CUPE LOCAL 1882

Your Benefit Plan as of February 24, 2017

DISCLAIMER

Every attempt is made to keep information up-to-date and accurate, however, there may be changes to your plan terms that are not reflected in the latest published plan booklet available on the Manion website. Manion Wilkins & Associates Ltd. therefore makes no warranty, guarantee, or promise, express or implied, concerning the content of the benefit plan booklet. In addition, a new release of the booklet, reflecting changes in your coverage, may be uploaded to the Manion website at any time and without prior notification to plan members. You should contact the plan administrator for confirmation of benefit levels and coverage before relying on the information contained within this booklet.

TABLE OF CONTENTS

YOU SHOULD KNOW

Original Effective Date of Plan: **May 1, 2011**

Covered Classes: **All Eligible Members of CUPE Local 1882**

Life Coverage and Long Term Disability Coverage are underwritten by La Capitale Insurance and Financial Services Inc. under **Policy No. 3380.**

Basic Accidental Death and Dismemberment Insurance is underwritten by Industrial Alliance Pacific Insurance and Financial Services Inc. under **Policy No. 119-3606.**

Extended Health Care Coverage and Dental Care Coverage are provided through your employer under **Plan No. 002790001.** Your pay-direct drug plan has been arranged by Manion Wilkins & Associates Ltd. utilizing the services of Express Scripts Canada who specialize in drug card adjudication.

Emergency Out of Country Medical Coverage is underwritten and administered by AIG Insurance Company of Canada under **Policy No. CMG 9133604.**

PLAN ADMINISTRATOR:

MANION, WILKINS & ASSOCIATES LTD. (Manion)
500 – 21 Four Seasons Place
Etobicoke, Ontario M9B 0A5
Telephone: 416-234-5044
Fax: 416-234-2071
Email: info@manionwilkins.com
Website: www.manionwilkins.com

Contact Centre
416-234-3511
Toll Free – 1-866-532-8999

Conformity With Law

If any provision of this plan conflicts with any law which applies to individuals shown in the covered classes, the plan will be amended to conform to that law.

Notice Regarding Personal Information

When you apply for coverage Manion Wilkins & Associates Ltd. (the Plan Administrator) and the insurers set up a file, or series of files, with personal information relative to your Health and Dental benefits under the plan. This includes all of the information concerning your enrollment, your benefits and your claims.

The purpose of these files is to permit us to administer your benefits under the plan. This includes the following:

- arranging insurance coverage where applicable
- claims adjudication, management and payment
- internal and external audits
- income tax reporting purposes where applicable
- preparation of reports used by the plan sponsor (the employer) in the financial management of the plan

Your files will be kept in the offices of Manion, the insurers and the custodian. Your personal information is used within these companies and shared, only to the extent required by law, with your plan sponsor, your local union if applicable, and the coverage provider(s) and financial institutions involved in caring for your plan(s). Only authorized persons have access to your files when required for coverage purposes. The information in your files is securely stored and is not shared with any other parties, unless you authorize Manion to release it to them, or the disclosure is required by law.

You have the right to access the personal information in your file and, if necessary, have it corrected by submitting a written request to Manion, Wilkins & Associates Ltd.

Electronic Services – MWAOnline

Manion has offered you access to MWAOnline, a web service where you are able to consult your personal file with Manion at any time via the internet.

Through MWAOnline you may:

- Access your benefit information
- Access your claims history and view the status of the claims submitted for you and your dependents
- Update your email address and change your password for security purposes at anytime
- Access your claims forms, benefits booklet, brochures and print them for your convenience
- Minimize out-of-pocket expenses and manage your claims and appointments by referring to your plan maximum reports before incurring the expenses.

A user id and password and detailed instructions on accessing this site will be sent to you.

For more details, contact Manion and access your account today.

Direct Deposit Available for Claims Payments

You may choose to have your claims payment deposited to your bank account by enrolling in our direct deposit service. Direct deposit is convenient and expedites secure claims reimbursement. To enroll in the service, access your online account and fill in the banking section under the “Update My Profile” menu item.

Be sure to **READ THIS BOOKLET CAREFULLY** and keep it with your valuable papers for future reference. The booklet describes when benefits are or are not payable, and outlines the conditions, limitations and exclusions that apply to the coverages provided under this plan.

However, this booklet does not include all contractual provisions regarding definitions, eligibility, enrollment, termination of coverage, or specifications. You may access this information by consulting the contract available from your employer.

SUMMARY OF COVERAGES

Please note: Part-Time Employees and Employees who are hired to work in a long-term temporary position are covered for Extended Health Care and Dental Care benefits only.

EMPLOYEE COVERAGE

LIFE INSURANCE

Amount: 2 times your annual earnings, rounded to the next higher $1,000 if not already a multiple thereof, up to a maximum of $465,000

Termination: When you reach age 65 or retire, whichever occurs first.

RETIREE LIFE COVERAGE

Amount: $2,000

For Employees who were hired prior to March 23, 2004, and who retire with an unreduced OMERS pension -

You will be eligible for this coverage if you retire at age 65 or with an unreduced OMERS pension. This coverage will become effective on the date following your retirement date.

For Employees who were hired on or after March 23, 2004, and who retire with an unreduced OMERS pension and are under age 65 -

You will be eligible for this coverage if you retire with an unreduced OMERS pension. This coverage will become effective on the date following your retirement date and terminates when you reach age 65.

Note: The Retiree Life Coverage for all covered individuals will be funded by the City of Cambridge on an annual basis, or as required.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Amount (Principal Sum): 2 times your annual earnings, up to a maximum of $465,000

Termination: When you reach age 65 or retire, whichever occurs first.

LONG TERM DISABILITY COVERAGE

Monthly Benefit: 70% of your monthly earnings, as of the end of sick leave, up to a maximum of $5,400.

The amount of the monthly benefit payable may be reduced by other sources of income you receive as of the commencement of your total disability which is explained in the Long Term Disability Coverage section of this booklet.

Elimination Period: Benefits will be payable for each period of total disability after expiration of the sick bank credits and/or EI benefits or 119 days of continuous total disability, whichever is greater.

Maximum Benefit Period: Benefits are payable up to your 65th birthday or, if earlier, to the date you retire.

Taxability of Monthly Benefit: Taxable

Cost-of-Living Adjustment (Applies only to Employees who were hired on or after August 1, 2006): 50% of the annual increase in the Consumer Price Index for the previous 12 months with a maximum of 5%.

Termination of Eligibility: When the employee retires or reaches age 65, whichever is earlier. Coverage for active employees ceases when completion of the elimination period would occur on or after age 65.

EMPLOYEE AND DEPENDENTS COVERAGE

EXTENDED HEALTH CARE COVERAGE

Covered Percentage	100%
Deductible	None
Prescription Drugs Dispensing Fee	The Plan will pay the greater of $10.00 or 50% of the dispensing fee, per prescription
Overall Lifetime Maximum	Unlimited
Termination	
– Active Employees	No termination age
– If you were hired prior to March 23, 2004 and you retire with an unreduced OMERS pension	Your coverage terminates upon your death
– If you were hired on or after March 23, 2004 and you retire with an unreduced OMERS pension	When you reach age 65

BENEFITS INCLUDE	**MAXIMUM AMOUNT PAYABLE (Per Covered Person)**
Hospital services	
Hospital or Rehabilitation Hospital room and board in Canada	Semi-private; benefits begin on the 8th day of confinement
Private Hospital room and board in Canada	$10 per day up to a lifetime maximum of 120 days
Paramedical services	
Chiropractor	$40 per visit up to a maximum of 20 treatments per calendar year
Podiatrist	$50 per treatment up to a maximum of 20 treatments per calendar year
Osteopath	$50 per treatment up to a maximum of 20 treatments per calendar year
Naturopath	$50 per treatment up to a maximum of 20 treatments per calendar year

BENEFITS INCLUDE (Continued)	**MAXIMUM AMOUNT PAYABLE (Per Covered Person)**
Paramedical services (Cont'd)	
Physiotherapist	Based on reasonable and customary charges
Clinical Psychologist	$25 for the first visit and $10 for each subsequent visit up to a maximum of 10 visits per calendar year
Acupuncturist (when authorized by a physician)	$25 per treatment
Speech Pathologist (when authorized by a physician or dentist)	$200 per calendar year
Registered Massage Therapist (when authorized by a physician)	$50 per treatment up to a maximum of 20 treatments per calendar year
Private duty nursing in the home or hospital	A lifetime maximum of 720 hours
Orthotics	$500 per calendar year (must be preauthorized and prescribed by a physician, podiatrist or chiropodist)
Hearing aids	$4,000 of hearing aids every 3 years; hearing tests are also covered up to a maximum of $150 every 3 years. Hearing aids and hearing tests are subject to a combined maximum of $4,000 per ear every 3 years.
Eye examinations	$100 every 24 months
Vision care	- $450 every 24 months with a change in prescription or every 48 months without a change in prescription; this maximum amount payable may be applied towards laser eye surgery - $250 every 24 months for contact lenses prescribed for severe corneal astigmatism, scarring, keratoconus or aphakia, provided visual acuity can be improved up to at least 20/40 by contact lenses and cannot be improved to that level with eyeglasses

DENTAL CARE COVERAGE

Covered Percentage

Basic Services	100%
Major Services	75%
Orthodontic Services	60%

Deductible	None
Fee Guide	Ontario Dental Association Suggested Fee Guide for General Practitioners, the guide in effect on the date the service is rendered, minus one year

Maximum

Basic Services	Unlimited
Major Services	$2,500 per calendar year per covered person
Orthodontic Services	$2,500 per calendar year per covered person

The maximum amount of payment in a calendar year under this coverage for any covered person will be $3,000.

Termination

Active Employees	No termination age
Retired Employees	When you reach age 65

EMERGENCY OUT OF COUNTRY COVERAGE
(Not Applicable to any Retired Employee)

Maximum per trip	
– Duration	60 days
– Coverage	$1,000,000 per covered person
Deductible	None
Covered Percentage	100%
Termination	When you retire

DEFINITIONS

The following definitions apply throughout this plan unless a term is defined differently within a specific coverage for the purpose of that coverage.

ACCIDENT means a bodily injury confirmed by a physician and directly resulting from a sudden, unforeseeable and unintentional action of an external cause, and independently of any other cause.

ACTIVELY AT WORK means you are working at your usual place of employment, or such other location as may be required, and performing the essential and material duties of your regular occupation, on a permanent full-time and full-pay basis for the minimum number of hours shown below*. If you are not required to report for work on a specified date, you will be considered actively at work if you are not disabled to the degree that you could not have reported for work at your usual place of employment and performed the essential and material duties of your regular occupation.

* For Full-Time Employees: 30 hours per week for the employer.
* For Part-Time Employees: 24 hours per week for the employer, for more than 4 continuous months.

AGE means the age of a covered person on the person's birthday, at the time of calculation of premiums or benefits, or at the time an event provided for under this plan occurs.

COVERED PERCENTAGE is the percentage of eligible charges shown in the Summary of Coverages, which will be reimbursed under a coverage after satisfaction of the deductible.

COVERED PERSON is an individual who is covered as an employee or a qualified dependent under this plan.

DEDUCTIBLE is the amount of eligible charges shown in the Summary of Coverages, which must be paid by or on behalf of a covered person in any calendar year before reimbursement will be made under a coverage.

DENTIST means a doctor of dentistry duly licensed to practice dentistry in the place where the services are provided.

DEPENDENT CHILD means the natural, legally adopted, step or foster child of the employee or insured spouse, who is unmarried, not engaged in full-time employment, dependent on the employee or spouse for financial support and under age 21.

However, a child age 21 and older who meets all other requirements of this definition will continue to be eligible for coverage under this plan provided the child is

- Under age 25 and enrolled and in full-time attendance at an accredited educational institution which provides a recognized certificate of accreditation on completion, or
- Incapable of self support due to mental or physical infirmity which began while the child was covered as the employee's dependent. Satisfactory proof the infirmity must be given to the Plan Administrator within 30 days of the date the child's coverage would normally terminate. Proof that the infirmity continues must be provided from time to time, as required by the Plan Administrator.

DULY LICENSED means licensed, certified or registered to practice the profession by the appropriate regulatory authority in the jurisdiction in which the care or services are rendered, or where such authority does not exist, having a certificate of competency from the professional body that establishes standards of competence and conduct for that profession.

EARNINGS mean the employee's gross regular earnings from the employer excluding dividends, bonuses and overtime earnings. Earnings with respect to an employee who earns all or part of his or her remuneration on a commission or similar basis means the employee's actual earnings in the preceding two calendar years based on his or her T4 slips. This amount will be pro-rated if less than two years' earnings are available. The earnings of an hourly-rated employee will be based on his or her regular number of hours worked per week. An employee's earnings for benefit calculation purposes will be determined on the basis of 4.333 weeks per month and 12 months per year.

ELIMINATION PERIOD means a period that begins at the start of a period of total disability, during which no disability benefit is payable.

EMPLOYEE means a person who resides in Canada, is actively at work for the employer, and is included in the Covered Classes shown on the You Should Know page.

A person who retires from active employment with the employer will also be considered to be an employee provided that he or she meets the requirements for retiree coverage as defined under the plan.

EMPLOYER means THE CORPORATION OF THE CITY OF CAMBRIDGE.

ESSENTIAL AND MATERIAL DUTIES means the duties which are required for the performance of an occupation and which cannot be reasonably omitted or modified.

HOSPITAL means a duly licensed active treatment facility which has physicians and registered nurses on duty or on call 24 hours per day. Unless otherwise stated, this term does not include a federal hospital, a private hospital, rest home, nursing home, convalescent nursing home, chronic care facility, health spa or hotel, home for the aged or an institution used primarily for the care and treatment of alcoholism, drug addiction or mental illness.

HOSPITALIZATION means admission to a hospital as an in-patient for a minimum period of an overnight stay.

IN-PATIENT means a person confined to a hospital on the recommendation of the attending physician for a minimum period of an overnight stay.

NET EARNINGS means salary after deduction of applicable provincial and federal government income taxes, in accordance with the declarations of exemption made to the employer.

PHYSICIAN means a physician duly licensed to practise medicine in the place where the services are provided.

PROVINCIAL PLAN refers to any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives and which is governed by the Canada Health Act.

QUALIFIED DEPENDENT means your spouse and dependent children who are covered under the provincial plan.

SICKNESS means any disorder of the body or mind diagnosed by a physician, including any complications resulting from a pregnancy.

SPOUSE means your spouse by marriage or legally-recognized civil union, or a person who has been cohabiting in a conjugal relationship with you for at least 12 months. Only one person at a time may be covered as a spouse under this contract.

ELIGIBILITY

A. FOR EMPLOYEE COVERAGE

An employee who is actively at work will be eligible for coverage as follows

For Life, Basic Accidental and Dismemberment and Long Term Disability Coverage:

All full-time employees will be eligible on the first day of employment.

A retired employee will become eligible for the coverage specified in the Summary of Benefits on the date he or she meets the requirements for retiree coverage that are identified for that coverage.

For Extended Health Care Coverage, Dental Care Coverage and Emergency Out of Country Medical Coverage

All full-time employees will be eligible on the first day of employment.

A part-time employee will be eligible on the first day of the month coinciding with or next following four continuous months of employment

An employee who is hired to work in a long-term temporary position, as defined by the employer and the Collective Agreement will be eligible on the first day of employment.

A retired employee will be eligible for coverage under this Plan on the date he or she becomes retired as described in the employee definition on the Definitions page.

B. FOR DEPENDENTS COVERAGE

You are eligible for dependents coverage while you are eligible for employee coverage and you have a qualified dependent.

C. FOR EMPLOYEE AND DEPENDENTS COVERAGE

Any individual residing outside of Canada will not be eligible to be covered, unless an exception is requested by the employer and approved in writing by the Insurer.

If you and your spouse are both employed by the employer, each of you may be eligible for and apply for employee and dependents coverage.

EFFECTIVE DATE OF COVERAGE

A. EMPLOYEE COVERAGE

The effective date of your coverage will be determined as follows:

(1) On the later of the following dates:

   (a) The date you become eligible for employee coverage.
   (b) The date your completed written application is received by the Plan Administrator, provided application is made within 31 days of your date of eligibility. However, if you apply later than 31 days after your date of eligibility, you must provide evidence of good health and the effective date of your coverage will be the date the Plan Administrator approves the evidence.

(2) When your coverage exceeds the non-evidence maximum, if any, indicated in the Summary of Coverages, the excess coverage will be effective on the date the Plan Administrator approves the evidence of good health.

If you decline to enroll when first eligible because you are covered for comparable benefits under your spouse's group plan, you will be eligible for coverage under this plan from the date immediately following the termination date of coverage under your spouse's plan; provided you apply within 30 days of the termination date.

In any event, if you are not actively at work on the date your coverage is to be effective, it will become effective when you return to active work.

B. DEPENDENTS COVERAGE

The effective date of a dependent's coverage will be the latest of the following dates:

(1) If you already have a qualified dependent at the time you become eligible for employee coverage, that dependent's coverage will become effective on the date the employee coverage is effective.

(2) If you already have a dependent who is covered for extended health care and dental care coverage on the date another qualified dependent becomes eligible for coverage, such coverage will be effective immediately for the new qualified dependent.

(3) If you have no qualified dependents at the time you become eligible for employee coverage and you later acquire a qualified dependent, this dependent's coverage will be effective on the date you apply for dependents coverage, provided application is made within 31 days of the date you are first eligible for dependents coverage, otherwise the dependent's coverage will be effective on the date the Plan Administrator approves the evidence of good health required for the dependents.

(4) A dependent's coverage will be effective on the date the dependent is discharged from the hospital if the dependent, other than a newborn child, is confined in a hospital on the date his or her coverage would otherwise have commenced. This does not apply to the Dental Care Coverage.

Note: For late entrants, evidence of good health submitted to Manion is at your expense.

C. INCREASES AND DECREASES IN COVERAGE

An increase in the coverage of an employee or dependent will take effect on the later of:

- The date of eligibility for the increase; or
- The date any required evidence of good health is approved by the Insurer.

Increases in Life and Basic Accidental Death and Dismemberment benefits are made retroactively, even if the employee is not actively at work.

Monthly earnings with respect to Long Term Disability benefits are determined at the end of the sick leave if the employee's salary increases while he or she is disabled.

If the employee is not actively at work on the date coverage would otherwise increase, then the increase will take effect only when he or she is actively at work, except as described above.

A decrease in the coverage on any employee or dependent will take effect on the date of the change in classification or eligibility or the decrease in earnings.

However, if a dependent (other than a newborn child) is confined in a hospital on the effective date of the change, coverage will become effective as of the date the dependent is discharged from the hospital. This does not apply to the Dental Care Coverage.

D. EXTENSION OF COVERAGE

Any continuation of coverage is contingent on payment of premiums for that coverage to the Plan Administrator in the normal manner.

If you cease to be actively at work due to:

(a) Sickness or injury, coverage will continue until the earliest of:

- Recovery from sickness or injury; or
- Termination of employment with the employer.

(b) An approved maternity leave or parental leave of absence, coverage will continue for the duration of the period stipulated under any federal or provincial employment standard legislation, whether or not benefits are payable under the Employment Insurance Act of Canada.

(c) Leave of absence, strike, lockout or temporary lay-off, the employer may choose to continue coverage for as follows, without discriminating among persons in similar circumstances:

- For one month from the end of the month in which employment was interrupted, for Long Term Disability benefits;
- For up to six months from the end of the month in which employment was interrupted, for Life and Basic Accidental Death and Dismemberment benefits;
- For as long as this contract is in force, for all other benefits.

<u>For Life, Basic Accidental Death and Dismemberment and Long Term Disability Coverage</u>

If your employment is terminated by the employer, coverage will be extended for the minimum period of time stipulated under any federal or provincial employment standards legislation, provided you request the continuation of coverage in writing and the contract remains in force.

<u>For Extended Health Care Coverage and Dental Care Coverage</u>

If your employment is terminated by the employer, coverage will be extended for the period of time chosen by the employer without discriminating among persons in similar circumstances, provided the contract remains in force. However, in no event will the period of continuation be less than the minimum period of time stipulated under any federal or provincial employment standards legislation.

HOW TO MAKE A CLAIM

A. LIFE COVERAGE

The beneficiary must contact the Administrator or the Insurer to obtain all required claim forms and submit a claim for the insured amount.

B. BASIC ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

In the event of an Accidental Death or Dismemberment Insurance claim, the Plan Administrator should be notified immediately.

C. LONG TERM DISABILITY COVERAGE

Contact the employer to obtain the proper claim forms and instructions. Forms should be completed without delay to ensure prompt payment of benefits.

D. SUBMISSION OF EXTENDED HEALTH CARE AND DENTAL CARE CLAIMS

To make a health claim

Obtain the health claim form from the employer and return the completed form to the Plan Administrator.

(1) Keep a separate running record of the covered expenses for each covered person.
(2) Save all bills; in most instances they will serve as proof of claim.
(3) Submit claims when a reasonable number of bills and receipts have been accumulated.
(4) Avoid frequent submission of small claims, but large claims should be submitted promptly.
(5) Each claim, other than for drugs, should include all of the following:

- (a) The covered person's full name.
- (b) The date or dates the service was rendered or purchase was made.
- (c) The nature of the sickness or injury.
- (d) The type of service or supplies furnished.
- (e) The itemized charges.
- (f) The attending physician's written referral or prescription. (This is not required when the service or supplies are furnished by a physician. Physician is as defined in the definition section.)
- (g) The date and the employee's signature.

To make a drug claim

Your Benefit Card provides your pharmacist with immediate confirmation of covered drug expenses.

To fill a prescription for covered drug expenses:

(1) present your Benefit Card to the pharmacist at the time of purchase; and
(2) pay any portion of each prescription that is not covered under this plan.

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

(1) the pharmacy cannot access the pay direct drug adjudication system,
(2) you do not have your Benefit Card with you at that time, or
(3) the prescription is not payable through the pay direct drug adjudication system.

In these cases, send your claims directly to the Plan Administrator for reimbursement.

To make a dental claim

Electronic filing of dental claims – Option 1

Your plan offers electronic filing of dental claims. Tell your dentist that your plan accepts claims electronically and if your dentist has access to this service, show your dentist your Benefit Card which notes the plan number needed to verify that the Plan Administrator does accept electronic filing of dental claims.

Once your dentist office submits your claim to the Plan Administrator the system will automatically verify eligibility and coverage amounts and will expedite reimbursement to you or your dentist, if applicable.

Paper filing – Option 2

You can obtain the dental claim form from the employer, complete the claimant's portion and have the dentist complete the attending dentist's statement. The form should then be sent to the Plan Administrator for reimbursement.

Submit only original bills and receipts; photocopies or carbon copies are not acceptable.

All claims must be submitted not later than the end of the calendar year following the year in which the claim was incurred. Upon termination of an employee's coverage for any reason, claims must be submitted not later than 90 days following the date of such termination.

When submitting claims to the Plan Administrator send them to:

Manion, Wilkins & Associates Ltd.
Claims Department
626 – 21 Four Seasons Place
Etobicoke, ON M9B 0A6

Contact Centre
416-234-3511
Toll Free: 1-866-532-8999

The Plan Administrator and Insurer have the right and opportunity to examine any person whose injury or sickness is the basis of claim, when and as often as may reasonably be required during the assessment and payment period, if any, of such claim.

GENERAL INFORMATION

A. BENEFICIARY

Subject to the provisions of applicable legislation, you may designate a beneficiary or change an existing beneficiary designation by means of a written statement filed with your Employer. Your Employer, the Plan Administrator or the Insurer shall not be liable for the validity of any change of beneficiary.

The rights of any beneficiary who dies before the employee revert to the employee. If at the time of the employee's death the employee has not designated a beneficiary in writing, the amount of insurance becomes a part of the employee's estate.

B. OVERPAYMENT OF BENEFITS

Nothing in this plan will prevent the Plan Administrator or the Insurer from recovering any overpayment of benefits from the person or organization to whom such payment has been made, irrespective of the cause of such overpayment.

C. COORDINATION OF BENEFITS (Applicable to Extended Health Care, Dental Care and Emergency Out of Country Medical Coverages)

Your plan includes a Coordination of Benefits provision. If you have similar coverage through any other insurer, the amount payable through this plan shall be coordinated as follows, so that payment from all plans does not exceed 100% of the eligible charges. When both spouses of a family have coverage through their own employer benefit plans, the first payor of each spouse's claims is their own employer's plan. Any amount not paid by the first payor can then be submitted for consideration to the other spouse's benefit plan (the second payor).

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earlier birthday in a calendar year, and second to the other spouse's benefit plan. When submitting a claim to a second payor, be sure to include payment details provided by the first payor.

D. PAYMENT OF BENEFITS

Benefits under a coverage will be payable to the employee unless otherwise specified within the coverage.

E. CONVERSION (Applicable Only to Extended Health Care and Dental Care Coverages)

If your employment with the employer terminates, you have the right to convert your coverage to an individual plan without providing evidence of good health. In addition, if a dependent ceases to qualify as a qualified dependent under the contract, he or she also has the right to convert coverage to an individual plan without providing evidence of good health.

In order to apply for an individual plan of coverage, the person must submit a written application and the required premium to the Plan Administrator within 60 days of the date the coverage is terminated. The individual plan will not duplicate the coverage under this contract and is subject to the terms and conditions of the individual plan being offered at that time.

EMPLOYEE LIFE COVERAGE

A. DEFINITION

Where used in this coverage, "total disability" or "totally disabled" means, due to sickness or bodily injury, you are unable to perform the essential and material duties of any occupation for which you are reasonably fitted, or could so become, by training or experience and are not engaged in any occupation or employment for wage or profit.

However, if you are qualified to receive any Long Term Disability benefits under the plan, you will be deemed to be totally disabled with respect to that benefit.

B. DEATH BENEFIT

Following your death while this coverage is in force, the Insurer will pay your beneficiary the amount of life insurance specified in the Summary of Coverages, subject to the maximums provided for in the Summary of Coverages.

C. SPECIAL ADVANCE PAYMENT (TERMINAL ILLNESS)

A special advance payment may be made if you are suffering from a condition which is expected to result in death within 12 months of your request. The payment must be requested in writing and will be the lesser of $50,000 and 25% of your Basic Life Insurance coverage.

If you wish further details, please contact the Plan Administrator.

D. WAIVER OF PREMIUMS IN THE EVENT OF TOTAL DISABILITY

If you become totally disabled prior to your 65th birthday, and remain disabled for a period of 6 months, coverage is continued without payment of premium from the first of the month following the date of disability, provided that proof of total and continuous disability is submitted as required.

Written proof that total disability exists and has continued without interruption for at least six (6) months must be given to the Plan Administrator within nine (9) months after commencement of total disability. Satisfactory proof of total disability must be given to the Plan Administrator within three (3) months of the date of notice and thereafter when and as required by the Plan Administrator once each year.

The amount of life insurance coverage that is maintained is the amount for which you were covered at the date of commencement of total disability. However, if the coverage would normally reduce when you reach a certain age or for any other reason, the amount of life insurance maintained will be reduced accordingly.

Upon your death, the amount of life insurance coverage will be paid provided satisfactory proof is submitted that you were still totally disabled on the date of death.

If an individual policy of life insurance has been issued in accordance with the conversion privilege provision of this contract, payment will be made only if the individual policy is surrendered without any claim.

The waiver of premiums ends on the earliest of the following dates:

- the date on which the total disability ends;
- the date of your 65th birthday;
- the date you retire;
- the date you fail to submit any required proof of total disability.

If waiver of premiums ends after you have given proof of total disability and you have not returned to active work with the employer, you have the same rights and benefits under the conversion privilege provision, as if you ceased to be covered under this coverage.

E. RECURRENT DISABILITY

Separate periods to total disability occurring while this coverage is in force will be considered to be one period of total disability if:

- they result from the same or related causes and are separated by a period of six (6) consecutive months or less during which you again were actively at work; or
- they result from entirely unrelated causes and are separated by a period of less than one full day during which you again were actively at work.

If a period of total disability is considered to be a continuation of a previous total disability, the waiver of premium will be automatically reinstated.

F. CONVERSION PRIVILEGE

(a) **Termination of membership in the group**

If you are under age 65 and your membership in the group of insureds terminates and you hold an amount of life insurance of at least $10,000, you are entitled to convert your life insurance in whole or in part to an individual life insurance policy without having to provide evidence of insurability.

The amount of insurance on your life that may be converted must be at least $10,000 and may not exceed the amount of all the life insurance coverage that you held under the contract on the conversion date or $400,000, whichever is lower.

To exercise this conversion option, you must apply in writing to the Insurer within 31 days following the date on which your membership in the group of insureds terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, without however exceeding the aforementioned 31-day period. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

(b) **Expiry of the contract**

If you have been insured for a minimum of 5 years and have at least $10,000 of life insurance coverage, you are entitled to convert your life insurance coverage, in whole or in part, to an individual life insurance policy within 31 days following the expiry of this contract if it is not replaced or the replacement contract provides for a lesser amount of insurance.

The amount of insurance that may be converted must be at least $10,000 or 25% of the amount of your life insurance on the expiry of the contract, whichever amount is greater.

To exercise this conversion option, you are not required to provide evidence of insurability but must apply in writing to the Insurer within 31 days following the expiry date of this contract. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

(c) **Coverage available upon conversion**

If you exercise your conversion privilege according to the aforementioned provisions, you may obtain an individual whole life or term life insurance policy, without accessory coverage, of the type issued at that time by the Insurer in such circumstances and in accordance with applicable insurance regulations and governing legislation.

The premiums applicable to the individual life insurance products when exercising the conversion privilege are determined in compliance with applicable insurance regulations and governing legislation.

G. PAYMENT OF BENEFITS

Any benefits payable upon your death will be paid to your designated beneficiary or estate, if there is no designated beneficiary.

H. TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates:

(1) The date on which this contract terminates, subject to the provisions of "Waiver of premiums in the event of total disability" section.

(2) The date on which your employment terminates for a reason other than retirement.

(3) The due date of any unpaid premium, subject to the provisions of "Waiver of premiums in the event of total disability" section.

(4) The date on which you reach the maximum age specified for this coverage.

(5) The date you retire.

(6) The date of your 65th birthday in the case you become disabled before age 65.

(7) The date corresponding to the expiry of the Long Term Disability Insurance elimination period in the case you become disabled at age 65 or over and have not returned actively at work.

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.

A. 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	66 2/3%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

B. 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.

C. IDENTIFICATION BENEFIT ($10,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

D. SPOUSAL RETRAINING BENEFIT ($15,000)

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.

E. EDUCATION BENEFIT ($10,000)

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.

F. DAY CARE BENEFIT ($5,000)

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.

G. 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% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

H. FAMILY TRANSPORTATION BENEFIT ($15,000)

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. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

I. 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.

J. HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

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.

K. 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.

L. 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.

M. 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.

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.

N. 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 years of age; (d) the premium due date next following the date an insured is ineligible for coverage.

O. 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 AD&D 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.

LONG TERM DISABILITY COVERAGE

A. DEFINITIONS

Where used in this coverage, the following words and expressions have the meanings set forth below:

(1) "Maternity leave of absence" means:

(a) any period of maternity leave taken by you in accordance with a federal or provincial law or pursuant to mutual agreement between you and the employer; or
(b) any period of maternity leave which the employer requires you to take in accordance with a federal or provincial law.

The period of maternity leave will commence on the earlier of the elected date of the leave and the date of delivery, and will end on the day you are scheduled to return to work.

(2) “Net earnings” means the earnings paid by your employer, reduced by the applicable federal and provincial income taxes.

(3) "Pre-disability earnings" means your earnings as of the commencement of total disability.

(4) "Rehabilitation program" means any work for wage or profit approved by the insurer and performed by you while you are unable to work on a full-time basis because you are totally disabled.

(5) "Total disability" or "totally disabled" means because of bodily injury or sickness you are:

(a) not able to perform the essential and material duties of your regular occupation during the elimination period and the next 24 months; and
(b) thereafter, not able to perform the essential and material duties of any occupation for which you are reasonably fitted, or could so become, by training, education or experience.

In addition, you must not be engaged in any occupation or employment for wage or profit except as part of a rehabilitation program.

The availability of other occupations with the employer or any other employer will not be considered in assessing your total disability.

B. BENEFIT AMOUNT

The benefit amount corresponds to the percentage of monthly earnings specified in the Summary of Coverages. This benefit amount is subject to the maximums specified in the Summary of Coverages and will be reduced by the sum of the following amounts:

(1) Any disability income benefits you are entitled to receive, or which you would be entitled to receive if an application were submitted and approved, under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP), any applicable workers' compensation legislation, any provincial automobile insurance legislation or any other government plan or social legislation.

(2) All benefits, indemnities and income received from the employer, including notice and severance payments, or from a retirement plan of the employer or any previous employer.

In all cases involving a reduction of the benefit amount specified in the above sections 1 and 2, it is your responsibility to submit an application for disability benefits to the appropriate authority if the Insurer so requires, unless proof is submitted in due form to the Insurer demonstrating that an application has been submitted and declined.

No increase in any amount referred to in items 1 and 2 that is due to a cost-of-living adjustment shall reduce the benefit amount payable under this insurance coverage.

The disability benefit amount will be prorated, if applicable, to the number of calendar days in the month you are disabled, at a rate of 1/30 of the monthly benefit.

If any amount referred to in sections 1 and 2 is paid as a lump sum, you will be deemed to have received the monthly equivalent of the lump sum amount, and as such the Insurer may recover any overpayment of benefits, or cease or reduce benefits payable under this contract as if the income from other sources were paid in monthly instalments.

For the week of benefits coinciding with your return-to-work day, the benefit payable is prorated to the number of working hours effectively lost.

The total of the disability insurance benefits specified above and initial income from other sources may not exceed 85% of your gross salary at the onset of disability.

The following income is considered to be income from other sources:

(1) Disability benefits payable under:

- Any applicable workers' compensation legislation or any similar legislation.
- Any government automobile insurance legislation or any similar legislation.
- The Canada Pension Plan (initial benefit amount only).
- Any other social legislation and any other public or private group insurance plan, including any supplemental income plan to which the employer contributes or to which any previous employer has contributed.

(2) Any other remuneration received from the employer or any previous employer (with the exception of amounts received for a rehabilitation program).

If you are disabled and are entitled to disability income benefits under the CPP or QPP and you have applied for retirement income from the CPP or QPP, you will be presumed to have received the disability income benefits you would have received if an application had been submitted, or that you would continue to receive if an application for retirement income benefits had not been submitted.

C. BENEFIT PERIOD

The first benefit payment is made as of the 31st day following expiry of the elimination period and subsequent payments are made each month thereafter.

Furthermore, benefits cease to be payable on the earliest of the following events:

(1) The last day of the week in which you reach the maximum benefit period specified in the Summary of Coverages.

(2) The date you retire.

(3) The date on which your total disability ends.

(4) The date you fail to provide proof of continuing disability deemed satisfactory by the Insurer.

(5) The date you refuse to undergo a medical examination as required by the Insurer.

(6) The date of your death.

(7) The planned end date of employment for contractual employees.

(8) The date you are incarcerated in a prison, correctional facility or mental institution by order of a criminal court.

(9) When you are absent from Canada for longer than 4 weeks due to any reason, unless the Insurer agrees in writing in advance to pay benefits during any such period.

D. COST-OF-LIVING ADJUSTMENT

On the January 1 that follows the date you begin receiving Long Term Disability payments and on each January 1 thereafter, the monthly benefit (including any prior cost-of-living adjustments) will be increased by the lesser of the cost of living adjustment percentage shown in the Summary of Coverages or the increase in the Consumer Price Index for the 12-month period ending on October 31 of the previous year. In no event will this adjustment result in a decrease in the monthly benefits.

The maximum monthly benefit and the evidence of good health requirements applicable to the Long Term Disability Coverage will not apply to any cost of living adjustment. The all source limitation described in section B. will not limit the amount of any cost-of-living adjustment.

If there is a change in the way the Consumer Price Index is calculated, adjustments effective up to the date of the change will be calculated on the old basis, and adjustments effective on and after the date of the change will be calculated on the new basis.

E. RECURRENT DISABILITIES

During the elimination period, separate periods of total disability will be considered to be one period of total disability If they result from the same or related causes and are separated by a period of two weeks or less during which you were actively at work. In that case, the elimination period will be extended by the number of days during which you were actively at work.

After the elimination period, separate period of total disability will be considered to be one period of total disability if:

- they result from the same or related causes and are separated by a period of six months or less during which you were actively at work; or
- they result from entirely unrelated causes and are separated by a period of less than one full day during which you were actively at work.

If a period of total disability is considered to be a continuation of a previous total disability and benefits had previously been payable, benefits will resume immediately and will continue until the original maximum benefit period has been exhausted. The same monthly benefit amount that was applicable on the original date total disability began will be payable, subject to the Benefit Amount provision.

F. REHABILITATION PROGRAM

If you participate in a rehabilitation program sponsored by the Insurer, you will be entitled to the monthly rehabilitation benefits which are equal to the amount of your monthly benefit prior to registration in the rehabilitation program, reduced by an amount equal to 50% of the remuneration for work carried out under the rehabilitation program.

Payment of rehabilitation benefits ends in the event of any of the following:

(1) Expiry of a 24-month period following the beginning of the rehabilitation program.
(2) Interruption of the rehabilitation program.
(3) Withdrawal of the Insurer's approval of the rehabilitation program.

If your income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program exceeds 100% of the gross basic monthly salary received from your employer at the beginning of the elimination period, monthly rehabilitation benefits are reduced by the excess amount.

G. PROOF OF CLAIM

Written notice of claim must be given to the Plan Administrator not later than 30 days after commencement of total disability. Written proof of claim must be given to the Plan Administrator not later than 30 days after the expiry of the elimination period.

H. WAIVER OF PREMIUMS

If you become totally disabled as defined in this coverage, any premium due under this coverage will be waived commencing with the first full calendar month following expiration of the elimination period, until such time you return to active full-time employment. Subject to the Recurrent Disabilities provision of this coverage, the Long Term Disability Coverage will be reinstated upon your return to work and premiums will be charged commencing on the first of the next month.

I. EXCLUSIONS, LIMITATIONS AND REDUCTION OF COVERAGE

No benefit are payable under this insurance coverage:

(1) If total disability occurs due to any of the following causes:

   (a) War, whether declared or undeclared, or your active participation in an insurrection, whether real or apprehended.
   (b) Voluntary self-inflicted injury or self-mutilation, whether or not you are of sound mind.
   (c) Participation in a criminal act or an act deemed to be criminal.
   (d) Cosmetic surgery performed solely for aesthetic purposes, unless such surgery is required following an illness, an injury or an accident.
   (e) Any condition occurring while you are on active duty with the armed forces of any country.
   (f) Long Term Disability benefits are not payable for any total disability caused by the use of drugs or alcohol unless you are engaged in, and complete, a recognized rehabilitation program specifically for the treatment of substance abuse. Such treatment must begin during the elimination period. This exclusion will not apply if total disability is due to a related organic condition.

(2) For a period of total disability corresponding to one of the following periods:

   (a) A period of maternity leave taken in compliance with a provincial or federal statute or maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.
   (b) A period during which you are receiving maternity benefits provided for under the Employment Insurance Act or the Quebec Parental Insurance Act.

(3) For any disability period during which you are not under the care of a physician.

(4) No benefit is payable for any period during which you engage in any gainful occupation, except within a rehabilitation program.

(5) No benefit is payable if you are dismissed for reasons not related to disability and the disability does not prevent you from engaging in any gainful activity for which you are reasonably suited due to education, training or experience.

(6) No benefit is payable after the date you retire.

(7) No benefit is payable for any period during which you refuse to take part in a rehabilitation program or perform rehabilitative work considered appropriate by the Insurer.

(8) For any group without long term disability coverage under a previous contract at the time this contract comes into force:

If you become disabled following an accident or illness suffered prior to the effective date of this contract and have received any treatment or medical care for such illness or accident during the 3 months immediately prior to this date, you will not be eligible for any benefits under Long Term Disability Coverage and will not benefit from any waiver of premiums related to such disability. However, this exclusion no longer applies once you have been actively at work full time for a continuous 12-month period after insurance comes into force.

(9) For contractual employees, no benefit will be payable after the planned end date of employment.

(10) No benefit is payable for any period during which you are imprisoned.

J. TERMINATION OF COVERAGE

Long Term Disability Insurance coverage terminates on the earliest of the following dates:

(1) The date on which this contract or benefit terminates, subject to the provisions of any applicable legislation.

(2) The date on which your employment terminates.

(3) The due date of any unpaid premium, subject to the provisions of the "Waiver of premiums in the event of total disability" section.

(4) The date on which you reach the maximum age specified in the Summary of Coverages.

(5) The date you retire.

EXTENDED HEALTH CARE COVERAGE

FOR YOU AND YOUR QUALIFIED DEPENDENTS

A. DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) "Eligible charges" means the reasonable and customary charges for a service or supply which is ordered by a physician or dentist (unless otherwise specified), is medically necessary for the treatment of a covered person's sickness or injury, and is listed in the Eligible Charges section of this coverage.

(2) "Medically necessary" means a treatment, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the diagnosis, care or treatment of a specific medical condition, sickness or injury.

(3) "Reasonable and customary charge" means a charge which is usually made in the absence of this or any similar coverage, for a specific type of care, service or supply, based on representative fees and prices in the geographic area in which the charge for the care, service or supply was incurred.

(4) "Rehabilitation hospital" means an extended care hospital facility or institution which is licensed under a provincial hospital services plan, which is regularly engaged in the care of patients who do not require active medical treatment but do require skilled nursing care and continued medical supervision for the sub-acute phase of their sickness. Sub-acute care is the provision of time-limited, goal-oriented therapeutic services geared toward restoration of health and physical ability. The rehabilitation hospital must have a patient transfer agreement with an active treatment hospital and must be qualified to participate in and be eligible for payment under the provincial hospital services plan.

The term does not include a federal hospital, a nursing home, home for the aged, private rest home, chronic care facility, health spa or hotel, an establishment providing custodial care or an institution for the care and treatment of alcoholism, drug addiction or mental illness.

B. PAYMENT OF BENEFITS

Coverage is available only to a person who is entitled to benefits under a provincial health insurance plan or another plan providing comparable benefits.

A benefit will be paid if a covered person incurs eligible charges for the services and supplies described in section C, provided charges are made while this coverage is effective. A charge is considered to be incurred on the date of the service or purchase for which the charge is made.

For all eligible charges, benefits will be equal to the covered percentage (shown in the Summary of Coverages). Benefits payable are subject to the overall lifetime maximum (shown in the Summary of Coverages) per covered person.

No medical examination is required. Benefits apply anywhere in the world. Reimbursement for charges incurred outside of Ontario will be made in Canadian funds up to the same amount you would have received if the service(s) had been provided in Canada, plus the rate of exchange, if any, as determined from the date of the last service provided.

Pre-existing conditions are covered from the moment the Plan takes effect, except for dental care as a result of an accident.

C. ELIGIBLE CHARGES

Eligible charges are the reasonable and customary charges actually made to the covered person for the following medically necessary services and supplies for either a non-occupational sickness or injury:

(1) **Hospital services**

Accommodation – charges made by a public general or rehabilitation hospital, or charges by a licensed private hospital. Payment will be made for room and board charges in excess of those payable by your provincial health plan, up to the difference in amount between the hospital standard ward and the semi-private room charges. **No benefits are payable for the first 7 days of confinement in the hospital.**

Private hospital accommodation – charges made by a private hospital for room and board and normal nursing care, up to the maximum amount payable shown in the Summary of Coverages.

Hospital out-patient charges – charges by a hospital which are in excess of the amount payable under the provincial health insurance plan for the out-patient care or services.

If a covered person incurs expenses in a hospital outside his or her province of residence, the Plan will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

(2) **Ambulance** – professional ambulance services (the difference between the provincial health plan allowance and the reasonable and customary charge) for transportation to and from the nearest hospital.

(3) **Nursing care and services –** charges for private duty nursing services which can only be performed by a duly licensed registered nurse (R.N.) registered nursing assistant (R.N.A.) or licensed practical nurse (L.P.N.) when such services are provided in the covered person's home, or in a hospital, up to the maximum amount payable shown in the Summary of Coverages, provided –

- The Plan Administrator determines the services are medically necessary;
- If required by the Plan Administrator a detailed nursing assessment is conducted to determine the level of nursing skill required;
- The services are approved by the Plan Administrator prior to the commencement date of services; and
- Ongoing services are approved in advance by the Plan Administrator after periodic reassessments of the continuing need for services.

Payment will not be made for:

(a) Services which could be provided by a person who is not a registered nurse, registered nursing assistant, or licensed practical nurse;
(b) Services performed after the covered person no longer requires the skills of a registered nurse, registered nursing assistant, or licensed practical nurse;
(c) Agency fees, commissions or overtime fees;
(d) Services of a registered nurse, registered nursing assistant or licensed practical nurse who is related to the covered person by birth or marriage, or who lives in the home of the covered person, or who is an employee of the hospital; or
(e) Charges for custodial services.

Pre-Determination of Benefits

A treatment plan must be completed by the attending physician and submitted to the Plan Administrator. When the services are extended for more than 30 days, prior approval must be obtained from the Plan Administrator on a monthly basis.

(4) **Physician services outside province of residence** – charges incurred for the services of a physician, due to an emergency, while the covered person is traveling or temporarily living outside his or her province of residence will be payable on a reasonable and customary basis, less any amount paid by the provincial health plan.

(5) **Paramedical services** – charges for the services of the duly licensed practitioners listed in the Summary of Coverages. Unless specifically stated, no benefits will be payable for consultations with any person other than a covered person, tests, or completion of reports. A physician's or dentist's written authorization is only required as specified in the Summary of Coverages. The maximum amount payable is also shown in the Summary of Coverages.

Services provided by a chiropractor, osteopath or podiatrist are payable only after the applicable annual maximum allowance under your provincial health plan has been paid.

(6) **Diagnostic laboratory and x-ray services** - Diagnostic services including X-ray examinations (excluding dental x-rays), microscopic and lab tests and other diagnostic services, provided such services are not covered by any provincial government plan, when authorized in writing by the attending physician.

(7) **Drugs and medicines**

Charges for:

- Drugs, medicines and injected allergy sera which legally require a prescription. This includes extemporaneous preparations provided at least one of the ingredients is eligible.
- Drugs and medicines considered to be life-sustaining when purchased on the prescription of a physician or dentist and dispensed by a duly licensed pharmacist, physician, dentist or hospital. This includes extemporaneous preparations provided at least one of the ingredients is eligible.
- Insulin, needles, syringes and chemical testing agents for the management of diabetes.
- Injected vitamins.
- Fertility drugs.

Dispensing fees will be payable up to the maximum amount payable shown in the Summary of Coverages.

Excludes -

- Vitamins (other than injected vitamins), vitamin/mineral preparations, food supplements.
- Vitamin B6 and B12 injections when used for weight loss.
- Chelation therapy.
- Erectile dysfunction treatments.
- Smoking cessation aids.
- Hair growth stimulants.
- General public (G.P.) products whether or not prescribed.
- More than a three-month supply of a drug or medicine.

Pre-authorization by the Plan Administrator is required for certain drugs and medicines. A physician's letter describing the covered person's underlying medical condition may be required periodically.

When alternate sources of funding are available through a government plan or manufacturer's subsidy for certain drugs and medicines, the Plan Administrator will provide benefits for Eligible Charges not covered under that government plan or manufacturer's subsidy.

(8) **Prosthetic appliances** – Charges for the following prosthetic appliances, however, the Plan Administrator reserves the right to provide benefits based on the least costly prosthetic appliance which would produce a professionally adequate result, consistent with accepted standards.

If a covered person incurs expenses for prosthetic appliances outside his or her province of residence, the Plan Administrator will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

- Standard type artificial limbs.
- Artificial eyes.
- Repairs to standard prosthetic appliances, when required as a result of normal wear and tear.
- Braces (excluding dental braces), trusses, casts, cervical collars.
- External breast prostheses and up to a maximum of 6 surgical brassieres per calendar year when required as a result of a mastectomy.
- Ostomy supplies (where a surgical stoma exists).
- Tracheostomy supplies (excluding gloves).
- Stump shrinker.
- Surgical elastic stockings, up to a maximum of 6 pairs per calendar year.
- Wigs required after radiation or chemotherapy, once only to a lifetime maximum of $500.
- Custom-moulded orthopedic boots or shoes, or modifications and adjustments to stock item footwear, or in lieu of the above, modifications and adjustments to standard type footwear.
- Custom-moulded orthotics fabricated using raw material, when prescribed by a physician, podiatrist or chiropodist, up to a maximum amount payable of $225 per calendar year and 2 pairs per calendar year.

(9) **Medical aids, appliances and supplies -** Charges for the following medical aids, appliances and supplies. The Plan Administrator reserves the right to provide benefits based on the least costly alternative which would produce a professionally adequate result, consistent with accepted standards.

If a covered person incurs expenses for medical aids, appliances or supplies outside his or her province of residence, the Plan Administrator will not pay an amount that is greater than it would pay for such expenses when incurred in the province of residence.

- Crutches, canes, walkers.
- Apnea monitor.
- Aerochamber.
- Oxygen.
- Positive expiratory pressure (PEP) mask for the treatment of cystic fibrosis, limited to one every 48 consecutive months.
- Anaesthetics.
- Ileostomy, colostomy.
- Diabetic supplies.
- Ventilator.
- Surgical bandages or dressings.
- Lymphedema sleeve and pump when required as a result of a mastectomy.
- Intra uterine devices (when inserted by a physician).
- Rental or, at the Plan Administrator's option, purchase of a standard-type manual hospital bed, including mattress. Electric hospital beds are excluded unless medically required.
- Rental or, at the Plan Administrator's option, purchase of a standard-type manual wheelchair. Electric wheelchairs are excluded unless medically required.
- Rental or, at the Plan Administrator's option, purchase of iron lung and other mechanical equipment for the treatment of respiratory paralysis and equipment for the administration of oxygen.
- Repairs to a hospital bed or wheelchair when required as a result of normal wear and tear, excluding the cost of replacement batteries.

(10) **Hearing aids** prescribed by a Duly Licensed audiologist, otolaryngologist, otologist, or physician, as well as repairs and initial batteries, up to the maximum amount payable shown in the Summary of Coverages.

Hearing tests by an audiologist will be covered up to the maximum amount payable shown in the Summary of Coverages.

Excludes –
- Hearing examinations.
- Replacement batteries or replacement of hearing aids which are lost or broken.
- Hearing aids which were ordered or delivered prior to the effective date of this coverage, or after the termination date of this coverage.
- Replacement parts to hearing aids.
- Hearing aids which are not for the personal use of a covered person.

(11) **Eye examinations** – Charges incurred by a Duly Licensed ophthalmologist or optometrist, up to the maximum amount payable shown in the Summary of Coverages.

(12) **Vision care** – When prescribed by a Duly Licensed ophthalmologist or optometrist and dispensed by a Duly Licensed ophthalmologist, optometrist or optician for eyeglass frames and corrective lenses, contact lenses and laser eye surgery, up to the maximum amount payable shown in the Summary of Coverages.

Charges will be considered incurred on the date the covered person incurs an obligation with the provider for eligible vision care expenses.

Excluding –

- Non-prescription sunglasses.
- Safety glasses, whether prescribed or not.
- Services or supplies which are not for the personal use of the covered person.
- Tints other than No. 1 and No. 2.
- Replacement of lost or broken lenses or frames.
- Duplicate glasses, lenses or frames.

(13) **Radium therapy** – radium and radioactive isotope treatments.

(14) **Blood products** – blood transfusions, blood plasma and other blood products.

(15) **Dental accident coverage** – dental care provided by a dentist for care or services for treatment of a fractured or dislocated jaw, or for the repair or extraction and replacement of natural teeth damaged as a result of an accidental injury involving an external force or blow to the mouth, provided such accident occurs and treatment is performed while the covered person's coverage is in force.

Payment will be made based on the fees set out in the Ontario Dental Association Fee Guide for General Practitioners in effect on the date of treatment. If a covered person incurs expenses outside Canada, the Plan Administrator will not pay an amount which is greater than it would pay for such expenses when incurred in Ontario.

Treatment must begin within six months following the date of the accident and must be completed while the employee's coverage is in force.

(16) **Prescribed smoking cessation programs for Active Employees only** - paid once during the employee's lifetime up to a maximum of $250 (dependents are not covered for this benefit). This is paid for, and administered by, the City of Cambridge. ***Please submit directly to the City of Cambridge NOT the Plan Administrator.***

D. EXCLUSIONS

The Plan will not pay for:

(1) Services covered by any provincial government plan or workers' compensation board.

(2) Any care, services or supplies which are not medically necessary, as determined by the Plan Administrator.

(3) Dental care or services other than those described under Eligible Charges.

(4) Care, services or supplies utilized as treatment of lifestyle choices, as determined by the Plan Administrator.

(5) Services or supplies which are primarily for cosmetic purposes.

(6) Rest cures, travel for health reasons or examinations for the use of a third party.

(7) Services or supplies provided in a health spa, psychiatric or chronic care hospital or chronic care unit in a general hospital.

(8) Services or supplies provided while confined in a nursing home or home for the aged.

(9) Drugs or medicines, services or supplies which have been self prescribed, or prescribed by or for family members.

(10) Drugs or medicines, services or supplies required for the condition requiring hospitalization while the covered person is an in-patient in a hospital.

(11) Service agreements.

(12) Drugs, injectables, supplies or appliances which are experimental or which are not approved by the Health Protection Branch of Health & Welfare Canada for use in Canada.

(13) Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.

(14) Additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as a result of a pathological change, unless prior approval in writing is obtained from the Plan Administrator.

(15) Vaporizers or nebulizers.

(16) Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.

(17) Charges for the completion of claim forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for transfer of medical files.

(18) Expenses incurred for benefits or that part of benefits which cease to be payable under any government program.

(19) Expenses which involve willful concealment or misrepresentation of any material fact or circumstance concerning this coverage, either before or after the incurrence of an expense. In the event that any claim(s) submitted by the covered person is (are) found to be inappropriate after due investigation, then the covered person shall indemnify Manion, Wilkins & Associates Ltd. from all costs related to the investigation. (Waiver by the Plan Administrator of its rights to indemnification in any particular instance will not preclude the Plan Administrator from exercising its rights in any other situations that may exist.)

E. EXTENSION OF COVERAGE ON YOUR DEATH (SURVIVOR BENEFITS)

If your dependents are covered for this coverage on the date of your death, their coverage will continue until the earliest of:

(1) 3 months from the date of your death; in addition, the coverage may be continued for a further 3 months provided your family pays the premium costs;
(2) the end of the month in which your spouse remarries;
(3) the date the dependent is no longer a qualified dependent;
(4) the date that similar coverage is obtained elsewhere;
(5) the date the coverage is cancelled; and
(6) the date the plan is cancelled.

F. TERMINATION OF COVERAGE

An employee's coverage will terminate on the earliest of:

(1) the last day of the month for which the current premiums have been remitted for the employee;
(2) the day on which the employee ceases to the actively at work, except with respect to a retired employee;
(3) the day on which the employee ceases to be listed as a member of an eligible class;
(4) the day on which the employee attains any termination age specified in the Summary of Coverages; and
(5) the date this plan terminates.

A dependent's coverage will terminate on the earliest of the following dates:

(1) the date the employee's coverage terminates for any reason;
(2) the last day of the month in which the person ceases to be a qualified dependent;
(3) the date dependent coverage under this plan terminates; and
(4) the date this plan terminates.

DENTAL CARE COVERAGE

FOR YOU AND YOUR QUALIFIED DEPENDENTS

A. DEFINITIONS

The following definition applies exclusively within the description of this coverage:

"Eligible charges" means the charges for a service or supply which are made to the covered person for services which are included for payment in the List of Dental Services described in the following pages, and which are reasonable, necessary and customary for good dental care and are performed or recommended by a dentist; to the extent that the charges:

- ordered or provided by a dentist (When services provided by a denturist are covered, the services may also be rendered by a duly licensed denturist.);
- included in the List of Dental Services and not performed or provided in connection with an ineligible service or supply; and
- generally accepted by the dental profession as essential, effective, appropriate and customarily used in the diagnosis, care or treatment of a specific dental condition or injury;

provided the charge for the service or supply does not exceed the amount specified in the applicable fee guide described in the Summary of Coverages.

B. PAYMENT OF BENEFITS

Reimbursement of charges incurred by a covered person for the following dental procedures will be made up to the monetary rates outlined in the applicable Dental Association Fee Guide shown in the Summary of Coverages.

Benefits will be equal to the covered percentage up to the maximum shown in the Summary of Coverages. The covered percentage is shown in the Summary of Coverages.

When you incur charges outside Ontario/Canada, the Plan Administrator will not pay an amount which is greater than it would pay for such charges when incurred in Ontario.

C. LIST OF DENTAL SERVICES

The following list of dental services provides a general description of the services covered. Determination of the actual dental procedure codes which are eligible for each listed service will be made by the Plan Administrator.

In-office and commercial laboratory charges applicable to eligible dental services will be an eligible charge under the dental plan and will be payable at the same covered percentage as the related dental service.

BASIC SERVICES

EXAMINATIONS
Complete oral examination (once every 2 years)
Recall oral examination (once every 6 months for eligible dependent children, once every 9 months for employees and their spouses)
Emergency examination
Specific oral area examination

CONSULTATIONS
With patient (maximum 2 units every 12 months)
With a member of the profession

RADIOGRAPHIC EXAMINATION (X-RAY)
Complete series intra oral films (once every 2 years)
Periapical films
Occlusal films
Bitewing films (once every 6 months for eligible dependent children, once ever 9 months for employees and their spouses)
Extra oral films
Sinus examination
Sialography
Use of radiopaque dyes to demonstrate lesions
Panoramic film (once every 2 years)
Interpretation of radiographs from another source
Treatment planing

DIAGNOSTIC SERVICES
Biopsy, soft-hard tissue

PREVENTIVE SERVICES
Polishing (once every 6 months for eligible dependent children, once every 9 months for employees and their spouses)
Scaling (once every 6 months for eligible dependent children, once every 9 months for employees and their spouses)
Fluoride treatment
Oral hygiene instruction (only once)
Pit and fissure sealants
Interproximal discing of teeth
Space maintainers, when not for orthodontic purposes

RESTORATIVE SERVICES
Caries/pain control
Amalgam restorations (silver fillings) – primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth
Pins, retentive per restoration
Stainless steel/plastic full coverage, preformed restorations
Tooth coloured restorations, permanent teeth
Tooth coloured restorations, primary teeth

PERIODONTAL SERVICES
(Diagnosis & treatment of gum tissue)

Application of displacement dressing
Oral manifestations, oral mucosal disorders
Desensitization
Surgical curettage
Gingivoplasty
Gingivectomy
Flap approach with osteoplasty / ostectomy
Flap approach with curettage
Soft tissue grafts
Free connective tissue grafts
Osseous grafts
Distal wedge procedure
Post surgical treatment
Periodontal abscess or pericoronitis
Vestibuloplasty

ADJUNCTIVE PERIODONTAL SERVICES
Occlusal equilibration (8 units of time every 12 months)
Root planing

SURGICAL SERVICES
Removal of erupted teeth (uncomplicated)
Removal of erupted teeth (complicated)
Removal of impacted teeth
Removal of residual roots
Surgical exposure of teeth
Alveoloplasty
Excision, removal of bone
Reduction of bone, tuberosity
Gingivoplasty and/or stomatoplasty
Surgical excision (cysts and tumors)
Surgical incision and drainage
Fractures
Repair lacerations, uncomplicated
Frenectomy
Management of TMJ dislocation
Miscellaneous surgical services

ANAESTHESIA

PROFESSIONAL VISITS

MAJOR SERVICES

MAJOR RESTORATIVE SERVICES (once every 5 years – natural teeth only)
Metal onlay restoration
Composite onlay restoration
Retentive pins
Post and core
Crowns
Plastic repair
Porcelain repair
Natural tooth preparation
Metal cast coping crowns
Other restorative services

ENDODONTIC SERVICES
(Root canal treatment)

Pulpotomy
Root canal therapy
Apexification
Re-insertion of dentogenic media
Apicoectomy / apical curettage
Retrofilling
Root amputation
Hemisection
Surgery, endodontic, exploratory
Perforations/resorptive defect, pulp chamber repair, or root repair, non surgical
Perforations/resorptive defect, pulp chamber repair, or root repair, surgical
Isolation of endodontic tooth/teeth
Emergency procedures
Replantation, avulsed tooth/teeth
Repositioning of traumatically displaced teeth

PROSTHODONTIC SERVICES – REMOVABLE
Complete dentures (once every 5 years)
Partial dentures (once every 5 years)
Denture remakes (once every 5 years)

DENTURE REPAIRS, REBASING, RELINING
Denture adjustments (complete or partial dentures

Minor adjustments
Denture repairs/additions
Denture rebasing, relining
Denture, tissue conditioning
Resetting of teeth

PROSTHODONTIC SERVICES FIXED (once every 5 years)
Diagnostic casts
Pontics
Repairs
Retainers
Retainers – inlay, onlay
Abutment preparation under existing partial denture clasp
Retentive pins for retainers

ORTHODONTIC SERVICES

DIAGNOSTIC SERVICES
Extra oral films
Cephalometric films
Hand and wrist (as diagnostic aid for dental treatment)
Tomography
Orthodontic casts
Diagnostic photographs

OBSERVATION & ADJUSTMENT
Observation
Observation and adjustment
Repairs
Alterations
Re-cementations
Separation
Removal of fixed orthodontic appliances

ORTHODONTIC APPLIANCES
Removable
Fixed or cemented
Retention appliances
Appliances to control oral habits
Appliances, control of oral habits, adjustments, repairs, maintenance

OTHER ORTHODONTIC SERVICES
Surgical exposure of tooth
Enucleation of unerupted tooth
Gingival fiber incision

Prior to commencement of orthodontic treatment, the dentist should prepare a report outlining the details with respect to malocclusion, diagnosis, proposed treatment and applicable fees. This treatment plan should be forwarded to the Plan Administrator for review to establish the extent of payable benefits.

D. EXCLUSIONS

Benefits are not payable for:

(1) Services or supplies not listed under List of Dental Services.

(2) Services or supplies for cosmetic purposes.

(3) Charges for procedures or appliances connected with implants.

(4) Services or supplies related to temporomandibular joint problems.

(5) Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.

(6) Charges incurred as a result of self-inflicted injury.

(7) Charges incurred while committing, or attempting to commit, directly or indirectly, a criminal act under legislation in the jurisdiction where the act was committed.

(8) Charges for the completion of claim forms or other documentation, or charge incurred for failing to keep a scheduled appointment or for transfer of medical files.

(9) Charges for procedures in excess of those stated in the Fee Guide for General Practitioners, as shown in the Summary of Coverages.

(10) Services or supplies covered by any government plan.

(11) Services completed after termination of coverage.

(12) Replacement of dentures if such replacement

- is of lost or stolen dentures,
- occurs within 12 months after the date the covered person becomes covered under this plan, or
- within 5 years of the date of placement of the last replacement for which benefits were payable hereunder.

(13) Dental care, services or supplies provided after the date of termination of this coverage, except for prosthetic appliances which were fitted and ordered prior to the termination and which are delivered within 31 days after such date.

E. EXTENSION OF COVERAGE ON YOUR DEATH (SURVIVOR BENEFITS)

If your dependents are covered for this coverage on the date of your death, their coverage will continue until the earliest of:

(1) 3 months from the date of your death; in addition, the coverage may be continued for a further 3 months provided your family pays the premium costs;
(2) the end of the month in which your spouse remarries;
(3) the date the dependent is no longer a qualified dependent;
(4) the date that similar coverage is obtained elsewhere;
(5) the date the coverage is cancelled; and
(6) the date the plan is cancelled.

F. TERMINATION OF COVERAGE

An employee's coverage will terminate on the earliest of:

(1) the last day of the month for which the current premiums have been remitted for the employee;
(2) the day on which the employee ceases to the actively at work, except with respect to a retired employee;
(3) the day on which the employee ceases to be listed as a member of an eligible class;
(4) the day on which the employee attains any termination age specified in the Summary of Coverages; and
(5) the date this plan terminates.

A dependent's coverage will terminate on the earliest of the following dates:

(1) the date the employee's coverage terminates for any reason;
(2) the last day of the month in which the person ceases to be a qualified dependent;
(3) the date dependent coverage under this plan terminates; and
(4) the date this plan terminates.

EMERGENCY OUT OF COUNTRY MEDICAL COVERAGE

The following benefits provide protection when you and/or your eligible dependents are vacationing or traveling outside the province of residence for other than health reasons. Eligible expenses over and above those paid by the provincial government health plan are covered when emergency illness or injuries occur outside the province of residence.

Coverage is limited to a maximum of 60 consecutive days per trip, beginning on and including the date of departure. If you are in hospital on the 60th day, coverage will be extended until date of discharge. The total amount payable for all eligible expenses will not exceed the maximum amount payable per trip shown in the Summary of Coverages.

Any benefit maximums listed are in Canadian funds.

When eligible expenses are incurred for benefits which have a limitation, i.e., accidental dental, balances may be eligible through your employer's Extended Health Care Coverage plan. Refer to the Summary of Coverages for information regarding reimbursement of the following benefits.

A. BENEFITS

(1) Hospital Accommodation: Reasonable and customary charges in excess of the provincial health plan allowance for active treatment hospital room accommodation (not a private room or suite). Payment will also be made for outpatient services provided by an active treatment hospital, in excess of the provincial health plan allowance. If coverage expires after admission to hospital, benefits continue until discharge.

(2) Doctor Bills: Reasonable and customary charges in excess of the provincial health plan allowance.

(3) Private Duty Registered Nurse: Reasonable and customary charge for private duty nursing services which can only be performed during or immediately following hospitalization. Private duty nursing services must be certified in writing as medically necessary by the attending physician and cannot be performed by a relative.

(4) Ambulance: Reasonable and customary charges for ground ambulance service from the placed of illness or accident to the nearest qualified medical facility.

(5) Air Ambulance: The cost of air evacuation between hospitals or for repatriation for hospital admission in your province of residence, when the transfer is approved in advance by the Insurer. Any unused portion of your air ticket must be returned to the Insurer. (Arrangements must be made through the Coordination Centre.)

(6) Paramedical Services: Payment for charges made by a physiotherapist, chiropractor, chiropodist, podiatrist or osteopath (including x-rays), when required for emergency treatment, as outlined in the Summary of Coverages.

(7) Diagnostic Services: Reasonable and customary charges for laboratory tests and x-rays when prescribed by the attending physician.

(8) Treatments: The cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes are covered, when rendered due to emergency hospitalization.

(9) Prescriptions: When required for emergency treatment, reasonable and customary charges for drugs, medicines and injected sera, when purchased on the prescription of a physician or dentist and dispensed by a licensed pharmacist. Benefits are not payable for vitamins, vitamin/mineral preparations, food supplements, general public (G.P.) products or over-the-counter drugs or medicines, whether prescribed or not. Requires original receipt, showing name of prescribing physician, prescription number, name of medication, date, quantity and total cost.

(10) Medical Appliances: Cost of splints, casts, crutches, canes, slings, trusses, walkers and/or the temporary rental of a wheelchair prescribed by the attending physician, will be reimbursed when required due to an accident or unexpected illness which occurs, and when devices are obtained, outside your province of residence.

(11) Accidental Dental: Up to $2,000 will be reimbursed for treatment by a dentist to natural teeth when necessitated by a direct, external accidental blow to the mouth. Treatment must begin within the period of coverage and be completed within 183 days of the accident. An accident report is required from the dentist or physician, immediately following the accident.

(12) Repatriation: When your emergency is such that:

- the attending physician specifies in writing that you should immediately return to your province of residence for immediate medical attention, the Insurer will reimburse the extra cost incurred for the purchase of the most economical airfare (available only when you are not holding a valid open-return air ticket), plus the additional most economical airfare, if required, to accommodate a stretcher, to return you by the most direct route to the air terminal nearest the departure point in your province of residence. This benefit also applies to one member of the family who is covered by this plan, and is traveling with the person at the time of the illness or injury. (Arrangements must be made through the Coordination Centre.)

- the attending physician or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant (not a relative), the Insurer will reimburse the reasonable and customary fee charged by a medical attendant registered in the jurisdiction in which treatment is provided, including the most economical airfare and overnight hotel and meal expenses, if required. (Arrangement must be made through the Coordination Centre.)

(13) Friend/Family Hospital Visits: The most economical airfare by the most direct route from your province of residence will be reimbursed for any one family member or friend to:

- visit a covered person confined in hospital. Benefit requires the covered person to have been an inpatient for at least 7 days outside the province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit.
- identify deceased prior to release of the body, where necessary. (Arrangements must be made through the Coordination Centre.)

(14) Automatic Extension of Coverage: Coverage will be extended to the covered person and any accompanying family members for up to 72 hours:

- following discharge date (and including the period of hospitalization) when return to the province of residence is delayed due to hospitalization, where such confinement continues beyond the 60th day following the date of departure from the province of residence;
- beyond the 60th day following the date of departure from the province of residence when return to the province of residence is delayed, by order of the attending physician, due to a covered illness or accidental injury;
- beyond the 60th day following the date of departure from the province of residence when return to the province of residence is delayed, due to the delay of a common carrier (airplane, bus, taxi, train) on which a covered person is a passenger; or the delay is caused by a traffic accident or mechanical failure of a private automobile en route to the departure point. Claims must be supported by documented proof.

(15) Return of Deceased: Up to $5,000 will be reimbursed towards the cost of preparation and homeward transportation of a deceased covered person to the province of residence OR up to $2500 for cremation and/or burial at place of death. Benefit excludes the cost of a burial coffin.

(16) Meals and Accommodation: Up to $1500 (for you and your dependents combined, limited to a daily maximum of $150) will be reimbursed for the extra cost of commercial accommodation and meals incurred by a covered person remaining with a traveling companion, when return to the province of residence is delayed beyond the planned termination date of the trip due to illness or injury to a traveling companion or a covered person. Claims must be verified by the attending physician and supported with receipts from commercial organizations.

(17) Vehicle Services: Up to $1000 will be reimbursed towards the cost of driving your vehicle, either private or rental, to the province of residence or nearest appropriate vehicle rental agency when you are unable to do so due to unexpected illness or physical injury and your traveling companion is unable to do so. Medical certification is required, as well as receipts for costs incurred (i.e., fuel, accommodation, meals, airfares).

If your private vehicle is stolen or rendered inoperable due to an accident, costs will be covered for the most economical airfare to return the covered persons, by most direct route, to point of departure in the province of residence. Requires official policy report of the loss or accident.

(18) Relief of Dental Plan: Treatment for the emergency relief of dental pain, excluding root canals, is covered to a maximum of $200. Treatment must be rendered at a location at least 200 km from the province of residence.

(19) Hospital Expenses: Payment of up to $100 per hospital stay to cover incidental expenses. Paid receipts must be submitted.

B. EMERGENCY AND PAYMENT ASSISTANCE

Hospital/Medical Payment: Many hospitals around the world require a substantial deposit when non-residents are admitted for emergency treatment. And, before the patient is discharged from care, most hospitals and physicians expect payment in full for services provided. The Coordination Centre will arrange and/or coordinate payment in full on your behalf, whenever possible. Be sure to call for assistance.

Emergency Helpline: In the event of any emergency, illness or accident while traveling outside your province of residence, call the Coordination Centre. The toll-free numbers are listed on the back of the identification card.

WHEN HOSPITALIZATION OCCURS, THE COORDINATION CENTRE MUST BE CONTACTED WITHIN 24 HOURS OF ADMISSION. FAILURE TO CONTACT THE COORDINATION CENTRE MAY RESULT IN A DELAY IN THE SETTLEMENT OF YOUR CLAIM.

Note: You must be able to provide your provincial health insurance number to the Coordination Centre before payments can be arranged on your behalf. Be sure to travel with your provincial health insurance number and the number of each member of your family. **Provide the Coordination Centre with the Insurer's group policy number and certificate number shown on your benefit card.**

If you require general information about your travel benefit, please call Manion, Wilkins & Associates Ltd.'s Contact Centre at 416-234-3511 or toll free at 1-866-532-8999.

C. TRAVEL ASSISTANCE BENEFITS

Assistance Related to Medical Services

- Help you locate a physician, clinic or hospital.
- Confirm coverage to the hospital or physician.
- Arrange payment to the hospital or physician wherever possible.
- Monitor the medical treatment and keep the family informed.
- Arrange transportation of a family member to the patient's bedside or to identify the deceased.
- Arrange for transportation home of the patient, if medically permissible.

General Assistance

- Provide emergency response in most major languages.
- Assist in contacting your family, business partner or family physician.
- Arrange for local care of dependent children and coordinate their return home, if the covered person is hospitalized.
- Arrange for the transportation of urgent messages to family members or business partners.
- Assist in the event of loss of passports or airline tickets.
- Help you to access legal counsel in the event of a serious accident.
- Coordinate claims processing with your provincial health plan.

D. DEFINITION

"Travelling companion" is any person who has prepaid accommodation and/or transportation with the covered person. (Maximum four persons, including the covered person)

E. GENERAL INFORMATION

(1) Coverage is available only to residents of Canada who are covered by a provincial government health plan while they are traveling outside their province of residence.

(2) The availability, quality or results of any medical treatment, transport or other services, or the failure of the person to obtain medical treatment or other services will not be the responsibility of the Insurer or the Coordination Centre.

(3) To be eligible, the hospital or medical benefits covered must have been provided at the nearest eligible facility capable of providing adequate service at the time the illness or injury occurred.

(4) The Insurer will make benefit payments, based on reasonable and customary charges, after receipt and evaluation of satisfactory claim information. Reimbursement will be made in Canadian funds based on the rate of exchange you would be charged within the country of travel as determined by the Insurer in its sole discretion, based upon advice of any Schedule One Canadian bank. No sum payable will carry interest.

(5) Where required, benefits listed herein will be payable only on receipt of certification from the attending physician that services have been rendered and were for emergency treatment. Costs for completion of medical certificates or documentation required for the assessment of claims are the responsibility of the covered person.

(6) The Insurer, in consultation with the attending physician, reserves the right to transfer the covered person to another hospital or return the covered person to his or her province of residence. If any covered person is able to return to the province of residence following the diagnosis of, or the emergency medical treatment for, a medical condition which requires continuing medical care, treatment or surgery and the covered person elects to have the care, treatment or surgery performed outside the province of residence, no benefits will be payable with respect to such continuing care, treatment or surgery. The immediate availability of care, treatment or surgery on return to the province of residence is not the responsibility of the Insurer or the Coordination Centre.

(7) The coverage provided under this benefit is subject to change by the Insurer. If this benefit and/or its provisions are revised by the Insurer, coverage for trips commencing on or after the effective date of such revisions will be in accordance with such revised benefits and/or provisions.

F. EXCLUSIONS

The Insurer will not pay benefits for expenses incurred:

(1) For care, services or supplies which are not medically necessary, as determined by the Insurer.

(2) For elective (non-emergency) treatment or surgery. This includes treatment or surgery:

- not required for the immediate relief of acute pain and suffering;
- which medically could be delayed until the covered person has returned to Canada; or
- which the covered person elects to have rendered or performed outside Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.

(3) For hospital accommodation or treatment received in a hospital which is not an active treatment hospital, such as a nursing home, health spa, chronic care hospital or chronic care unit of a public hospital.

(4) Outside the province of residence when the covered person could have been returned to the province of residence without risk to the covered person's life or health, even if the treatment available in the province of residence is of lesser quality than that available elsewhere.

(5) For a medical condition for which, prior to departure, medical evidence would suggest that treatment or hospitalization could be required while on the trip.

(6) By a covered person who is traveling outside the province of residence, with intent or incidentally, to seek medical advice or treatment, even if the trip is on the recommendation of a physician.

(7) For hospitalization or services rendered in connection with or in any way associated with:

- general health examinations for check-up purposes;
- ongoing maintenance of an existing medical condition;
- rehabilitation or ongoing care in connection with drug, alcohol or other substance abuse;
- a rest cure or travel for health reasons; or
- cosmetic treatment.

(8) In connection with or in any way associated with travel booked or commenced contrary to medical advice or after receipt of a terminal prognosis.

(9) For hospital or medical care of either a covered person or a newborn child as a result of, in connection with or in any way associated with:

- full-term birth;
- medical complications after the 26th week of pregnancy; or
- deliberate termination of pregnancy.

(10) For services provided by naturopaths or optometrists or for cataract surgery.

(11) As a result of, in connection with or in any way associated with driving a motorized vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood. (For the purpose of this exclusion, “motorized vehicle” means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to, an automobile, truck, motorcycle, moped, snowmobile or boat.)

(12) As a result of, in connection with or in any way associated with abuse of medication, toxic substances, alcohol or the use of non-prescribed drugs.

(13) As a result of, in connection with or in any way associated with suicide, attempted suicide or self-inflicted injury, whether sane or insane.

(14) As a result of, in connection with or in any way associated with committing, or attempting to commit, a criminal act under legislation in the jurisdiction where the act was attempted or committed.

(15) As a result of, in connection with or in any way associated with parachuting, hand gliding, bungee jumping, mountaineering, cave exploring, participation in professional sports or any speed contest by a motorized vehicle. (For the purpose of this exclusion, “motorized vehicle” means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to, an automobile, truck, motorcycle, moped, snowmobile or boat.)

(16) As a result of, in connection with or in any way associated with a flight accident unless the covered person is riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more.

(17) As a result of, in connection with or in any way associated with the radioactive, toxic, explosive or other hazardous properties of nuclear materials or by-products.

(18) As a result of, in connection with or in any way associated with any of the following, regardless of any other cause or event contributing concurrently or in any other sequence thereto: war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, hijacking or any act of terrorism or any action taken in controlling, preventing or suppressing any of the foregoing. (For the purpose of this exclusion, “act of terrorism” means an act, including by not limited to, the use of force or violence and/or the threat thereof, by any person or groups of persons, whether acting alone or on behalf of or in connection with any organization or government, committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear that has been determined by the appropriate federal authority to have been an act of terrorism.)

(19) As a result, in connection with or in any way associated with service in the armed forces.

(20) For services or supplies to the extent to which they are available under any government plan, or would be available without charge is this coverage was not in effect.

The Insurer will not provide emergency assistance services which relate in any way to expenses which are excluded above.

G. TERMINATION OF COVERAGE

An employee's coverage will terminate on the earliest of:

(1) the last day of the month for which the current premiums have been remitted for the employee;
(2) the day on which the employee ceases to the actively at work, except with respect to a retired employee;
(3) the day on which the employee ceases to be listed as a member of an eligible class;
(4) the day on which the employee attains any termination age specified in the Summary of Coverages; and
(5) the date this plan terminates.

A dependent's coverage will terminate on the earliest of the following dates:

(1) the date the employee's coverage terminates for any reason;
(2) the last day of the month in which the person ceases to be a qualified dependent;
(3) the date dependent coverage under this plan terminates; and
(4) the date this plan terminates.

H. EXTENSION OF COVERAGE ON YOUR DEATH (SURVIVOR BENEFITS)

If your dependents are covered for this coverage on the date of your death, their coverage will continue until the earliest of:

(1) 6 months from the date of your death;
(2) the end of the month in which your spouse remarries;
(3) the date the dependent is no longer a qualified dependent;
(4) the date that similar coverage is obtained elsewhere;
(5) the date the coverage is cancelled; and
(6) the date the plan is cancelled.

IN AN EMERGENCY HERE IS WHAT TO DO

In the event of a medical emergency, the Insured Person or someone acting on his or her behalf must call Travel Assist immediately. Its operators are backed by a team of emergency care professionals – Physicians and nurses who work closely with the doctor looking after the patient and, if necessary, his or her family or company doctor, to help ensure that the Insured Person receives the medical care needed.

Telephone Travel Assist at the numbers listed below.

In Canada: 1 877 204 2017
Outside Canada: 0 715 295 9967 collect

An operator will ask the following:

- The Insured Employee's name and the patient's name, location and the details of the emergency
- The group name of the policy: **THE CORPORATION OF THE CITY OF CAMBRIDGE**
- The Policy Number: **CMG 9133604**