

Welcome to the

THE TRAINING GROUP

Benefit Booklet
for

DOUGLAS COLLEGE



Douglas
College

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GENERAL POLICY INFORMATION

Manulife Financial Benefits

The following benefits are underwritten by Manulife Financial:

Group Policy 788004
Policy Number 788204

Life Insurance
Extended Health Care and Dental Benefits

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

Important Notes

What this 'e-booklet' is:

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

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SUMMARY OF BENEFITS

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

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

WAITING PERIOD

None

EMPLOYEE LIFE INSURANCE

\$10,000

EXTENDED HEALTH

Deductible:

\$25 single or family per calendar year

Benefit Percentage:

100% for Hospital and Vision Care expenses
95% for all other eligible expenses

Lifetime Maximum:

Unlimited

Hospital:

up to semi-private room (not subject to the deductible)

Pay-direct Drugs:

prescriptions by law

Paramedical Services:

\$275 maximum per calendar year for each of the following:

Chiropractor, Naturopath, Podiatrist/ Chiropodist, Osteopath, Psychologist,
Speech Therapist, Physiotherapist or
Massage Therapist

Orthopedic Shoes:

reasonable and customary charges

Orthotics:

one pair per calendar year, subject to a maximum of \$450 per pair

Private Duty Nursing:

\$5,000 every 36 months

Hearing Aids:

\$600 every 60 consecutive months

Vision Care:

\$20 every 12 consecutive months for **eye exams**

\$40 every 24 consecutive months for **non-prescription reading glasses**

\$250 every 24 consecutive months for **glasses or contacts**

SUMMARY OF BENEFITS

DENTAL EXPENSE

Deductible:	None
Benefit Percentage:	100% Basic Services 60% Major Services 50% Orthodontics
Maximums:	Basic & Major Services: unlimited Orthodontics: \$2,500 lifetime
Recall Exams/Fluoride/ Polishing:	once every 9 months (twice per calendar year for dependent children under age 19)
Scaling/Root Planing :	8 units per calendar year

GENERAL PROVISIONS

Eligibility

Contract Faculty employees who have contracts of quarter-time or more for at least 90 days duration, will become eligible for coverage on the later of the plan Effective Date, or the date employment commences.

When Your Insurance Starts

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

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

Evidence of Insurability

Evidence of Insurability is required if:

- you apply for insurance more than 31 days after becoming eligible to apply; or
- you reapply after your insurance has terminated due to non-payment of premium;

When Your Insurance Terminates

Your insurance terminates in the event of:

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

Note:

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

Change in Amounts of Insurance

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

GENERAL PROVISIONS

Eligible Dependents

Eligible dependents under this plan shall include:

- Unmarried children who are under age 21, or under age 25 if attending an accredited school, college, or university as a full time student. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.
- A child of your spouse provided,
 - i) he/she is also your biological child; or
 - ii) your spouse is living with you and has custody of the child.
- Your spouse, which includes:
 - i) a person married to you as a result of a valid civil or religious ceremony; or
 - ii) a person whose common law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose, provided the existence of such relationship includes continuous cohabitation and public representation of married status.

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

Extended Coverage to Surviving Dependents

If you should die while insured under this policy, benefits will continue to be paid to your surviving eligible dependents for up to

- i) 12 months following your death for Extended Health Care, and
- ii) 3 months following your death for Dental Care benefits.

Co-ordination of Benefits

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

Order of benefit payment will be determined as follows:

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

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

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

GENERAL PROVISIONS

Co-ordination of Benefits (Continued)

For Claims incurred by you or your Dependent Spouse:

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

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

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

For Claims incurred by your Dependent Child:

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

When parents are separated or divorced, the following order applies:

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

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

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

Submitting a Claim for Co-ordination of Benefits

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

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

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

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

GENERAL PROVISIONS

Time Limitations

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

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

Medical Information Bureau (MIB)

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

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

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

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

EMPLOYEE LIFE INSURANCE

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

Benefit Amount	\$10,000
Termination Age	Your coverage terminates on the date you attain age 71 or the date you retire, whichever is earlier.

Waiver of Premium for Disability

If you become totally disabled for 6 consecutive months before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first.

To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation and you must submit proof of your continuing disability as may be required by Manulife Financial.

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

Conversion Privilege

If your Group Benefits terminate and you are under 65 years of age, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Life Insurance. For information on the conversion privilege, please see your Human Resources Department.

EXTENDED HEALTH CARE

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

Deductible	\$25 Single per calendar year; or \$25 Family per calendar year
Coinsurance	100% of Hospital and Vision Care expenses 95% of all other eligible expenses
Lifetime Maximum	Unlimited
Termination Age	Your coverage terminates at the end of the month in which you attain age 71 or on the last day of the month following the month in which you retire, whichever is earlier.

Eligible Expenses

Hospital

Charges, in excess of the hospital's public ward charge, for semi-private accommodation are not subject to the deductible.

Vision Care

- Eye examinations performed by a qualified Optometrist or Ophthalmologist, up to a maximum benefit of \$20 during any 12 consecutive months.
- One pair of non-prescription reading glasses, up to a maximum benefit of \$40 during any 24 consecutive month period.
- Purchase and fitting of prescription glasses or contact lenses or laser eye surgery, up to a maximum benefit of \$250 during any 24 consecutive month period.

Ambulance

Licensed ambulance service, including air ambulance, to and from the nearest hospital where adequate treatment is available, up to maximum benefit of \$300 per calendar year.

Convalescent Care

Semi-private accommodation for confinement in a convalescent care facility which begins following a minimum of 3 days hospital confinement.

EXTENDED HEALTH CARE

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

Practitioner	Calendar Year Maximum	Maximum per Visit
Chiropractor	\$275	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Osteopath	\$275	Reasonable and customary charges.
Podiatrist or Chiropodist	\$275	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Naturopath	\$275	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Speech Therapist	\$275	Reasonable and customary charges.
Clinical Psychologist	\$275	Reasonable and customary charges.
Physiotherapist	\$275	* The first 12 visits are covered up to \$10 maximum per visit each calendar year.
Massage Therapist**	\$275	* The first 12 visits are covered up to \$10 maximum per visit each calendar year

Note:

- * After the first 12 visits, eligible expenses for the remainder of that year will be based on reasonable and customary charges.
- **A new physician's written referral for treatment by a Massage Therapist is required every 6 months.
- X-rays: \$50 per practitioner per calendar year.

Private Duty Nursing

Services provided in your home (other than custodial care, homemaking services and supervision) by a Registered Nurse, a Registered Nursing Assistant, a Certified Nursing Assistant, or a Licensed Practical Nurse, to a maximum of \$5,000 per 36 consecutive months.

Services provided must be services which are deemed to be within the practice of nursing.

Charges for the following services are not eligible:

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

Hearing Aids

Cost, installation and maintenance (excluding charges for batteries and repairs), up to a maximum of \$600 every 60 consecutive months.

Accidental Dental

Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 6 months of the accident, excluding injuries due to biting or chewing.

EXTENDED HEALTH CARE

Orthopedic Shoes and Foot Orthotics

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

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

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

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

must be dispensed by one of the following provider types:

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

EXTENDED HEALTH CARE

Medical Equipment and Supplies

Rental or, at your employer's option, purchase of the following services, supplies, appliances and prosthetic devices provided they are prescribed by a physician:

- standard wheelchairs, (excluding electric wheelchairs except for quadriplegics);
- standard hospital beds (excluding electric hospital beds), bed rails and trapeze bars;
- splints (excluding dental splints), canes, walkers, crutches and casts;
- Jobst burn garments, Jobst sleeves for lymphoedema following mastectomy and Jobst support hose;
- braces with rigid supports (excluding lumbar supports);
- stump socks, shoulder harnesses, head halters, traction apparatus and cervical collars;
- colostomy apparatus, ileostomy apparatus and catheters;
- enuretic devices;
- PUVA therapy for psoriasis, when administered by a dermatologist;
- intermittent positive pressure breathing machine;
- aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma;
- apnea monitors for respiratory dysrhythmias;
- iron lung;
- insulin syringe and Clinitest or similar home chemical testing supplies for diabetics;
- artificial eyes (including repairs);
- one pair of eyeglasses or contact lenses following cataract surgery;
- artificial limbs (including repairs and replacement but excluding myoelectrical limbs);
- external breast prostheses, once per calendar year, post-mastectomy;
- transcutaneous nerve stimulator for up to 6 months;
- non-union bone stimulators;
- pacemakers;
- intrauterine devices, when inserted by a physician.

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

If, while traveling outside your province of residence, hospitalization or medical treatment is required due to emergency and nonelective reasons, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by any provincial government plan.

1. reasonable and customary charges for semi-private accommodation;
2. reasonable and customary charges for the services of a physician;
3. reasonable and customary charges for hospital services and supplies furnished during hospitalization, and for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

The charges listed above are covered when referred by a physician for non-emergency treatment outside Canada, when treatment is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada. Only charges which are in excess of any provincial government plan and eligible for reimbursement in whole or in part by any provincial medical plan are covered.

EXTENDED HEALTH CARE

Exclusions

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

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

Survivor Benefits

Extended Health Care coverage for eligible dependents will continue following the death of the employee up to a maximum of 12 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

Extended Benefits

If you or one of your dependents is wholly disabled on the date insurance coverage ceases, Extended Health Care coverage will continue for a period of 90 days from such date or during the continuation of such disability, whichever is less. Coverage ceases upon termination of this policy or benefit, if either occurs while coverage is being extended.

Wholly disabled, with respect to employees, means you are incapacitated to the extent that you are unable to perform all of the usual and customary duties of your occupation. With respect to dependents, wholly disabled means the dependent is confined to a hospital or incapacitated to the extent that the dependent is not able to perform all of the usual and customary duties or activities of a person in good health and of the same age.

PRESCRIPTION DRUGS

(part of Extended Health Care)

Deductible	\$25 Single per calendar year; or \$25 Family per calendar year
Coinsurance	95% of eligible expenses
Termination Age	Your coverage terminates at the end of the month in which you attain age 71 or on the last day of the month following the month in which you retire, whichever is earlier.

Eligible Expenses

Reasonable and customary charges for medically necessary drugs and medicines **(excluding oral medications prescribed for erectile dysfunction)** which are dispensed by a licensed pharmacist and are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of a diagnosed illness or injury. They include:

- a) drugs which by law require a prescription for purchase ; and
- b) drugs, medicines, oral contraceptives, injectable preparations, insulin and other diabetic supplies and allergy serums

Note:

- 1) Smoking cessation aids which require a physician's prescription are covered up to a lifetime maximum of \$500 per individual
- 2) Fertility drugs, lab tests and x-rays including ultrasound are covered to a lifetime maximum of \$2,500 per individual.

Supply Limits

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

Purchase Options:

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

- (A) Purchase your drugs and submit your receipts as a paper claim for reimbursement,

OR

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

DENTAL EXPENSE BENEFIT

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

Deductible	Nil
Coinsurance	100% for Plan A - Basic Services 60% for Plan B - Major Restorative Services 50% for Plan C - Orthodontics
Benefit Maximums	Unlimited for Plan A & Plan B (Basic & Major Services) \$2,500 per lifetime for Plan C (Orthodontic Services)
Termination Age	Your coverage terminates at the end of the month in which you attain age 71 or on the last day of the month following the month in which you retire, whichever is earlier.

Dental Fee Guide

The British Columbia fee guide for General Practitioners and Specialists in effect on the date the charge is incurred.

Alternate Benefits and Submission of Treatment Plan

Where there are two or more courses of treatment available to adequately correct a dental condition, Manulife Financial will determine reimbursement based on the least expensive treatment.

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

DENTAL EXPENSE BENEFIT

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide for General Practitioners and Specialists of the British Columbia Dental Association. Further details may be found in the Master Policy.

Plan A - Basic Services

Diagnostics:

- Standard oral and specific examinations combined: once every 9 months (twice in any calendar year for dependent children under age 19).
- Bitewing x-rays: two in any calendar year.
- X-rays: complete mouth series or equivalent once every 24 consecutive months.
- Panoramic x-rays once every 24 consecutive months.
- Consultations: twice in any calendar year

Preventive Services:

- Topical fluoride: once every 9 months (twice per calendar year for dependent children under age 19).
- Polishing: one unit every 9 months (two units in any calendar year for dependent children under age 19).
- Scaling and/or root planing: eight units in any calendar year.
- Oral hygiene: recall instruction twice in any calendar year (initial instruction once every 24 months).
- Passive space maintainers for missing primary teeth for dependent children under age 16.
- Pit and fissure sealants for permanent teeth for a dependent child under age 16, limited to once per tooth per lifetime.

(One unit of time = 15 minutes)

Restorative Services:

Amalgam, silicate, acrylic and composite restorations. White fillings on molar teeth are covered.

Surgical Services:

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

Endodontics:

Treatment of diseases of the pulp chamber and pulp canal (root canal).

Periodontics:

- Treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth, but not bone or tissue grafts.
- Acute infections, occlusal adjustment.
- Gingival curettage, gingivoplasty, gingivectomy or osseous surgery.
- Special periodontal appliances.

Prosthetic Repairs:

- Rebased or relining of dentures once in any period of 24 consecutive months.
- Repairs to dentures twice in any calendar year.
- Adjustments to dentures twice in any calendar year.

DENTAL EXPENSE BENEFIT

Eligible Expenses (Continued)

Plan B - Major Services

Extensive Restorative Dentistry: Those procedures, including gold inlays, onlays and crowns (including stainless steel crowns), used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling.

Gold foil or cast gold restorations on teeth posterior to the second bicuspid if such treatment could not have been rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

Fixed Prosthetic Devices: The initial installation of fixed bridgework.

Re-cementing and replacement of the facing or veneer of the fixed bridgework.

Replacement of an existing appliance is not covered except if:

- The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or
- The existing appliance is at least 5 years old and no longer serviceable.

Removable Prosthetic Devices: The initial installation of partial dentures or full dentures.

Replacement of an existing appliance is not covered except if:

- The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or
- The replacement is more than 12 months after the individual became insured under this coverage, and the existing appliance is at least 5 years old and no longer serviceable.

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

Other Major Services

Excision of hyperplastic tissue, conditioning of tissues and equilibration in connection with denture repair limited to once in any period of 24 consecutive months for each procedure

Surgical incision and drainage

Osteoplasty

Alveoplasty, removal of neoplasms and enucleation of teeth

Stomatoplasty, frenectomy and sialolithotomy

Removal of root from maxillary sinus

Diagnostic laboratory procedures including soft tissue biopsy, oral pathology, cytological tests and bacteriological examinations

Post-surgical treatment

Excision of torus palatinus, and unilateral and bilateral excision of torus mandibularis

Plan C - Orthodontics

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

DENTAL EXPENSE BENEFIT

Exclusions

No benefit is payable for the following:

- Miscellaneous charges such as for counselling, travel, broken appointments, completion of forms, written reports or communication costs.
- Services or supplies that are primarily for cosmetic dentistry.
- Services or supplies resulting from self-inflicted injuries.
- Services or supplies resulting from war (whether declared or undeclared), riot, insurrection or civil commotion.
- Services or supplies resulting from committing or attempting to commit an assault or criminal offence.
- Hospital charges for room and board and related services and supplies.
- Services which are payable by any provincial government plan.
- Services or supplies for which no charge would normally be made in the absence of group benefit coverage.
- Any dental examination 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.
- Services and supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
- Services or supplies in connection with any procedures not listed as an eligible expense.

Survivor Benefits

Dental expense coverage for eligible dependents will continue following the date of the employee's death provided:

- covered expenses are incurred within 90 days after the date of the employee's death,
- a treatment plan has been filed and approved by Manulife Financial, and treatment has commenced while coverage was in force prior to the date of the employee's death, and
- dependent coverage terminated solely because of the employee's death.