

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

Dental Care - Covered Expenses

Level I - Basic Services

complete oral exam, two per lifetime

complete series x-rays, one per 36 months

panoramic x-rays, one per 60 months

diagnostic models, 2 per calendar year

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

initial oral hygiene instruction, plus one recall

fillings and retentive pins. Composite fillings on molar teeth are not eligible. Replacement fillings are covered provided:

- the existing filling is at least 24 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

pit and fissure sealants, one per 24 months, limited to dependent children under age 19 only

pre-fabricated full coverage restorations (metal and plastic). Stainless steel crowns are limited to once per tooth per 60 months.

space maintainers (appliances placed for orthodontic purposes are not covered)

Dental Care - Level I - Basic Services

Your Group Benefits

minor surgical procedures and post surgical care

extractions (including impacted and residual roots)

consultations, 2 units of time per calendar year

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

prosthetic repairs

recementation or rebonding of inlays, onlays, crowns, veneers, posts or natural tooth fragments, up to two units of time

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

Your Group Benefits

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

**Dental Care - Level III -
Dentures**

Level IV - Major Restorative Services

crowns and onlays, including porcelain crowns on molar teeth when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay. Onlays are limited to one per 60 months.

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

veneers, limited to one per tooth per 60 months

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

**Dental Care - Level IV -
Major Restorative
Services**

Level V - Orthodontics

orthodontic services for dependent children only

**Dental Care - Level V -
Orthodontics**

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.

**Dental Care -
Pre-Determination of
Benefits**

Your Group Benefits

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 12 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, Manulife Financial, on behalf of your employer, may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

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

Exclusions

Dental Care - Exclusions

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

services or supplies that are primarily for cosmetic dentistry

service or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his or her license

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

miscellaneous charge such as for counselling, (instruction, except if included as eligible expense in the Group Benefits Schedule), travel, broken appointments, communication costs or filling of forms

services or supplies resulting from any intentionally self-inflicted wound

any services which are covered by an government plan or program, or for which no charge is made; or which Manulife Financial is not permitted by law to cover

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

Your Group Benefits

any hospital charge for board and room and related services and supplies

any dental examinations required by a third party

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

any charges which would not normally have been made but for the presence of this coverage or for which you or your dependent are not legally obligated to pay or furnished while you or your dependent were not covered under this plan

services or supplies in connection with any procedures excluded as eligible expenses

services or supplies for or in connection with a procedure which is not listed as an eligible expense

implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture would provide professionally adequate results for the condition, Manulife Financial, acting on behalf of your employer, will consider benefits as if the least expensive of a denture were used.

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, your employer will continue the Extended Health Care 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 last day of the month following your death, or

the date the Plan Document terminates

Benefits Insured by Industrial Alliance Pacific

SUMMARY OF INSURANCE COVERAGE

Policy No. 10000_____ issued by Industrial Alliance Pacific Insurance and Financial Services Inc.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot or Entire Sight of One Eye or Speech or Hearing in both Ears.....	75%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear.....	25%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs) or Paraplegia (total paralysis of the lower limbs).....	200%
Hemiplegia (total paralysis of one side of the body)	200%

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

DAY CARE BENEFIT (\$10,000)

If injury results in the loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of the accident, or within the 12 months following.

EDUCATION BENEFIT (\$5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there is no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of \$2,500.00 to the designated beneficiary.

Benefits Insured by Industrial Alliance Pacific

FAMILY TRANSPORTATION BENEFIT (\$10,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT (\$10,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REHABILITATION BENEFIT (\$15,000)

If injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REPATRIATION BENEFIT (\$15,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% subject to a maximum of \$25,000 if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT (\$10,000)

If injury results in the loss of life, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 65 or earlier retirement; (d) the premium due date next following the date an insured is ineligible for coverage.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

- (a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
- (b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Benefits Insured by Industrial Alliance Pacific

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This group Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy, not this summary.