

WCS Waste Control Services Inc.

Policy #810364

GROUP BENEFITS PLAN BOOKLET



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Through **EQUITABLE LIFE OF CANADA**, your Employer is providing you with the Group Benefits Plan outlined in this booklet.

We know how important financial security is to you and your family. With this in mind your Group Benefits Plan is designed to help meet some of your financial needs in the event of sickness or death.

We encourage you to read and understand the benefits that your Employer is providing for you. If you have any questions, please contact the person in your company who administers your Group Benefits Plan.

Where provincial legislation permits, you may obtain copies of the application, evidence of insurability, policy and booklets.

We welcome you as a member of this Equitable Life Group Benefits Plan.

Group Department

How to contact Equitable Life:

For services in English or French, call toll-free: 1-800-265-4556

IMPORTANT

This booklet is meant to provide information about your Group Insurance Plan. It is not a legal contract. The Master Policy itself determines the benefits, amounts and effective dates that apply to you.

PROTECTING YOUR PRIVACY

At Equitable Life of Canada, we are committed to protecting the confidentiality and security of your personal information. We follow the privacy principles established by the *Canadian Standards Association Model Code for the Protection of Personal Information*.

To protect and safeguard your personal information, we have set up files in which we maintain your personal information that is needed to administer, service, underwrite, adjudicate and process all aspects of the Group Policy, including the payment of claims.

Your personal information may be accessed by, or exchanged with, authorized employees of Equitable Life and of relevant third parties. These third parties include service providers retained by us, reinsurers, other insurance companies, investigative organizations, health care providers (such as pharmacies, physicians and dentists) and any other person or party whom you authorize.

You have the right to access your personal information held in our files, subject to any legal or business restrictions. If applicable, you can have your personal information corrected.

For more information regarding our privacy policies, please refer to "*Our Commitment to Protecting Your Privacy*" which you can find on our website at www.equitable.ca under "Privacy".

You may contact us with any questions, concerns or suggestions with respect to our management of your personal information at the address below:

Chief Privacy Officer
One Westmount Road North
P. O. Box 1603, Station Waterloo
Waterloo, On
N2J 4C7

Telephone 1-800-265-4556
Facsimile (519) 883-7425
Email: privacyofficer@equitable.ca

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Equitable Life Group Benefits

Department Contact List

<p>● Group Benefits Administration <i>General Policy Inquiries, Personal Information Changes & Web Support</i></p> <p>Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST</p>	<p>Email: groupbenefitsadmin@equitable.ca Phone: 1 (800) 265-4556 x 283 Toll Free Fax: 1 (888) 878-7747</p>
<p>● Dental Claims <i>Dental Claim Inquiries</i></p> <p>Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST</p>	<p>Email: group-dental-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373</p>
<p>● Health Claims <i>Health Claim Inquiries</i></p> <p>Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST</p>	<p>Email: group-health-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373</p>
<p>● Group Disability Claims <i>Short Term (STD) and Long Term Disability (LTD) Claim Inquiries</i></p> <p>Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST</p>	<p>Email: group-disability-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373</p>
<p>● Group Life Claims <i>Life and AD&D Claim Inquiries</i></p> <p>Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST</p>	<p>Email: group-life-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373</p>
<p>● Travel Assist 24 Hour Helpline <i>(Allianz Global Assistance I.D. #9089)</i></p>	<p>Within Canada & U.S.A: 1-800-321-9998 Elsewhere Call Collect: 519-742-3287</p>
<p>● Equitable Life of Canada Fraud Hotline <i>(Anonymous Call)</i></p>	<p>Phone: 1 (800) 265-8899</p>

EquitableHealth.ca

Health and wellness solutions that matter™

A standard feature of all Equitable Life Group Benefit plans is the easy to access, reliable Canadian health and wellness resources available through EquitableHealth.ca®. This website connects you with Canadian health and wellness resources through the Equitable HealthConnector® platform and LifeWorks® Online.

HealthConnector – Supporting your Health:

Whether you need help knowing what questions to ask your doctor, are dealing with a family or personal medical issue, or are looking for available health resources where you live, the Equitable HealthConnector is there to support you. Go online or phone your personal HealthConnector Information Specialist at 1-888-344-5658 and connect with the support and information you need to navigate the Canadian healthcare system and make more informed health decisions.

The first time you visit EquitableHealth.ca, take a moment to click on *My Services* to see all the health and wellness resources available to you through HealthConnector – it will be time well spent.

LifeWorks Online – Balance and Understanding:

An important part of being truly healthy is recognizing and understanding the non-medical factors that can impact your daily life. LifeWorks allows you to browse articles and other resources that can help you better cope with everyday issues ranging from work-life balance and parenting concerns, financial and legal issues to dealing with aging loved ones. You can also download relevant printed and recorded information and tools directly to your computer that can help you lead a balanced, productive life.

Innovations Plan Member Web Services through EquitableHealth.ca

Innovations is the fast, convenient online way to access information about your Group Benefits whenever you need to. Innovations will help you understand and manage your Group Benefits more effectively and saves valuable time and effort by allowing you to:

- Get real time coverage information, claim status and claims history;
- Access claims and administration forms;
- View and confirm the details of your coverage, including information on your eligible dependents;
- Update personal information, including your address and banking information; and
- Sign up for Electronic Explanation of Benefits (E-EOB) and Direct Deposit payment E-Solutions that will allow you to get your claim payments faster.

Get your claim payments faster with Electronic EOB and Direct Deposit payment E-Solutions through EquitableHealth.ca

These E-Solutions reduce the amount of paper we produce when paying claims and give you access to your benefit information in a secure, online environment.

Electronic EOB will send an automatically generated email notification telling you that your most recent Health or Dental claim has been processed and that you can go to EquitableHealth.ca to view the details of your claim.

Direct Deposit Payment allows you to add or update personal banking information which enables us to deposit the claim payment directly to your bank account, meaning you get your money faster.

Links and instructions for these E-Solutions are available at the top of your Innovations Plan Member Web Services Welcome Page.

If you require any assistance in signing up for or accessing EquitableHealth.ca, please contact Group Administration at: 1-800-265-4556 ext. 283 or by email at groupbenefitsadmin@equitable.ca.

SCHEDULE OF BENEFITS

The Plan described in this booklet is effective as of January 1, 2015.

In this booklet “the Company”, “we” and “us” means The Equitable Life Insurance Company of Canada.

IMPORTANT NOTE

The information on the Schedule of Benefits pages and the Summary of Health Benefit Maximums pages in this booklet is only a brief summary of your Group Plan. They outline the benefits, schedules, deductibles, reimbursement percentages and most of the maximums that apply to your Plan.

See the descriptive pages following the Summary for more information you need to know, such as eligible expenses, exclusions, specific requirements (such as written prescriptions/referrals from your Physician), definitions of Practitioners (qualifications they must have), and other maximums that may apply.

CLASSIFICATION(S)

All Eligible Employees

GENERAL INFORMATION

Maximum Age for Dependent Children

Maximum age for dependent children who are not in school full-time: under age 21

Maximum age for dependent children who are in full-time attendance at school: under age 25

(See the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents, including the requirements for continuing coverage for disabled children.)

Co-Habitation Requirement for Partners *(see the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents):*

6 consecutive months

Maximum Age for Coverage *(also refer to 6. “When Does Your Insurance Terminate” in the General Provisions):*

Long Term Disability terminates on your 65th birthday, less the elimination period.

All other benefits terminate on your 70th birthday.

Minimum Number of Hours Per Week employees must work to be eligible for coverage:

20 hours per week.

Waiting Period: *(see the General Provisions page in this booklet for more important information)*

3 months

SCHEDULE OF BENEFITS

DEFINITION OF "EARNINGS"

If any benefits are based on earnings, "earnings" are defined as follows:

"Gross earnings" means your actual income from employment with this Employer. **It does not include:**

- * bonuses
 - * expense allowances (including car allowance)
 - * profit-sharing plans
 - * dividends
 - * gratuities (tips)
 - * overtime pay
- or any other income that varies in amount or that you don't get on a regular basis.

If you receive commissions and they are to be included in the definition of "earnings", your earnings **will include your commissions** from the previous calendar year (from January to December), **based on a 1-year average**. If you didn't work for this Employer for a full calendar year, the amount of commissions you did earn will be prorated to reflect a full calendar year amount.

The amount of earnings used to calculate the benefit amounts you're entitled to will be the lesser of:

- (1) the earnings your Employer has reported at the time of a claim, or
- (2) the earnings reported by your Employer and for which premiums have been paid.

"Net Earnings" means your gross earnings less tax, pension plan deductions, CPP/QPP, Quebec Parental Insurance Plan (QPIP), and EI premiums.

EMPLOYEE LIFE INSURANCE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

A flat amount of \$25,000

No-Evidence Limit:

Evidence of insurability is not required.

Reduction:

On your 65th birthday, the amount of your insurance will be reduced by 50%.

DEPENDENT LIFE INSURANCE

Eligible spouse:	\$10,000
Eligible dependent children from birth:	\$ 5,000

SCHEDULE OF BENEFITS

EMPLOYEE LONG TERM DISABILITY (L.T.D.) INSURANCE

66.67% of your monthly earnings to the next higher \$1.00 (if not already a multiple of \$1.00) to a maximum benefit of \$5,000 per month.

All Source Maximum: (See 3. *Coordination of Benefits in the Long Term Disability (L.T.D.) section in this booklet.*) In no case will the benefit amount be higher than 85% of your net earnings if your plan is non-taxable or 85% of your gross earnings if your plan is taxable. (See *Tax Status below.*)

No-Evidence Limit:

Satisfactory evidence of insurability must be approved by the Company for amounts over \$3,500.

Elimination Period: (See *Elimination Period in 1. Description of this Benefit in the L.T.D. section.*)

119 consecutive days of disability

Benefit Commencement:

120th consecutive day of disability

Maximum Benefit Period:

to your 65th birthday

C.P.P./Q.P.P. Offsets (see 3. *Coordination of Benefits in the L.T.D. section of this booklet for an explanation of offsets*):

Primary

Definition of "Totally Disabled":

During the first 24 months of benefit payments, you must be unable to perform the essential duties of your own occupation as a result of injury or illness and you must not be working at any job. Availability of your own occupation is not relevant when assessing disability from your own occupation.

After that, you must be unable to perform the essential duties of any occupation that you're qualified to do or that you might reasonably become qualified for through education, training or experience with earnings equivalent to the benefit amount provided under this plan. Availability of occupations is not relevant when assessing total disability from any occupation.

Note: If you lose your license or fail to pass a periodic examination required by the Ministry of Transport or any other licensing body, this is not proof that you're totally disabled.

Maximums under 5. Retraining and Re-Employment Benefits (Rehabilitation):

Family Care Expense Credit per eligible child: \$200 per month

Education Expense Credit per eligible dependent child: \$200 per month

The maximum for the Family Care Expense Credit and Education Expense Credit combined cannot exceed \$1,000 per month.

Number of months for which the Family Care Expense Credit and Education Expense Credit are eligible: 3 months

Partial Disability:

Maximum Benefit Period for Partial Disability: up to a maximum of 24 months beyond the Benefit Commencement Date, but not beyond the "own occupation" period in the definition of "totally disabled" above.

Tax Status:

Benefit payments are taxable if your Employer pays any portion of the L.T.D. premium. According to information provided by your Employer and our current records, your L.T.D. benefit payments are **non-taxable** income to you and we will not provide you with a T4A. Any dispute regarding the taxation of your benefits shall be governed by applicable legislation and decisions of tax authorities. Please contact your Group Plan Administrator or your tax advisor if you have any questions or concerns.

SCHEDULE OF BENEFITS

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Deductible Amount per prescription for the Drug Plan:

Nil

Deductible Amount per calendar year for all other benefits:

Nil

Reimbursement Percentage (up to reasonable and customary charges):

Drug Plan:	80%
Major Services:	100%
Travel Assist:	100%
Hospital Services:	100%
Vision Care Services:	100%

Benefits:

Pay-Direct Drug Plan #88GA

Claim Payment Type: Electronic submission at the pharmacy

Note: This is a Mandatory Generic Plan. The maximum that will be reimbursed is an amount equal to the lowest priced alternative drug in accordance with Equitable Life of Canada's adjudication practices at the time of claim.

An alternative drug includes but is not limited to:

- i) an alternative drug (typically a generic) to the brand name drug deemed to be interchangeable by law where the drug is dispensed; or
- ii) a subsequent entry biologic.

Maximum supply eligible: a 34-day supply, except a 100-day supply for maintenance or long-term therapy drugs.

Major Services

Major Services includes Travel Assist.

Semi-Private Hospital

Vision Care (see the Vision Care Section in this booklet for more details):

Eye Glasses or Contact Lenses or Laser Eye Surgery. Maximum \$200

This maximum applies in any period of 24 months for both adults and dependent children.

Special Contact Lenses (#3 on the Vision Care page): Maximum: \$300

This is a lifetime maximum per insured person.

Eye Examinations are included. Maximum: \$100

One eye examination is eligible in any period of 24 months for both adults and dependent children.

Lifetime Maximum Amount per insured person (see 7. What Are The Overall Maximum Amounts?" in the Health General Provisions):

Unlimited, except there is a \$5,000,000 lifetime maximum for services received outside the employee's province of residence.

SUMMARY OF HEALTH BENEFIT MAXIMUMS

THE FOLLOWING MAXIMUMS APPLY TO THE DRUG PLAN:

Note: Drug claims for you and/or your dependents who are insured under this Drug Plan will be administered in accordance with the applicable provincial legislation.

Maximum for Fertility Drugs:
not eligible

Maximum for Smoking Cessation Products (such products must have a DIN and the insured person must have a written prescription from a physician):
\$500 lifetime maximum per insured person

Maximum for "lifestyle" drugs (such as drugs to treat erectile dysfunction, anorexiant/diet pills/injections):
not eligible

Maximum for Vaccines and Immunizations:
not eligible

THE FOLLOWING MAXIMUMS APPLY TO ITEMS COVERED UNDER MAJOR SERVICES:

Note: Eligible expenses will be limited to reasonable and customary charges up to the maximums.

The numbers at the left refer to the item numbers on the Major Services pages in this booklet. **Please see the Major Services descriptive section in this booklet for more details about these benefits.**

- #1 **Maximum Payable for Convalescent Home Services:**
\$20 per day for a maximum of 180 days per disability per insured person
- #3 **Maximum Amount Payable for Private Duty Nursing Care Services (PDN):**
\$10,000 less the amount paid in the preceding 2 calendar years per insured person
- #4(a) **Maximum Period for Rental of Equipment:**
6 months
- #4(c) **Maximum for Breast Prosthesis and Surgical Brassiere(s):**
one breast prosthesis per affected breast in any 12 month period
two surgical brassieres per calendar year
- #4(e) **Maximum for Hearing Aids:**
\$700 per insured person in any period of 60 consecutive months
Hearing aid batteries are not eligible.
- #4(f) **Maximum Amount for Orthopaedic Shoes and Other Orthotics:**
(Note: To be eligible, orthopaedic shoes and other orthotics must be specially constructed for the patient and prescribed by a physician, chiropractor, podiatrist or chiropodist.)
\$300 per insured person per calendar year for orthopaedic shoes and all other orthotics combined
- #4(h) **Maximum for Wigs and Hairpieces (after chemotherapy or radiation therapy):**
\$200 lifetime maximum per insured person
- #4(i) **Maximum for Glucometers:**
1 glucometer every 4 years per insured person

SUMMARY OF HEALTH BENEFIT MAXIMUMS

MAXIMUMS THAT APPLY TO ITEMS COVERED UNDER MAJOR SERVICES (Continued):

Note: Eligible expenses will be limited to reasonable and customary charges up to the maximums.

#6 Maximums per insured person per calendar year for Paramedical Services:

Athletic Therapist	\$500
Audiologist	\$500
Chiropractor (including x-rays)	\$500
Dietician	\$500
Registered Massage Therapist	\$500
Naturopath (including x-rays but not tests or supplements)	\$500
Osteopath (including x-rays)	\$500
Physiotherapist	\$500
Podiatrist/Chiropodist (including x-rays)	\$500
Psychologist (including MSW / Clinical Counsellors)	\$500
Specialist in Acupuncture	\$500
Speech Therapist	\$500

A physician's prescription (referral), which includes the reason for the treatment, is required for the following Paramedical Practitioners (if shown as eligible above) and should be submitted with your first claim. Please note that you will need to submit a new prescription (referral) every 12 months.

- Athletic Therapist
- Dietician
- Registered Massage Therapist
- Physiotherapist
- Psychologist (including Master of Social Work-MSW / Clinical Counsellors)
- Specialist in Acupuncture
- Speech Therapist

#7 Services Outside the Province:

Time Limit for Commencement of Emergency Treatment (*see #7 (b) under Major Services*):
90 days

Pre-Existing Medical Condition Time Period for Emergency Treatment Outside the Province (*see the definition of "Emergency Treatment" in #7. Services Outside the Province under Major Services*):

For actively-working employees under age 70 and their dependents:

the 3-month period prior to the insured person's date of departure from the province of residence

Other expenses eligible under Major Services, if prescribed by a physician:

Extremity Pumps for Lymphedema:	\$1,500 lifetime maximum per insured person
Laryngeal Speaking Aids:	\$1,000 lifetime maximum per insured person
Surgical Stockings / Support Hose combined:	4 pair per insured person per calendar year
TENS Machine:	\$700 lifetime maximum per insured person

SCHEDULE OF BENEFITS

EMPLOYEE AND DEPENDENT DENTAL BENEFITS

Deductible Amount per calendar year:

Nil

Type A - Basic Services:

Recall Examination Period:

once in any period of 5 months (Note: This is 5 months from the last paid checkup)

This Dental Plan includes the following Basic Services Options:

Space Maintainers

Major Surgical Services

Periodontal Services

Maximum units for periodontal scaling and root planing combined: 8 units per calendar year.

Endodontic Services

Denture Repair Services

Type B - Major Restorative Services:

This Dental Plan includes the following Major Restorative Options:

Dentures

Services Other than Dentures

Reimbursement Percentage:

Type A: 80%

Type B: 50%

Maximum Amount:

Annual calendar year maximum for Type A and Type B combined: \$2,000

Dental Fee Guide:

For employees who do not reside in the province of Alberta:

The current Dental Association Fee Guide for the province or territory of residence of the employee.

For employees who reside in the province of Alberta:

The 1997 Alberta Dental Association Fee Guide plus the inflationary adjustment as determined by the Company for the current year.

SURVIVOR BENEFIT

For the following benefits only: Health and Dental

Maximum Period for Survivor Benefit: 24 months

NOTE

The following pages are standard descriptive pages. Some sections will tell you to look on the Schedule of Benefits or Summary of Health Benefit Maximums pages for the details that apply to your own Group Plan. It is very important that you read these descriptive pages as they provide information you need to know.

GENERAL PROVISIONS

1. WHO IS ELIGIBLE TO JOIN THE GROUP PLAN?

You're eligible if you:

- * live and work in Canada as a permanent employee for this Employer, and
- * have provincial health care coverage in your province of residence, and
- * actively and regularly work "full-time" for this Employer ("full-time" means working the **Minimum Number of Hours Per Week** shown in the Schedule of Benefits), and
- * belong in one of the Classifications shown in the Schedule of Benefits.

2. WHEN AM I ELIGIBLE TO JOIN THE GROUP PLAN - IS THERE A WAITING PERIOD?

You are eligible to apply for coverage under this Group Plan after you have served the **Waiting Period** shown in the Schedule of Benefits.

3. HOW DO YOU JOIN?

- * Complete the required application form.
- * We must receive your application form **before** (but **not later than 31 days** after) you become eligible to join the Group Plan.

Important: If we don't receive your Form within the 31 days, you'll be a "**late applicant**". You must then provide **satisfactory evidence of insurability**. Your benefits will become effective on the date the evidence is approved by the Company. Some or all of your benefits could be declined or restricted.

4. WHEN DOES YOUR INSURANCE COVERAGE BECOME EFFECTIVE?

You'll be given a **wallet card** showing the Effective Date of your entry into the Group Plan.

If you're not actively at work on the date your benefits should take effect, your coverage will become effective on the date you return to active work. You must also be actively at work for any future increases in your coverage to be effective.

You must be insured under this Group Plan to be eligible for any benefits.

5. WHAT CAN I DO WHEN I DISAGREE WITH A CLAIM DECISION?

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation.

GENERAL PROVISIONS

6. WHEN DOES YOUR INSURANCE TERMINATE?

Your insurance terminates on the earlier of the following dates:

- * on the date of your retirement, unless this Group Plan provides any benefits for retirees.
- * on the date you are no longer employed by the Employer
- * on the date your Employer terminates your coverage
- * on the date this Group Policy terminates
- * on the date you no longer qualify for coverage
- * on the date you reach the **Maximum Age for Coverage** shown in the Schedule of Benefits
- * on the date it is proven to the satisfaction of the Company that you have engaged in fraudulent activity with respect to claims under this Policy.

7. EVIDENCE OF INSURABILITY

The Schedule of Benefits tells you if evidence of insurability is required for any amounts of insurance coverage. If the amount available without evidence (the **No-Evidence Limit**) changes under this Group Plan, the amount of coverage you're eligible for will be determined by the Company according to the terms of the Master Policy.

GENERAL PROVISIONS FOR DEPENDENTS

1. WHO ARE ELIGIBLE DEPENDENTS?

Eligible dependents must not be permanent residents outside Canada and include:

Your **spouse**. This means:

- * your legally married husband or wife, or
- * your partner (a person of the same or opposite sex who resides with you in a conjugal relationship and who you publicly represent as your partner)

You can only cover one spouse at a time. You must notify us in writing if you want to change your spouse.

Your **child**. This means:

- * your **natural child, adopted child, stepchild, child you have been granted final guardianship or custody of by an order of the Court, or child of your spouse.**

To be eligible, the child must not have a spouse or partner, be supported by you, and not be working on a full-time basis. Look in the Schedule of Benefits to see the **Maximum Age for Dependent Children**.

Note: If dependent children must be in school full-time to be eligible for coverage, proof of this will be required.

Your **permanently developmentally or physically disabled child**. This means:

- * Your developmentally or physically disabled natural child, adopted child, stepchild or child of your spouse.

To be eligible, the child must not have a spouse or partner and we must have a Doctor's certificate stating he/she is incapable of self-sustaining employment and chiefly dependent upon you for support. This child must have been insured under this Group Policy before reaching the Maximum Age for Dependent Children in the Schedule of Benefits.

2. HOW TO APPLY TO COVER YOUR DEPENDENTS

If you have any eligible dependents when you complete the required application form:

- * Fill in the "Number of your Dependent Children" box.
- * Fill in the name of your spouse.
- * Check off the box marked "Family" in the Health and/or Dental sections if the Group Plan includes these benefits and you wish to cover your eligible dependents.

If you don't have any eligible dependents when you join the Group Plan, tell your Group Plan Administrator as soon as you do acquire a dependent (when you get married, start living with your partner, or have a child). Complete the required forms so your spouse or child can be included. We must be notified **within 31 days** of the date you acquire a dependent or the dependent will be a "**late applicant**". He/she must then provide **satisfactory evidence of insurability**. Benefits for your dependents will become effective **only** if the evidence is approved by the Company. Some or all of your dependent's benefits could be declined or restricted.

If you want to cover your partner, look under **Co-Habitation Requirement for Partners** in the Schedule of Benefits to see if there's any minimum period that you and your partner must live together before your partner and his/her children become eligible for coverage.

To continue coverage for a developmentally or physically disabled child, you must apply to the Company **in the 31-day period before the child's 21st birthday**.

If your spouse and/or dependent child(ren) are eligible for benefits elsewhere (such as with your spouse's Employer's group plan), it can still be to your advantage for you and your eligible dependents to be covered under both plans. Please discuss this with your Group Plan Administrator.

GENERAL PROVISIONS FOR DEPENDENTS

3. WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?

If you applied for dependent coverage when you joined the Group Plan, coverage for your dependents is effective on the date your own coverage is effective. If you apply for dependent coverage after you joined, coverage for your dependent will be effective on the date you applied, provided your own coverage is in force and you notify us within 31 days of acquiring the dependent.

Important: If a dependent, other than a newborn child, is **hospitalized** on the date coverage would have been effective, coverage will become effective after final discharge from the hospital. If a dependent is a "**late applicant**", satisfactory evidence of insurability is required and his/her coverage will only become effective on the date the evidence of insurability is approved by the Company.

4. WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?

- * on the **date your own coverage terminates**
- * on the **date the dependent no longer qualifies** as an eligible dependent as described in #1 above.
- * on the date it is proven to the satisfaction of the Company that the dependent has engaged in fraudulent activity with respect to claims under this Policy.

EMPLOYEE GROUP LIFE INSURANCE

1. DESCRIPTION OF THIS BENEFIT

If you die from any cause while insured under this Plan, the amount of Group Life Insurance you're eligible for will be paid to the beneficiary you named. If you do not name an eligible beneficiary, proceeds will be paid in accordance with applicable provincial legislation.

Group Life Insurance cannot be assigned (it can't be used as collateral for a loan).

2. HOW TO NAME YOUR BENEFICIARY

When you joined the Group Plan, you named a beneficiary on Form #191 - Employee Group Insurance Application. You can change your beneficiary anytime. Complete the appropriate section on **Form #438 - Employee Change Form** and have your Group Plan Administrator forward it to us.

Important: If any beneficiary is a minor (is under age 18), be sure to **fill in the name of a Trustee**. If you don't, it could cause a delay in payment of the proceeds and affect who the proceeds are paid to.

3. HOW WILL YOUR LIFE INSURANCE PROCEEDS BE PAID?

Your Group Plan Administrator should notify Equitable Life when there is a claim. We'll supply the required forms to be completed and returned to us. Proceeds will be paid to your beneficiary in one lump sum (unless he/she chooses another payment option).

4. EXTENDED LIFE INSURANCE (LIFE WAIVER)

Definition of "Totally Disabled" for the Extended Life Insurance (Life Waiver):

- * If you are insured for Employee Long Term Disability (L.T.D.) Insurance under this Group Plan with Equitable Life, the definition of "totally disabled" for the Life Waiver is the same as the definition of "totally disabled" that applies to the L.T.D. benefit (see the L.T.D. section in the Schedule of Benefits).
- * If your Group Plan does not provide an L.T.D. benefit with Equitable Life, but it does provide an Employee Long Term Disability (L.T.D.) benefit through another insurance carrier, the definition of "totally disabled" in respect of the Life Waiver will be the same as the definition of "totally disabled" that applies to the L.T.D. benefit. If you lose your license or fail to pass a periodic examination required by the Ministry of Transport or any other licensing body, this is not proof that you're totally disabled.
- * If your Group Plan does not provide an Employee Long Term Disability (L.T.D.) benefit, the definition of "totally disabled" in respect of the Life Waiver is that you must be unable to work at any job, not just your own job. If you lose your license or fail to pass a periodic examination required by the Ministry of Transport or any other licensing body, this is not proof that you're totally disabled.

If you become **totally disabled before your 65th birthday**, you can apply for **Extended Life Insurance** (also known as "**Life Waiver**"). If accepted for Life Waiver, your Group Life Insurance will remain in effect and the Life premium doesn't have to be paid. From time to time you'll be asked to send in proof that you're still disabled.

The Life Waiver benefit can continue until your 65th birthday (as long as you remain totally disabled).

How to apply for Life Waiver:

- * If your Equitable Life Group Plan includes Employee Long Term Disability Insurance benefits, you don't need to do anything. We will assess your eligibility for Life Waiver when we assess your disability claim.
- * If your Group Plan does not include disability benefits at all, your Employer should notify us after you've been disabled for 6 months and the appropriate forms will then be sent to you.
- * If you have Long Term Disability benefits through another insurance carrier, as soon as you have been approved for Long Term Disability benefit payments, send satisfactory proof to us and we'll assess your eligibility for Life Waiver under our Group Plan.

If your employment with the Employer terminates while you're still totally disabled, you have up to 1 year to apply for the Life Waiver, provided you have remained totally disabled since the date your employment terminated.

EMPLOYEE GROUP LIFE INSURANCE

5. LIVING BENEFIT

If you become terminally ill, 50% of your Employee Life Insurance to a maximum of \$50,000, could be paid to you under the following conditions:

- * you are under age 63, and
- * you have been approved for the Extended Life Insurance (Life Waiver) benefit described above, and
- * your Employer requests, in writing, that the Company consider your application for the Living Benefit, and
- * the Company has received a Physician's Statement indicating that you have 12 or less months to live, and
- * we have received consent, in writing, on forms provided by the Company, from both you and from all of the primary beneficiaries of your Group Employee Life Insurance that the Living Benefit be paid.

If the Living Benefit is paid, the amount of Employee Life Insurance that will be payable at your death is the amount of Employee Life Insurance for which you are eligible, less the amount paid under the Living Benefit, subject to the provisions of the Policy.

6. THE CONVERSION PRIVILEGE

If **you terminate from the Group Plan**, or if **the Group Policy terminates**, and you are under 70 years of age, you can convert (change) all or part of your Group Life Insurance to an individual Life Insurance policy without having to provide evidence of insurability. If you want to convert your Group Life Insurance, request an application form from Group Accounts Service at the Head Office of Equitable Life. Please note the following conditions that apply to the conversion:

- * You must **apply in writing and pay the first premium within 31 days** of terminating from the Group Plan. If you should die within that time, the Company will pay to your beneficiary the maximum amount of individual Life Insurance that you could have obtained under this Conversion Privilege (even if you hadn't applied for it).
- * The premiums for the individual policy will be based on your age, sex, and whether you've smoked a cigarette in the past 12 months.
- * Not all types of individual plans are available under Conversion and the individual policy wouldn't include Disability, Double Indemnity or other special features.
- * The individual policy may have to be for a minimum dollar amount.
- * The maximum amount of Group Life Insurance that can be converted cannot exceed the full amount of your basic Group Life Insurance less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed \$200,000, or such higher amount if required by applicable provincial legislation.

7. HOW TO SEND IN A CLAIM

Your Group Plan Administrator should notify Equitable Life if there is a claim. We'll supply the required forms to be completed and returned to us.

DEPENDENT LIFE INSURANCE

(Dependent children covered from live birth)

1. **DESCRIPTION OF THIS BENEFIT**

If an eligible dependent should die while you're insured under this Group Plan for the Dependent Life benefit, the amount of Dependent Life Insurance **shown in the Schedule of Benefits** will be paid to you.

2. **WHO ARE YOUR ELIGIBLE DEPENDENTS?**

Eligible dependents are your spouse and dependent children as defined in the General Provisions for Dependents in this booklet. A dependent child is eligible provided the child results from a live birth. Any birth resulting from a gestation of less than 20 weeks, stillbirths, miscarriages, abortions and fetal deaths are specifically excluded.

3. **CAN I SELECT A SPECIFIC BENEFICIARY FOR DEPENDENT LIFE?**

When you joined the Group Plan, the Company automatically designated you (the employee) as the beneficiary for Dependent Life.

THIS POLICY CONTAINS A PROVISION REMOVING OR RESTRICTING THE RIGHT OF THE GROUP LIFE INSURED TO DESIGNATE PERSONS TO WHOM OR FOR WHOSE BENEFIT INSURANCE MONEY IS PAYABLE.

4. **DOES THE CONVERSION PRIVILEGE APPLY TO DEPENDENT LIFE?**

Yes. If your own insurance terminates, your spouse can convert his/her Dependent Life Insurance to an individual insurance policy. The Conversion Privilege doesn't apply to dependent children, unless required by applicable provincial legislation. The conditions outlined in the Conversion Privilege under the Employee Group Life Insurance in this booklet also apply to Dependent Life.

5. **HOW DOES MY SPOUSE APPLY FOR CONVERSION?**

If your spouse wants to convert the Dependent Life Insurance, request an application form from us. He/she must apply and pay the first premium **within 31 days** of the date your coverage terminated.

6. **DOES THE EXTENDED LIFE INSURANCE APPLY TO DEPENDENT LIFE?**

Yes. If you become totally disabled and are accepted for the Extended Life Insurance (Life Waiver) described under the Employee Group Life Insurance in this booklet, the Dependent Life Insurance is also continued without cost.

7. **HOW TO SEND IN A CLAIM**

Your Group Plan Administrator should notify Equitable Life if there is a claim. We'll supply the required forms to be completed and returned to us.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1. DESCRIPTION OF THIS BENEFIT

If you suffer a loss while insured under this Plan, the amount shown in #2 below will be paid to you (to your beneficiary if loss of life). Any **loss must occur within 365 days of the accident** and be a **direct result of bodily injury caused solely by accidental, violent and external means**, independently of all other causes.

2. WHAT LOSSES ARE COVERED AND HOW MUCH WILL BE PAID?

Note: Unless otherwise shown below, the maximum amount payable for any one accident shall not be more than the amount of your AD&D insurance.

The **full amount** of your AD&D Insurance will be paid for **loss of**:

- * life
- * both arms and both legs
- * both arms
- * both legs
- * both hands
- * both feet
- * the sight of both eyes
- * speech and hearing in both ears
- * one arm and one leg on one side of the body
- * one hand and one foot
- * one hand and the sight of one eye
- * one foot and the sight of one eye

75% of the amount of your AD&D Insurance will be paid for **loss of**:

- * one arm
- * one leg
- * one hand
- * one foot
- * the sight of one eye
- * speech
- * hearing in both ears

50% of the amount of your AD&D Insurance will be paid for **loss of**:

- * thumb and index finger
- * four fingers on one hand

25% of the amount of your AD&D Insurance will be paid for **loss of**:

- * all toes of one foot
- * hearing in one ear

Twice the amount of your AD&D Insurance will be paid for **loss of use of**:

- * both arms and both legs (Quadriplegia)
- * both arms (Paraplegia Superior)
- * both legs (Paraplegia)
- * one arm and one leg on one side of the body (Hemiplegia)

75% of the amount of your AD&D Insurance will be paid for **loss of use of**:

- * one arm
- * one leg
- * one hand
- * one foot

The maximum amount payable for any one accident shall not be more than the amount of your AD&D insurance.

If you suffer a Loss, a benefit set out in the above tables may be paid. Where more than one Loss results from an Accident, only one benefit will be payable. The benefit payable will be for the loss that provides the highest benefit.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT

WHAT LOSSES ARE COVERED AND HOW MUCH WILL BE PAID? (Continued)

Damage Due to 3rd Degree Burns

If, while insured under this Policy, you suffer a cosmetic disfigurement (but not loss of life) due to a burn, the amount shown below will be paid to you.

BURN SCHEDULE		
*	Face, Neck and Head	The Amount of Insurance
*	Front or Back Torso	35% of the Amount of Insurance
*	One Hand and Forearm	25% of the Amount of Insurance
*	One Upper Arm (above the elbow)	15% of the Amount of Insurance
*	One Thigh or One Lower Leg (below the knee)	10% of the Amount of Insurance

The amount payable for any one loss will be determined by multiplying the percentage of Body Surface actually burned by the Maximum Amount Payable as shown in the Burn Schedule above. The Attending Physician will determine the actual percentage applicable to each burn. If you sustain burns in more than one area (for any combination of burned body parts) as the result of one accident, the total benefits for all such burns will not exceed the Amount of Insurance.

ADDITIONAL BENEFITS

Seat Belt:

If, while insured under this Policy, you die or are injured while you're a passenger in or the driver of a private passenger type car and your seat belt is properly fastened, benefits payable under this AD&D benefit will be increased by 10%. Verification that you were using your seat belt must be part of the official accident report or certified by the investigating officer.

Repatriation:

If you die while insured under this Policy, we will pay the provider for the reasonable and customary expenses actually incurred to transport your body to the first resting place (including, but not limited to, a funeral home or the place of internment) in proximity to your normal place of residence, including charges for the preparation of your body for such transportation. The maximum payable will not exceed, in the aggregate, \$10,000 for all such expenses, less any amounts payable for similar coverage under the Employer-sponsored benefit program.

Rehabilitation:

If, while insured under this Policy, you suffer an injury (other than loss of life) which results in us making a payment under the Table of Losses and Benefits, we will pay to the provider the reasonable and necessary expenses that you actually incur if you engage in a formal occupational training program within 3 years from the date of the accident in order to become qualified for active employment in an occupation for which you would not otherwise have sufficient qualifications. The maximum payable for all such expenses as the result of any one accident will not exceed, in the aggregate, \$10,000, less any amounts payable for similar coverage under the Employer-sponsored benefit program. Expenses for room, board or other ordinary living, travelling or clothing expenses are not eligible.

Occupational Training for the Employee's Spouse:

If you die while insured under this Policy, we will pay to the training provider the reasonable, necessary and customary expenses actually incurred by your spouse if he/she engages in a formal occupational training program in order to become qualified for active employment, provided your spouse is not already employed (including self-employment). The maximum payable for all such expenses will not exceed, in the aggregate, \$10,000. Expenses must be incurred within 3 years of your death. Expenses for room, board or other living, travelling or clothing expenses are not eligible.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT

Home Alteration and Vehicle Modification:

If, while insured under this Policy, you sustain the loss of, or loss of use of, both feet or both legs, or if you become Quadriplegic, Paraplegic or Hemiplegic and, as a result, a benefit has become payable under this Policy, and you subsequently require the use of a wheelchair to be ambulatory, we will pay to the provider the reasonable, necessary and customary expenses that were actually incurred within the 3 years from the date of the accident which caused such loss. The following is eligible:

- (a) the cost of alterations to your principal residence, and/or
- (b) the cost of modifications to one motor vehicle that is used by you, when such modifications are approved by licensing authorities (where required) in order to make the vehicle wheelchair accessible.

The maximum payable for the total of all such expenses incurred by you, or for you, will not exceed \$10,000 as the result of any one accident, less any amounts payable for similar coverage under any other benefits included in this Policy.

Bereavement Benefit:

In the event of your accidental death, we will arrange for and will pay the reasonable, necessary and customary expenses associated with grief counselling by a professional counsellor for your surviving spouse and eligible dependent children. We will pay up to an overall maximum of \$1,000 per family, less any amounts payable for similar coverage under any other benefits included under this Policy. Payment will be made to the provider. Providers for which there would not normally be a fee associated with their services (such as a Minister or other Clergy) or providers who are related to you or to the survivors are not eligible for reimbursement.

Funeral Expense Benefit:

In the event of your accidental death, we will make reimbursement for the reasonable, necessary and customary expenses associated with your burial or cremation, less any amount payable by another insurance company, subject to a maximum of \$5,000. Payment will be made to the provider except, if the provider has already been paid, payment will be made to the person(s) who paid the provider.

Child Benefit:

In the event of your accidental death, we will pay a lump sum benefit, subject to any applicable law(s), equal to the lesser of

- (i) 5% of the Amount of Insurance, or
- (ii) \$5,000,

to be divided equally between your dependent children.

3. WHAT IS MEANT BY "LOSS OF"?

- * An arm or leg must be severed through or above the elbow or knee joint.
- * A hand or foot must be severed through or above the wrist or ankle joint but below the elbow or knee joint.
- * A thumb or finger must be severed at or above the metacarpophalangeal joint but below the wrist joint.
- * A toe must be severed at or above the metatarsophalangeal joint but below the ankle joint.
- * Sight, speech and hearing must be complete loss.

In all cases, the loss must be complete and irrecoverable and beyond remedy by surgical or other means.

4. WHAT IS MEANT BY "LOSS OF USE"?

This is the total and irrecoverable loss of use of your arm(s), leg(s), hand or foot beyond remedy by surgical or other means. The loss must have continued **for a period of 365 days** and be **permanent** before any benefits are payable.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT

(Alcohol Limitation applies)

5. **BENEFITS PAYABLE AS A RESULT OF DISAPPEARANCE AND EXPOSURE**

If you're insured under this Policy and you disappear as a result of an accident in which the conveyance (such as a boat or plane) that you were riding in sinks or disappears, and if your body is not found within 365 days of the accident, it will be assumed that you suffered loss of life as a result of bodily injury caused by the accident (unless there's evidence to the contrary).

If you couldn't avoid being exposed to the elements as a result of the accident, and you consequently suffer a loss shown in #2, the appropriate amount will be paid.

6. **WHEN ARE AD&D BENEFITS NOT PAYABLE?**

Benefits are **not** payable for any loss that results directly or indirectly, wholly or partially, from any of the following causes:

- (a) suicide or self-inflicted injuries (whether you're sane or insane)
- (b) war (declared or undeclared) or hostilities of any kind, whether you were participating in them or not
- (c) travel or flight in any aircraft (if you have any duties relating to that aircraft or flight) or if you're flying during aviation training or instruction, or if you take part in the training or manoeuvres of any branch of the armed services
- (d) ptomaine or bacterial infections (other than those resulting from an accidental wound)
- (e) if you take any poison or poisonous substances
- (f) if you receive any injuries where there is no visible wound or contusion (bruise) on the exterior of your body (except in the case of drowning or internal injuries that show up in an autopsy)
- (g) committing or attempting to commit an assault or criminal offense
- (h) operating a motor vehicle while your blood alcohol concentration was in excess of the legal limit in the location you were in at the time of the offense.

7. **HOW TO SEND IN A CLAIM**

Your Group Plan Administrator should notify Equitable Life if you have an AD&D claim. We'll supply the required forms to be completed and returned to us.

EMPLOYEE LONG TERM DISABILITY (L.T.D.)

1. DESCRIPTION OF THIS BENEFIT

This benefit replaces a portion of your employment earnings that you lose if you can't work because you become totally disabled (as defined in the Schedule of Benefits) from an injury (accident) or sickness **prior to your 65th birthday** and while you're insured under this Group Plan. While you're receiving L.T.D. benefit payments, the L.T.D. premium doesn't need to be paid.

The Schedule of Benefits tells you:

- * the **Long Term Disability schedule**: How to calculate the amount of L.T.D. available (the amount actually payable is subject to #3 below).
- * the **Elimination Period**: This is the number of consecutive days that you are totally disabled (starting with the first day of disability) during which no benefits are payable. If, during the Elimination Period, you cease to be totally disabled and return to work for up to 30 calendar days for each return to work attempt, the Elimination Period and Benefit Commencement Date shown in the Schedule of Benefits will be extended by the number of days you were not totally disabled and this disability will be treated as continuous. The Elimination period and Benefit Commencement Date cannot be extended by more than 60 calendar days.
- * the **Benefit Commencement Date**: On what day payments begin, if you're disabled because of either injury or sickness.
Note: If you're eligible for Weekly Indemnity benefits from any Group Policy issued to your Employer, payments won't start under this L.T.D. Plan until the Maximum Benefit Period for S.T.D. has been reached.
- * the **Maximum Benefit Period**: The maximum length of time benefits are payable during any one period of disability, whether from one or more than one cause.

Long Term Disability benefits are **paid once a month**. Once your L.T.D. claim has been approved by the Company, payment is made at the end of each month for that particular month. Benefits are calculated on a **30-days-a-month** basis (1/30th of your Long Term Disability benefit will be payable for each day that you're eligible for disability payments).

Benefits are **taxable** if your Employer pays any portion of the L.T.D. premium. We don't automatically deduct the income tax from your benefit cheque (unless you live in Quebec). If L.T.D. is taxable, you'll be given a **T4A** for benefits received in a tax year and you must include the disability earnings when filing your Income Tax Return.

2. GUARANTEED BENEFITS FOR SEVERE DISABILITIES

If you are totally disabled due to a severe disability (as described below), benefit payments will continue, subject to the provisions of this Policy, during the guaranteed period (defined below), provided:

- (a) such total disability occurs while you are insured under this Group Plan and occurs within 180 days of the date you sustained the injury or disease, and
- (b) you have completed the L.T.D. Elimination Period shown in the Schedule of Benefits, and
- (c) satisfactory proof of your total disability is submitted to the Company, and
- (d) the disability and payment of L.T.D. benefits are not excluded by the terms and conditions of the Policy.

"Guaranteed period" means the earlier of:

- (i) 24 consecutive months, or
- (ii) the number of months remaining until the Maximum Benefit Period shown in the Schedule of Benefits is reached, or
- (iii) the date of your death.

The severe disabilities eligible for Guaranteed Benefits are:

- (a) the total and irrecoverable loss of:
 - * sight in both eyes, hearing in both ears, or speech
 - * both hands or both legs
 - * one hand and one leg.

EMPLOYEE LONG TERM DISABILITY (L.T.D.)

2. GUARANTEED BENEFITS FOR SEVERE DISABILITIES (Continued)

"Loss of" means:

- * Sight, hearing and speech must be the complete loss.
- * A leg must be severed through or above the knee joint.
- * A hand must be severed through or above the wrist joint.

In all cases, the loss must be complete and irrecoverable and beyond remedy by surgical or other means.

(b) life-threatening cancer with uncontrolled growth and spread of malignant cells

(c) a severely disabling heart attack or stroke that results in one of the following, which may be expected to continue beyond the end of the guaranteed period or result in death prior to the end of the guaranteed period:

- * a markedly restricted ability in transferring (described below under "Activities of Daily Living"), and the inability to safely and completely perform at least two of the other activities of daily living (ADL) described below without the assistance or verbal cueing of another person, or
- * the loss of cognitive ability due to deterioration or loss in intellectual capacity which requires the need for assistance or verbal cueing of another person for your protection or the protection of others.

"Activities of Daily Living (ADL)" means:

- * bathing: your ability to wash yourself, either in a bathtub or shower or by sponge bath, with or without equipment or adaptive devices, including the task of getting into or out of a bathtub or shower
- * dressng: your ability, with or without the aid of assistive devices, to put on, take off, fasten or unfasten clothing and medically necessary braces or artificial limbs. You are not dependent for dressing if reasonable alterations to or changes in the clothing usually worn would enable you to dress without substantial physical assistance
- * toiletng: your ability to get to and from and on and off the toilet, with or without the aid of assistive devices, and perform associated personal hygiene
- * transferring: your ability to move in and out of a chair or bed, with or without using equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices, including mechanical or motorized devices
- * continence: your ability to either voluntarily control bowel and bladder function or, if incontinent, perform associated personal hygiene, including caring for a catheter or colostomy bag
- * feeding: your ability to get food into your body, with or without the aid of assistive devices, through the mouth, or by a feeding tube. Feeding does not include cooking or preparing meals.

EMPLOYEE LONG TERM DISABILITY (L.T.D.) (Occupational - 24-Hour Coverage)

3. COORDINATION OF BENEFITS

The amount of L.T.D. you're eligible for (according to the L.T.D. schedule and the definition of "earnings" in the Schedule of Benefits) will be reduced by all of the following:

- (a) any benefits you receive or are entitled to receive from Workers' Compensation or similar law will be deducted dollar for dollar if they're payable for the same period of disability
- (b) any benefits you receive or are entitled to receive under the Canada Pension Plan (C.P.P.) or Quebec Pension Plan (Q.P.P.) will be deducted dollar for dollar if they're payable for the same period of disability (except for any cost-of-living increases made by C.P.P./Q.P.P. after your Long Term Disability payments start)

The L.T.D. section in the Schedule of Benefits tells you what C.P.P./Q.P.P. "offsets" (reductions) will apply for this Group Plan.

- * **"full offsets"** means we'll deduct both the disability benefits that you yourself are eligible for ("**primary**" benefits) as well as benefits you're eligible for on behalf of your dependent children under age 18 ("**secondary**" benefits)
- * **"Primary offsets"** means we'll deduct the disability benefits that you yourself are eligible for but not benefits you're eligible for on behalf of your dependent children, but we will take them into consideration under the "all sources" clause in (c) below
- * **"nil offsets"** means we won't deduct either your own or your dependent C.P.P./Q.P.P. disability benefits, but we will take them into consideration under the "all sources" clause in (c) below
- (c) any benefits you receive or are entitled to receive from "**other sources**", including:
 - * benefits received or receivable from the Canada or Quebec Pension Plan for you and any dependents
 - * benefits received from the Quebec Parental Insurance Plan
 - * benefits under the Workers' Compensation Act or similar law
 - * remuneration from any employer, including monies paid as a result of termination or severance from employment
 - * loss of income or disability benefits provided under a group insurance contract
 - * retirement income and pension earnings
 - * loss of income damages from any completed or pending legal action
 - * loss of income or disability benefits provided under any government or regulatory body
 - * automobile income replacement insurance benefits, where permitted by legislation.
 - * loss of income or disability benefits from any other third parties not listed above, excluding loss of income or disability benefits from an individual disability insurance contract, bank loan insurance contract, and mortgage insurance contract.

If you're eligible for any income from (c) above, the L.T.D. benefit payable under this Group Plan will be reduced so that the total amount of benefits that you're eligible for from "all sources" (including this Policy) are not more than the All Source Maximum shown in the Schedule of Benefits.

If you were already getting a disability pension (such as a War Veterans Pension) before you became disabled, we'll only include an increase in that pension when calculating the "all sources" clause.

Be sure you apply for any other disability benefits you may be eligible for.

We may pay the full L.T.D. benefit (without taking off the deductions shown above) for a short period of time, **as long as you agree to refund any overpayment** we make.

4. WHAT HAPPENS IF YOU BECOME DISABLED AGAIN (RECURRENT DISABILITY)?

If you recover and return to active work and then become disabled again, the new disability will be treated as if it is a continuance of the first disability if:

- * you work for **less than 6 months** and become disabled again from the **same or related** causes.

NOTE: Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least 1 day.

EMPLOYEE LONG TERM DISABILITY (L.T.D.)

4. **WHAT HAPPENS IF YOU BECOME DISABLED AGAIN (RECURRENT DISABILITY)?** (Continued)

If you recover and return to active work for this Employer and then become disabled again from the same cause(s) within 90 days after this Group Policy terminates, the new disability will be treated as if it is a continuance of the first disability, as long as you:

- * returned to work for less than 6 months from the date you last received L.T.D. benefits under this Policy, and
- * are not eligible for benefits under any policy issued by another insurance carrier within 31 days after the date this Policy terminated that replaces this Policy and covers the same period of disability.

When the new (recurrent) disability is treated as if it were a continuation of the first (original) disability:

- * you don't have to go through another elimination period
- * the amount of benefit payable is based on the original period of disability
- * the Maximum Benefit Period available will be based on the original period of disability (benefits are payable for what's left of the original Maximum Benefit Period)
- * no L.T.D. benefits are payable under this Policy if Short Term Disability (S.T.D.) benefits are payable for the same period of disability under any other Group Insurance Policy issued to your Employer.

5. **RETRAINING AND RE-EMPLOYMENT BENEFITS (REHABILITATION)**

If you've been receiving L.T.D. disability benefits for some time, the Company may determine that a rehabilitation programme will be the best way to help you return to work. Note that the Company must approve any rehabilitation programme before you begin it.

While participating in the rehabilitation programme, L.T.D. benefits will continue to be paid to the earlier of:

- * the length of time allowed (this will be determined by the Company, but would not be more than 24 months from the date you start the rehabilitation programme), or
- * the date benefits would have stopped if you had remained totally disabled.

The Company may reimburse you for up to the following amounts for rehabilitation expenses, provided the Company determines these expenses are necessary to enable you to return to work and pre-approves them in writing. The expenses must have been paid by you and not be eligible for payment or reimbursement through any other source. Eligible expenses could include, but are not limited to:

- * up to \$5,000 for schooling and retraining
- * up to \$2,000 for occupational assessment, skills analysis and job search
- * up to \$5,000 for special assistive devices and equipment
- * up to \$5,000 for relocation.

The Company may, at its discretion, reimburse additional amounts and expenses, subject to the above conditions.

In order to help you return to work, the Company may reimburse up to \$4,000 to the Employer for the costs incurred to make reasonable accommodations for you. Reasonable accommodations are changes made to your work environment, or to the way you perform your work. Eligible expenses include the cost of tools, equipment, furniture, computer software, or other necessary items. To be eligible, the following conditions apply:

- * you must be participating in a rehabilitation programme approved by the Company, and
- * the Employer's expenses are incurred in making reasonable accommodations for you, and
- * the reasonable accommodations are approved in writing by the Company prior to implementation and before the expenses are incurred.

The Company may, at its discretion, reimburse additional amounts, subject to the above conditions.

If you're unable to continue in the rehabilitation programme because of total disability, further benefit payments will be considered under the recurrent disability clause (see #4 - What Happens If You Become Disabled Again).

While you participate in a rehabilitation programme approved by the Company, the amount of your monthly L.T.D. benefit payments may be reduced so that the income you get from "all sources" isn't more than 100% of your pre-disability earnings (adjusted for inflation).

EMPLOYEE LONG TERM DISABILITY (L.T.D.)

5. RETRAINING AND RE-EMPLOYMENT BENEFITS (REHABILITATION) (Continued)

To help you return to work in the rehabilitation programme, starting with the date you commence the rehabilitation programme, you may be eligible for:

- * a monthly Family Care Expense Credit for each eligible child, and
- * a monthly Education Expense Credit for each eligible dependent child.

These credits will extend the all source limit allowed under the Coordination of Benefits clause.

The maximums for the Family Care Expense Credit and Education Expense Credit are shown in the Schedule of Benefits.

Family Care expenses are those you actually incur to provide care for your child so you can return to work under the rehabilitation programme. The child must be:

- * under age 15, or dependent on you for support and maintenance because of a permanent developmental or physical disability.
- * cared for by a child-care provider who is not ordinarily resident in your home or related to you by birth or marriage (or related to you through your spouse).

To be eligible for the Education Expense Credit, the dependent child must meet the definition of dependent child shown under 1. Who Are My Eligible Dependents in the General Provisions for Dependents page.

Note: If you refuse to participate in any rehabilitation programme, assessment or employment that the Company deems to be appropriate, your L.T.D. benefit payments will stop.

6. WHEN L.T.D. BENEFITS ARE NOT PAYABLE

Benefits are not payable for disabilities in the following situations:

- (a) as a result of:
 - * wilfully self-inflicted injury or any suicide attempt (whether you're sane or insane)
 - * active participation in a riot, rebellion or insurrection
 - * war or hostilities of any kind (whether or not war is declared)
 - * committing or attempting to commit a criminal offence, or
- (b) any period of disability during a time when you're an inmate in a prison or correctional institution, or
- (c) if total disability begins within 12 months of the effective date of your L.T.D. insurance under this Policy, and the disability is a result of a condition for which you either received medical care or took prescribed drugs during the 90-day period before your L.T.D. coverage became effective (unless this Limitation is waived in the Master Policy), or
- (d) if you become disabled during a strike, lockout, layoff or leave of absence (including parental leaves of absence), no benefits are payable for the duration of the strike, lockout, layoff or leave of absence, however:
 - if you're still totally disabled on your scheduled date of return to active, full-time work, you'll become eligible for disability benefit payments:
 - (i) on your scheduled date of return to work, provided the waiting period before payments begin (see * below) has expired and if your L.T.D. benefit has remained in force, or
 - (ii) on the Benefit Commencement date shown in the Schedule of Benefits, if later.
 - (* this "waiting period" is the number of consecutive days you must be totally disabled before the Benefit Commencement date)
- (e) as a result of alcohol or drug abuse (unless you're getting regular and personal medical supervision, treatment and counselling from a licensed medical doctor, rehabilitation centre or provincially designated institution that's approved by the Company), or
- (f) if you're not receiving regular and personal medical supervision and treatment that's satisfactory to the Company, by a physician or surgeon who is duly licensed to practice medicine and who is qualified to treat such disability.

EMPLOYEE LONG TERM DISABILITY (L.T.D.)

7. WHAT HAPPENS IF YOU BECOME PREGNANT?

If you have requested a maternity leave from your Employer, your leave will begin on the earlier of the date you and your employer have agreed the leave will begin, and the date your child is born. Your leave will end on the earlier of your scheduled return to work date and the actual date you return to work.

The Company will determine which period of your maternity leave is health-related and which is non-health-related. The health-related period is the time that you are unable to work for health reasons relating to childbirth or recovery from childbirth. This period must be supported with appropriate medical documentation. Benefits will only be payable during the health-related period when required to comply with employment standards, human rights, employment insurance, or any other applicable legislation.

8. WHEN DO L.T.D. BENEFITS TERMINATE?

- (a) on the date you're no longer "totally disabled" (according to #2 in this L.T.D. section and the definition of "totally disabled" shown in the Schedule of Benefits), or
- (b) on the date the Maximum Benefit Period is reached, or
- (c) on your 65th birthday, or
- (d) the date you retire or would normally have retired under the Employer's employment practices, or the date you told your Employer that you intended to retire, or
- (e) on the date you start any employment for pay or profit or any volunteer work (other than rehabilitative employment approved by the Company), or
- (f) on the date you refuse to participate in any rehabilitation assessment, programme or employment considered appropriate by the Company, or
- (g) on the date you fail to provide satisfactory evidence that you're still "totally disabled", or
- (h) on the date you stop receiving regular and/or appropriate medical treatment (that is satisfactory to the Company) by a physician or surgeon, or
- (i) on the date of your death.

If this Group Policy terminates, you'll still be entitled to (or can apply for) disability benefits if you're totally disabled on the date the Policy terminates and:

- * you're receiving L.T.D. benefit payments, or
- * you notify the Company of a pending L.T.D. claim within 30 days of the date of termination of this Policy.

9. HOW TO SEND IN A CLAIM

Access Form 181 "**HOW DO I SUBMIT AN APPLICATION FOR LONG TERM DISABILITY BENEFITS?**", which is available on the Equitable Life public website www.equitable.ca. Follow the step-by-step instructions. If you don't have access to the website, contact us (see the telephone and extension number on the first page of this booklet).

The claim must be submitted within 90 days of the date you become disabled.

IMPORTANT: If your insurance terminates, or if the L.T.D. Benefit under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination.

Once we start paying benefits, **Form 422 - Supplementary Report on Claim for Disability Benefits** (to be completed by you and the doctor) or **Form #563** (to be completed by the doctor only) may be included with your cheque from time to time.

Benefit payments will stop and won't start again until the fully-completed form 422 (or Form 563) is returned to us, so please be sure it's sent back quickly.

EMPLOYEE LONG TERM DISABILITY (L.T.D.) PARTIAL DISABILITY

10. PARTIAL DISABILITY

If you're receiving L.T.D. benefit payments, and you return to work in a reduced capacity, the following provisions apply:

- (a) Your monthly L.T.D. benefits will continue to be paid while your earnings are 80% or less of the amount you earned before you became totally disabled. However, benefit payments will end on the earlier of:
 - (i) the date they would have stopped if you had remained totally disabled, or
 - (ii) when the Maximum Benefit Period for Partial Disability shown on the Schedule of Benefits has been reached.
- (b) Your monthly income from all sources can't be more than:
 - * 90% of your **gross** earnings before you became totally disabled if the L.T.D. benefits are **taxable**, or
 - * 90% of your **net** earnings before you became totally disabled if the L.T.D. benefits are **not taxable**.
- (c) The "earnings" used in b) will be adjusted for inflation.
- (d) The Partial Disability benefit payable will not be more than the amount you were eligible for according to the L.T.D. schedule.
- (e) L.T.D. premiums must be paid (they are not waived) while you're getting Partial Disability benefits.
- (f) Each month, you must provide proof satisfactory to the Company of the amount of your income from employment.

EMPLOYEE LONG TERM DISABILITY SURVIVOR BENEFIT

11. LONG TERM DISABILITY SURVIVOR BENEFIT

If you die while you're receiving L.T.D. benefit payments and the Company receives satisfactory written proof of your death, the Company will pay a Long Term Disability Survivor Benefit.

The amount of your Long Term Disability Survivor Benefit is shown on the Schedule of Benefits. It is payable to the beneficiary of your Employee Life Insurance, if that beneficiary meets the definition of "dependent" (see 1. Who are Eligible Dependents? under the General Provisions for Dependents in this booklet). If that beneficiary is not an eligible dependent, payment will be made to your estate.

If you're receiving L.T.D. benefit payments and are diagnosed as terminally ill, you may apply to receive the Long Term Disability Survivor Benefit prior to your death. The following applies:

- (a) A written request must be received by the Company asking that the benefit payment be considered, and
- (b) A Physician's Statement must be submitted to the Company stating that, in the opinion of your Physician, you have 12 or less months to live, and
- (c) The maximum amount payable will be equal to 3 times the amount of the monthly Long Term Disability benefit payment you receive from the Company.

If you choose to receive the Long Term Disability Survivor Benefit prior to your death, any balance will be payable to the applicable beneficiary.

HEALTH BENEFITS GENERAL PROVISIONS

1. DESCRIPTION OF THIS BENEFIT

If you or your eligible dependents incur expenses described on the following pages while insured under this Group Plan, you'll be reimbursed for the eligible charges. The amount payable is subject to the **Co-Ordination of Benefits** (see #6 below) and any **Deductible Amount** (see #2 below) and **Reimbursement Percentage** (see #3 below). Eligible expenses mean reasonable and customary charges for necessary services, supplies, products, and appropriate treatments (see #4 below) (deemed satisfactory by the Company) or materials prescribed by a legally licensed physician or surgeon, or for care provided by a practitioner specifically included as an eligible practitioner in the Policy.

2. WHAT IS THE "DEDUCTIBLE AMOUNT"?

This is the amount you must pay before any benefits become payable under the Group Plan. The Deductible Amount for your Plan is **shown in the Schedule of Benefits**.

Note: If the Family Deductible Amount is greater than the Single Deductible Amount, no more than the Single Deductible Amount can be taken from any one family member towards satisfying the Family Deductible Amount.

Eligible claims incurred during October, November and December of a calendar year that are used to satisfy the Deductible Amount for that year will also be used towards satisfying the Deductible Amount for the next calendar year. **Please note that Pay-Direct Drug claims cannot be used for this purpose.**

3. WHAT IS THE "REIMBURSEMENT PERCENTAGE"?

This is the percentage (portion) of eligible expenses that is paid by the Company after any Deductible Amount has been reached. The Reimbursement Percentage for this Group Plan is **shown in the Schedule of Benefits**.

4. WHAT IS CONSIDERED AN APPROPRIATE TREATMENT?

A treatment is considered to be appropriate if it is:

- (a) accepted by the Canadian medical profession; and
- (b) medically necessary; and
- (c) proven to be effective; and
- (d) used for a Health Canada approved indication; and
- (e) of a form, intensity, frequency, and duration essential to the management of disease or injury

5. WHAT IS MEANT BY PRIOR AUTHORIZATION?

Benefits payable under this policy as indicated in the Schedule of Insurance may be subject to Prior Authorization. Equitable Life of Canada reviews and maintains a limited list of services, supplies, products and treatments that require Prior Authorization.

Prior Authorization is intended to ensure that a service, supply, product or treatment is deemed by Equitable Life of Canada to be an eligible expense and appropriate treatment and potentially a cost effective alternative for you or your dependent.

In the event that there is an alternative service, supply, product or treatment that represents an eligible expense and appropriate treatment and a suitable substitution, Equitable Life of Canada may require you or your dependent to provide medical evidence why the alternative service, supply, product or treatment cannot be used before coverage is confirmed and provided for the service, supply, product or treatment.

HEALTH BENEFITS GENERAL PROVISIONS

6. HOW DOES THE "COORDINATION OF BENEFITS" WORK?

If **you and your spouse** both have Family coverage under the Group Insurance Plans where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first insurance company.

Claims for **your dependent children** should be submitted as follows:

If you and your spouse are living together, or are separated but have joint custody, claims should first be submitted through the Group Plan of the parent with the earlier birthday (month and day) in the calendar year. Any balance is then submitted through the other parent's Group Plan. For example, if your birthday is October 10 and your spouse's birthday is May 25, claims for your dependent children should be sent to your spouse's insurance company first (because your spouse's birthday is earlier in the year). Any unpaid balance would then be submitted to Equitable Life, along with a copy of what your spouse's insurer paid.

If you and your spouse share the same birthday, submission of claims should be determined based on the alphabetical order of the parent's first names.

If you and your spouse are separated, but do not have joint custody, claims should be submitted in the following order:

1. The Group Plan of the parent with custody of the Dependent Child,
2. The Group Plan of the Spouse of the parent with custody of the Dependent Child,
3. The Group Plan of the parent not having custody of the Dependent Child,
4. The Group Plan of the Spouse of the parent not having custody of the Dependent Child.

Total reimbursement for any claim cannot be more than 100% of the actual expense.

7. WHAT ARE THE OVERALL MAXIMUM AMOUNTS?

The Lifetime Maximum Amount is **shown in the Schedule of Benefits**. It applies to each insured person for the entire time he/she is covered under this Group Plan. Once the Lifetime Maximum Amount has been paid for an insured person, further eligible expenses for him/her are limited to \$1,000 per calendar year. Once the Lifetime Maximum Amount has been reached, it can be reinstated if the insured person submits satisfactory evidence of insurability and the Company accepts this in writing.

Any Annual Maximum Amount is **shown in the Schedule of Benefits**.

HEALTH BENEFITS GENERAL PROVISIONS

8. DEFINITIONS

Practitioners:

Below is the definition for practitioners (the qualifications they must have for claims to be eligible). In all cases, the practitioner must be a member in good standing of the Provincial Association and/or regulatory body applicable to his/her specialty and be licensed to practice under the laws of the applicable province. A Practitioner is eligible only if included as an eligible expense under this Group Plan.

Paramedical practitioners:

- * **"Athletic Therapist"** means a person who is a Certified Athletic Therapist.
- * **"Audiologist"** means a person who has a Masters degree specializing in hearing loss.
- * **"Dietician"** means a person who is registered with the Dieticians of Canada Association.
- * **"Chiropractor", "Naturopath", "Osteopath" and "Speech Therapist"** means a person who holds a degree from a recognized school.
- * **"Registered Massage Therapist"** means a person who is a member of the applicable Provincial Association of Masseurs and who is classified as a Registered Massage Therapist.
- * **"Master of Social Work (MSW)"** means a person who has a Master's degree in Social Work.
- * **"Physiotherapist" and "Podiatrist (Chiropodist)"** means a member of the Canadian Association or any applicable affiliated provincial association.
- * **"Psychologist"** means a permanently certified psychologist with a Doctor's degree in Psychology.
- * **"Specialist in Acupuncture"** means a person allowed to perform acupuncture under the laws of the applicable province and who is recognized as a specialist by the Company.

Other practitioners:

- * **"Dentist"** means a person who is legally licensed in dentistry.
- * **"Optometrist"** means a member of the Canadian Association of Optometrists or any other applicable associated provincial association.
- * **"Ophthalmologist"** means a person who is a medical doctor who is legally licensed to practise ophthalmology.
- * **"Physician"** means a person who is legally licensed to practise medicine.
- * **"Pharmacist"** means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which the pharmacist is practising.
- * **"Registered Graduate Nurse", "Registered Nursing Assistant", "Certified Nursing Assistant" and "Licensed Practical Nurse"** means a person listed on the appropriate provincial registry.

Reasonable and Customary charges:

- (a) For practitioners in Canada practising in a province that has an official fee schedule: the provincial fee schedule that is in effect on the date of the service.
- (b) For other practitioners practising in an area that has an official fee schedule or recommended fee practices and tariff guide: the fee schedule or tariff guide in effect on the date of the service.
- (c) In all other cases, the charge for similar services, supplies, products or treatments made by other providers, practitioners or suppliers of the same standing in the geographical area where the charge is incurred, as determined by Equitable Life, or in accordance with a payment schedule established by Equitable Life.

Province of Residence:

For both employees and dependents, this means the province in which the employee resides.

HEALTH BENEFITS GENERAL PROVISIONS

9. RECURRENT DISABILITY

If **you** return to active work after being disabled due to illness or accident and you then become disabled again within 14 days from the same or related causes, it will be assumed that the original disability has continued. If **one of your eligible dependents** is disabled due to sickness or accident and recovers but then becomes disabled again within 90 days from the same or related causes, it will be assumed that the original disability has continued. This could apply to those Health Benefits, which include a maximum period of time during which benefits are payable for any one disability or period of disability (such as Convalescent Home Services under Major Services, if this is included in the Group Plan).

10. WHAT HAPPENS IF YOUR HEALTH BENEFITS TERMINATE?

If you or any of your insured dependents are totally disabled on the date when your Health Benefits terminate, coverage for the disabled person can continue while that person is totally disabled, or until one of the following dates, if earlier, provided we receive proof that is acceptable to the Company that the person is totally disabled:

- * the date the person is no longer totally disabled, or
- * the date the maximum benefits have been paid under this Policy, or
- * the date the person becomes eligible for similar insurance under another insurance policy, or
- * the 91st day after your Health Benefits terminated.

11. WHAT IS NOT COVERED?

Health Benefits are not payable for expenses that result from the following:

- (a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)
- (b) active participation in a riot, rebellion or insurrection
- (c) war or hostilities of any kind (whether or not war is declared)
- (d) committing or attempting to commit a criminal offence
- (e) services performed by a person who usually lives in the patient's home or is related to the patient by birth or marriage, or related to the patient through the patient's spouse
- (f) services that are provided free or for a nominal (small) amount by public authorities or tax-supported agencies, by the Workers' Compensation Act or some other law, or where no charge would be made if the person didn't have any insurance
- (g) charges that are covered under a Provincial Health Care Plan (whether or not the person is actually insured under it), or by any other insurance carrier, or as a result of legal action or settlement
- (h) charges for un-kept appointments, telephone time, or to complete forms or reports
- (i) charges for periodic or routine health examinations or examinations for a third party (for example, if you need to get a medical exam in order to get a license)
- (j) costs involved if you have to move or travel for health reasons
- (k) services for which it's not legal to provide insurance
- (l) expenses for treatment or materials for dental care, eyeglasses, physician services, or services outside the province of residence (unless they're specifically included under this Group Plan)
- (m) cosmetic surgery or treatment or medication (unless it's required as the result of accidental injuries and provided the surgery or treatment begins within 90 days of the accident)
- (n) charges for lifestyle counselling (such as counselling for weight loss or to stop smoking)
- (o) charges for treatment or materials, which (in the opinion of the Company's medical advisors) are experimental or illegal to use or are not a recognized form of treatment
- (p) any charge related to in vitro fertilization or any other fertility programme (other than the Maximum Amount for Fertility Drugs, if any, shown in the Summary of Health Benefit Maximums)
- (q) services and supplies for an out-patient at a hospital, such as anaesthesia for a surgical procedure, use of an examination or operating room, drugs administered at the hospital, bandages, dressings and casts
- (r) anaesthesia, blood and blood plasma
- (s) expenses that are not actually charged to you or your eligible dependent

HEALTH BENEFITS GENERAL PROVISIONS

- (t) lifestyle drugs (unless shown on the Summary of Health Benefit Maximums), such as drugs to treat erectile dysfunction (such as Viagra) and for weight loss
- (u) sphygmomanometer (blood pressure monitor) and insulin pumps for diabetes, unless shown as an eligible expense in the Summary of Health Benefits Maximums.
- (v) any services, supplies, products or treatments purchased from a provider who is not approved by Equitable Life of Canada may be ineligible
- (w) any portion of an eligible expense and appropriate treatment for which there is alternative funding available through a government or other patient support program may be ineligible
- (x) any portion of an eligible expense and appropriate treatment including drugs, may be limited to that of a lower cost alternative that represents appropriate treatment
- (y) any services, supplies, products or treatments that require Prior Authorization may be ineligible if the service, supply, product or treatment has not been approved by Equitable Life of Canada

HEALTH BENEFITS

PAY-DIRECT DRUG PLAN #88 Comprehensive Health Care Plan (RX and selected OTC Products)

1. WHAT IS COVERED SUBJECT TO THE EXCLUSIONS?

- a) Expenses for drugs which require a prescription by law, approved by Equitable Life, and prescribed by a doctor or dentist are eligible. In addition, certain drugs prescribed by other health professionals who are qualified and licensed will be considered if the applicable provincial legislation permits the professional to prescribe these drugs. In either case, the prescription must be filled by a licensed pharmacist at an accredited pharmacy.
- b) Selected prescription requiring medications, which have been assigned a valid Drug Identification Number (DIN) by Health Canada and are listed as prescription requiring in the Federal or Provincial Drug Schedules are eligible, with the exception of those drugs listed in the Exclusion section.
- c) Selected injectable drugs, injectable vitamins, insulins and non-patient specific allergy extracts bearing a valid DIN are eligible.
- d) Extemporaneous preparations or compounds are eligible if the primary active ingredient is eligible, medically necessary, legally requires a prescription and is compounded by a licensed pharmacist and is filled at an accredited pharmacy.
- e) Selected products from within the following classes of non-prescription requiring drugs are eligible:
- f) potassium supplements, iron supplements and vasodilating nitrates.
- g) Disposable needles, disposable syringes, lancets and chemical reagent testing materials used for insulin administration and monitoring in diabetes are eligible benefits.

2. MAXIMUM SUPPLY

The maximum eligible at any one time is shown in the Schedule of Insured Benefits, including the maximum supply for the following drugs and medicines used for maintenance or long-term therapy: antiasthmatics, antibiotics for acne, anticoagulants, anticonvulsants, antidepressants, antiparkinsons, cardiac drugs, diabetes drugs, female hormone replacement therapy, oral and transdermal contraceptives, potassium replacements, and thyroid agents.

3. EXCLUSIONS:

- a) Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment,
electronic diagnostic monitoring or testing equipment (such as a "Glucometers"), non-disposable insulin delivery devices (such as "Novolin Pen" and "Insulin Pumps"), spring loaded devices to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, delivery or extension devices for inhaled medications (such as "Diskhaler" or "Aerochamber"), or supplies and accessories for the aforementioned are not eligible
- b) Oral vitamins, minerals, dietary supplements, infant formulas, or injectable Total Parenteral Nutrition (TPN) solutions, whether or not such a prescription is given for a medical reason, except where Federal or Provincial law requires a prescription for their sale, are not eligible.
- c) Diaphragms, condoms, contraceptive jellies/foams/sponges/suppositories, non-medicinal Intrauterine Devices (IUDs) such as Gyne-T, contraceptive implants or appliances normally used for contraception whether or not such a prescription is given for a medical reason are not eligible.
- d) Herbal and Homeopathic preparations are not eligible benefits, even if combined with a prescription requiring medicine or with a product considered to be an eligible benefit.
- e) Any prescriptions administered to an outpatient in a hospital, or by any agency or provider controlled by a hospital or by any agency or provider funded in whole or part by a government at any level including emergency status and investigational status drugs are not eligible unless otherwise indicated in this policy or approved by the pay direct drug provider.
- f) All preventative immunization vaccines and toxoids are not eligible.
- g) All patient specific allergy extracts, compounded in a lab, and not bearing a DIN are not eligible.

HEALTH BENEFITS PAY-DIRECT DRUG PLAN #88 (continued)

3. EXCLUSIONS (Continued)

- h) Items deemed to be cosmetic in nature (even if a prescription is legally required), such as topical Minoxidil, or sunscreens, whether or not a prescription is given for medical reasons are not eligible.
- i) Any medication the person is eligible to receive under the Provincial Drug Benefit Plan is not eligible.
- j) Smoking cessation products are not eligible.
- k) Meridia™ and Xenical™ are not eligible.
- l) Oral erectile dysfunction drugs are not eligible.
- m) Medications and compounded products deemed to be fertility drugs are not eligible.
- n) Products not bearing a valid Health Canada issued DIN are not eligible.
- o) Fees to administer medication, consultation charges and/or professional fees for services rendered by a licensed physician, pharmacist, or other qualified health professionals (other than dispensing fees) are not eligible.
- p) Selected injections normally administered to patients admitted to hospital for treatment are not eligible.
- q) Products bearing a valid Natural Product Number (NPN) by Health Canada is not eligible.
- r) Mixtures and compounds that do not conform to the pay direct drug provider's current compound policy.

4. SERVICES OUTSIDE THE PROVINCE

The maximum amount eligible will be an amount up to (but not more than) the following:

- a) if the drug was purchased at a pharmacy that has signed an agreement with the Pay-Direct Drug Plan provider for the direct submission and payment of drugs, payment will be made for reasonable and customary charges and eligible expenses of the province in which the drug was purchased, or
- b) in all other circumstances, payment will be made according to the reasonable and customary charges and eligible expenses allowed in your province of residence.

5. HOW TO SEND IN A CLAIM?

Present your Pay-Direct Drug card to your Pharmacist each time you have a prescription filled. This way, your Pharmacist can tell you if the prescription is covered under your plan, and can also submit your drug claim electronically on your behalf. This means that you will only have to pay the Pharmacist for any expenses not covered under your plan.

If you forget to present your card at the pharmacy, you may have to pay the full cost of the prescription and then submit a claim to get your covered expenses reimbursed. You can submit these claims by completing form #466PD – Employee Reimbursement Form for Pay-Direct Drug Card Claims available online at www.equitablehealth.ca and sending it to the address indicated on the form.

Note: Drug claims must be received within 365 days of the date the claim is incurred.

6. CLAIMS

IMPORTANT: If your insurance terminates, or if the Drug Benefit under this Policy terminates, or if this Group Policy terminates, all claims incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

HEALTH BENEFITS MAJOR SERVICES

The following pages describe the expenses under the Major Services benefit, if shown as eligible in the Schedule of Benefits.

"Insured person" means you, your eligible spouse, or your eligible dependent child insured under this Group Plan for Health Benefits.

1. **CONVALESCENT HOME SERVICES**

Payment will be made for room and board if the insured person is confined in a **convalescent home** such as:

- * a sanitarium
- * a skilled nursing home
- * a special wing of a hospital that has a transfer agreement with a hospital.

(Homes for the aged and treatment centres for drug addiction and alcoholism are not included.)

Services are eligible as long as:

- * confinement in the convalescent home occurs within 7 days after the person was confined for at least 3 days in a licensed hospital and the Provincial Health Care Plan paid benefits for the same sickness or injury when the person was in the licensed hospital, and
- * confinement in the convalescent home is for rehabilitation purposes and not for custodial care.

See the Summary of Health Benefit Maximums page for the **Maximum Payable for Convalescent Home Services**.

2. **AMBULANCE SERVICES**

Reasonable and customary charges for professional ambulance services to or from the nearest hospital where the required treatment can be provided. If certified as medically necessary, air ambulance and charges for a registered nurse or paramedical assistant are eligible expenses.

3. **PRIVATE DUTY NURSING CARE SERVICES (PDN)**

Eligible expenses for private duty nursing care provided in the home of an acutely ill patient, if such care is prescribed in writing by a physician and is provided at a minimum of one 4-hour shift per day by a Registered Graduate Nurse, Registered Nursing Assistant, Certified Nursing Assistant or Licensed Practical Nurse who is not normally resident in the patient's home and is not related to the patient by blood or marriage. Only medical services that should reasonably be performed by one of the qualified practitioners listed above are eligible. Respite care is not covered.

The **Maximum Amount Payable for Nursing Care Services** for each insured person in a calendar year is shown on the Summary of Health Benefit Maximums page.

4. **APPLIANCES AND SUPPLIES**

Eligible expenses include the following, provided they are prescribed by a physician (we'll need a copy of the Doctor's written prescription):

- (a) reasonable and customary charges for the rental of:
- * a standard hospital bed
 - * equipment to administer oxygen
 - * equipment for the treatment of respiratory paralysis

provided the rental is:

- * for therapeutic use only, and
- * required for a period not exceeding 180 days.

(Rental of other durable medical equipment may be considered if required for therapeutic use.)

HEALTH BENEFITS MAJOR SERVICES

4. **APPLIANCES AND SUPPLIES** (Continued)

- (b) reasonable and customary charges for the purchase of:
- * casts, splints, trusses, crutches
 - * orthopaedic braces that are required for medical reasons (note that we may ask for additional information), including over-the-counter braces that have rigid supports, provided they are prescribed by a physician
 - * artificial limbs, artificial eyes, or laryngeal speaking aids
- provided they are required due to a disability which occurred while the person was insured under this Plan

The following are not covered:

- * replacement or repair (except for replacement or adjustments that are required because of pathological changes)
 - * charges for the purchase of devices used primarily to allow the person to participate in sports
 - * elastic supports
 - * support hose, surgical stockings and stump socks, unless specifically shown as an eligible expense on the Summary of Health Benefit Maximums page
- (c) purchase of a breast prosthesis and surgical brassiere(s) required as the result of a mastectomy, subject to the **Maximum for Breast Prosthesis and Surgical Brassiere(s)** shown on the Summary of Health Benefit Maximums page
- (d) reasonable and customary charges for the purchase of ileostomy or colostomy supplies
- (e) purchase or repair of hearing aids obtained on the written prescription of a certified otolaryngologist up to the **Maximum for Hearing Aids** shown on the Summary of Health Benefit Maximums page. Hearing aid batteries and hearing tests are not eligible unless specifically shown as an eligible expense on the Summary of Health Benefit Maximums page.
- (f) reasonable and customary charges for the purchase of the following, provided they are custom made for the patient and are prescribed by a physician, chiropractor, podiatrist or chiroprapist:
- * orthopaedic shoes (lifts, wedges, flares or similar shoe modifications)
 - * other orthotics

For custom made shoes the fabrication of the footwear must include the creation of a unique cast of the person's feet and must be constructed using 100% raw materials. In addition, the shoes must be prescribed to accommodate bony and structural abnormalities of feet and/or lower legs resulting from trauma, disease or congenital deformities subject to the **Maximum for Orthopaedic Shoes and Other Orthotics** shown in the Summary of Health Benefit Maximums.

Orthopaedic Shoes are expensive so if you have any questions about eligibility after reading the requirements, please call in advance to our Group Claims' Service team at 1-800-265-4556 to ensure that the item you have or plan to purchase is eligible.

Note: Stock orthopaedic shoes that can be purchased off-the-shelf are eligible only if they have been significantly modified for the patient and the Summary of Health Benefit Maximums specifies that they are eligible. Stock shoes that have not been modified for the patient are not eligible under any circumstances.

Sandals, even if modified are not eligible.

The following is required for proper claim review:

- * A medical referral must be provided from a physician, chiropractor, podiatrist or chiroprapist, and include the diagnosis or medical condition necessitating the product;
- * The paid receipt should show the name, credentials and College Registration number of the person who dispensed the custom made product;
- * The technique/process used for casting your foot (the casting method used must be three dimensional to be considered a custom made product);
- * A description of how the foot orthotic or custom made shoe was constructed including what raw materials were used; (please include a description of the modifications made to the shoes including a breakdown of the costs and the brand name and model of the shoe); and
- * The contact information of the laboratory where the custom made product was manufactured. The invoice must indicate the name of the patient and shipment date or date of completion.

HEALTH BENEFITS MAJOR SERVICES

- (g) reasonable and customary charges for oxygen (with a physician's prescription).
- (h) reasonable and customary charges for wigs and hairpieces required as a result of a medical condition while insured under this Group Plan, subject to the **Maximum for Wigs and Hairpieces** shown in the Summary of Health Benefit Maximums.
- (i) reasonable and customary charges for standard syringes, needles and diagnostic test material, including glucometers, required to treat diabetes. The maximum for glucometers is shown in the Summary of Health Benefit Maximums. Other supplies, such as automatic jet injectors, insulin pumps or other special equipment, swabs and rubbing alcohol are not covered, unless specifically shown as an eligible expense on the Summary of Health Benefit Maximums. However, for Pay-Direct Drug Plans, disposable needles (including disposable needles only, for non-disposable insulin delivery devices), disposable syringes, lancets and chemical reagent testing materials used for monitoring diabetes are eligible under the Pay-direct Drug Plan.
- (j) Diagnostic laboratory procedures: Reasonable and customary charges for medically necessary lab tests (including Prostate Specific Antigen tests - PSA tests), and x-rays (including Magnetic Resonance Imaging - MRI), if performed in the province of residence (but not in a hospital), subject to the **Maximum for Diagnostic Laboratory Procedures** shown in the Summary of Health Benefit Maximums. Genetic testing is excluded.

5. **DENTAL ACCIDENT**

This section of Major Services covers reasonable and customary charges for treatment by a Dental Surgeon for a fractured jaw or injuries to sound natural teeth that result from an accident that occurs while insured under this Group Plan. The accidental injuries must be caused by external, violent and accidental means. Coverage is not provided for injuries caused by an object placed in the mouth (even while eating or drinking).

Treatment must be completed **within 365 days** of the accident.

Pre-Determination: If the Dental Surgeon tells you that it will cost **more than \$300** to treat the injuries, a Treatment Plan and estimates of the charges should be sent to us **before** treatment begins. We'll then be able to tell you in advance how much will be eligible under the Group Plan.

Alternate Treatment: If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this Group Plan is equal to the cost of the **less** expensive treatment. If you choose to proceed with the more expensive treatment, then **you** will be responsible for the additional costs.

6. **PARAMEDICAL SERVICES**

Reasonable and customary charges for expenses incurred for services performed by eligible Paramedical Practitioners, subject to the **Maximums for Paramedical Services** in the Summary of Health Benefit Maximums. See Practitioners under #8 (Definitions) under the Health Benefits - General Provisions for the definition/qualifications of the various practitioners.

Note: In some provinces, if your Provincial Health Care Plan pays any portion of the charges made by Paramedical Practitioners, no payment is eligible under this Group Plan until the overall maximum allowed for that type of practitioner has been paid out by the Provincial Plan. For example, if a practitioner charges \$20 per visit and your Provincial Health Care Plan only pays \$10 per visit, the difference is **not covered** under the Group Plan. Once your Provincial Plan has paid the **overall maximum** that they allow for a practitioner (or if your Provincial Health Care Plan doesn't cover a particular practitioner), charges may then be eligible for payment under your Group Plan.

If your province does allow private insurers to pay the excess charged by certain practitioners over what the Provincial Health Care Plan pays, and **if your Employer has chosen to include these in your Group Plan**, this will be indicated in the Paramedical section in the Summary of Health Benefit Maximums.

HEALTH BENEFITS MAJOR SERVICES

7. SERVICES OUTSIDE THE PROVINCE

Reasonable and customary charges for eligible expenses incurred outside the employee's province of residence, provided:

- (a) The services are covered under the employee's Provincial Health Care Plan.
- (b) The services are for **emergency treatment** (see the definition of "emergency treatment" on the following page) for an injury or illness which occurs within the number of days shown under **Time Limit for Commencement of Emergency Treatment** shown in the Summary of Health Benefit Maximums after the insured person begins a temporary absence from the employee's province of residence, or
- (c) The services (or similar services) are not available in the employee's province of residence but they are available elsewhere in Canada. If the services aren't available in Canada, services performed outside Canada will be eligible. In either case, we require the written referral of the insured person's regular physician in the province of residence and confirmation from the Provincial Health Care Plan that the services are not available in that province.

"Emergency" means a sudden, unexpected, acute illness or accidental injury that requires immediate, medically necessary treatment, prescribed by a doctor. An emergency ends when the insured person is deemed medically stable to return to his province of residence. When an insured person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving their province of residence.

The following expenses are eligible for reimbursement, **subject to reasonable and customary charges** for the services in the geographical area where the expense is incurred. Any part of the expenses that are covered by a Provincial Health Care Plan will be deducted from the amount payable under your Group Plan:

- (a) services by a physician or surgeon
- (b) charges for daily room and board in a public ward of a hospital (or for a semi-private or private room if shown in the Schedule of Benefits); the maximum payable for any period of disability is 180 days of confinement
- (c) hospital charges for medically necessary services and supplies for an in-patient, as long as these charges aren't included in the daily room and board rate; the maximum payable for any period of disability is an amount equal to 30 times the hospital's standard public ward rate
- (d) professional ambulance services (including air ambulance if medically necessary) to the nearest hospital where the required treatment can be provided
- (e) other charges for out-of-province services are included only up to the amount that would have been payable under this Group Plan if the service had been performed in the employee's province of residence.

HEALTH BENEFITS MAJOR SERVICES

7. SERVICES OUTSIDE THE PROVINCE (Continued)

No benefit is payable under the Out-Of-Province Services for services performed in a country for which the Canadian Government or World Health Organization issued a travel warning or restriction prior to the insured's departure from the country.

No benefit is payable for injury that results from participation in any sport as a professional athlete or participation in a dangerous activity.

"Professional athlete" is defined as someone who receives payment for their athletic performance in the form of taxable income, prizes or sponsorships.

Examples of dangerous activities include, but are not limited to: extreme sports, off-trail skiing, sky-diving, mountaineering, scuba diving (without certification) and spelunking.

If you are unsure of whether your travel plans include activities that may be considered dangerous, please contact your travel provider for travel assistance before or during your trip. The phone number is on your wallet card.

Benefits are not payable under the Out-Of-Province Services for services performed outside Canada if the insured person lives outside Canada, except as shown below.

A dependent child will be eligible only for emergency treatment (see the definition of "emergency treatment" above) for an injury or disease which occurs while the child is a student outside Canada. The student must be enrolled in and attending an accredited educational institution on a full-time basis for the purpose of attaining a post-secondary degree or diploma. The following provisions apply:

- (i) We will require a letter from the post-secondary institution at the beginning of each school term confirming the enrolment and attendance of the student. A school term will include a co-op work term placement outside Canada which is part of the degree or diploma program.
- (ii) We will require a letter from the Provincial Health Care Plan of the student's province of residence confirming that coverage for the student will continue under that Plan while the student is attending school outside Canada.
- (iii) The student must immediately contact the Travel Assist provider when an eligible expense is incurred while outside Canada. The telephone numbers for the Travel Assist provider are shown in the Travel Assist section of this booklet and on the wallet card.
- (iv) Except for drugs, the emergency services must be eligible under the Provincial Health Care Plan of the student's province of residence.
- (v) The provisions of the policy will apply, including the Limitations and Exclusions, except for the Out-of-Province Time Limit for Commencement of Emergency Treatment shown on the Summary of Health Benefit Maximums.
- (vi) The student is covered only during the school term.
- (vii) Coverage is not provided during holidays or student absences during or between school terms that are longer than one month.
- (viii) Coverage will not be provided if the dependent child is a student in a country that is deemed to be high risk for travel on the date the school term begins.

In all cases, payment for services performed outside Canada will be in Canadian dollars at the exchange rate in force on the date the claim and all supporting information has been received by the Company's Head Office in Waterloo, Ontario.

HEALTH BENEFITS MAJOR SERVICES

8. HOW TO SEND IN A CLAIM

Use **Form #466 - Supplementary Medical Benefits Claim Form**. Follow the instructions on the form. Be sure to fill in:

- * the **Group Policy Number**
- * your **certificate number**
- * the **full birth date (day/month/year)** if the claim is for a dependent
- * **all information on a dependent child**, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

Remember to **attach all original receipts, written prescriptions, referral letters**, etc.

Note: In all cases, the original receipts, written prescriptions, referral letters, etc. which show the patient's name and the service provided or item purchased must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

Claims must be submitted **within 90 days** of the date of treatment.

IMPORTANT: If your insurance terminates, or if the Major Services Benefit under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

HEALTH BENEFITS

MAJOR SERVICES - TRAVEL ASSIST

"Insured traveller" means you or your eligible dependent, provided the person is covered for Health Benefits under this Group Plan and meets the conditions for coverage outside the province as described in 7. Services Outside the Province under the Major Services.

1. Assistance Services

- (a) access to multilingual help by telephone, telex and fax 24 hours a day, 365 days a year for both the insured traveller and the medical service provider
- (b) required emergency referral to a physician, dentist or appropriate medical facility
- (c) if the insured traveller is hospitalized, the Travel Assist provider's medical staff will contact the patient's attending physician to monitor the care and services being given and will, if necessary, contact the patient, the attending physician, and the patient's personal physician and family
- (d) referrals to a local legal advisor and, when necessary, help in arranging a cash advance from credit cards or funds from family and friends to post bail and pay legal fees
- (e) assistance in replacing necessary travel documents or tickets that have been lost or stolen (the cost of replacement is the responsibility of the insured traveller)
- (f) emergency telephone interpretation services in most major languages
- (g) exchange of emergency messages between the insured traveller and his/her family (messages are held up to 15 days)
- (h) trying to ensure that the insured traveller is not obligated to pay hospital charges or medical fees by:
 - (i) co-ordinating payment (where possible) directly by the appropriate Provincial Health Care Plan and the Company, or
 - (ii) making payment to the medical provider with funds provided by the Company and then recovering the expenses payable by the Provincial Health Care Plan and forwarding such funds to the Company
- (i) arranging all aspects of transporting the insured traveller if the Travel Assist provider's medical staff and the attending physician decide it's medically necessary to transport the person to the nearest appropriate medical facility or to Canada for treatment (including ground transport to and from the hospital and airport at the points of departure and arrival and medical accompaniment deemed necessary by the Travel Assist provider's medical staff); these costs are a Covered Expense
- (j) in the event of the death of an insured traveller, obtaining all necessary authorizations and making arrangements for the return of the remains to the place of its former residence; reasonable and necessary expenses of shipping the body back to the province of residence is covered by the Company, up to a maximum of \$5,000 (excluding the cost of any coffin other than the minimum necessary to transport the body).

2. Family Benefits

The family benefits outlined below are included, provided the insured traveller incurs a medical emergency outside his province of residence, subject to a maximum of \$5,000 for all such expenses for any one trip.

- (a) If an insured traveller is travelling alone and is hospitalized for more than 7 days outside his province of residence, the Travel Assist provider will arrange, and the Company will reimburse, for the round-trip economy class transportation of one family member from the patient's immediate family (spouse, parent, child, brother or sister). This includes transportation from the family member's place of residence in Canada to the place where the insured traveller is hospitalized, including reimbursement for expenses of up to \$150 per day for the family member's room and meals.
- (b) If the insured traveller requires hospitalization and any dependent child(ren) under age 16 travelling with him/her are left unattended by an adult, arrangement may be made for transportation of such child(ren) to their place of residence in Canada including, where necessary, escort for the child(ren).

HEALTH BENEFITS

MAJOR SERVICES - TRAVEL ASSIST

2. **Family Benefits** (Continued)

- (c) If an insured traveller requires hospitalization, the Travel Assist provider will arrange and the Company will reimburse for the cost of upgrading the transportation for the insured traveller (and any insured dependents travelling with him) to the one-way economy class fare of a regularly scheduled airline if their original tickets can't be used due to the necessity of rescheduling the return trip to adapt to the hospitalization.

Covered Expenses will also include up to \$500 towards the cost of returning a private vehicle owned or rented and being driven by the insured traveller to the location from which the insured traveller began driving it, provided that person is unable to continue because of a medical emergency that prevents him from travelling by vehicle.

3. **Limitations**

The following **Limitations** shall apply:

- (a) Circumstances (such as war, insurrection, epidemic, military operations, political conditions, local laws or orders of local legal and administrative agencies, strikes, flight conditions, severe weather, the geographical inaccessibility of health care providers) may delay, interfere or prevent the Travel Assist provider from providing some or all of the services described.
- (b) The Travel Assist provider and Equitable Life are not responsible in any way for the availability, quantity, quality or results of any medical treatment or other assistance received by the insured traveller or failure to receive medical services or other assistance for any reason.

Covered Expenses are processed through an arrangement between the Company and the Travel Assist provider (subject to change without notice). Travel Assist Services automatically terminate if this arrangement terminates and is not replaced by a similar arrangement.

Eligible Expenses must be specifically listed as such under the Extended Health Insurance in this booklet or in the Policy. If it's determined that an amount paid by the Travel Assist provider or the Company is not eligible under the Policy, the Company can take action to recover such amount (plus expenses) from the employee or other person who received the payment.

4. **How to contact the Travel Assist provider**

Call their hotline:

- * in Canada or the U.S.A.: 1-800-321-9998
- * elsewhere: call collect at 519-742-3287.

Give the Travel Assist provider:

- * your **name**
- * your **Group Policy number**
- * your **certificate number**
- * your **Government Health Insurance Plan number.**

You must contact the Travel Assist provider to verify coverages. Once coverage has been verified, the Travel Assist provider will assist you in obtaining any of the above services that you need.

HEALTH BENEFITS

SEMI-PRIVATE HOSPITAL

1. WHAT IS COVERED?

If you or one of your eligible dependents are confined as an inpatient **in a semi-private room** (a room with two beds) in a licensed hospital while insured under this Group Plan, a reimbursement will be made to the hospital for **reasonable and customary charges** made by the hospital (taking into account any Deductible Amount and Reimbursement Percentage shown in the Schedule of Benefits).

Expenses are not eligible:

- * if the person is confined in a special ward or unit that would qualify as a "convalescent home" under the Policy or which would otherwise not qualify as a hospital
- * if the semi-private room is the lowest level of accommodation available
- * if the semi-private room is required for medical reasons.

The maximum amount eligible is the excess of:

- * reasonable and customary charges actually made by the hospital for semi-private care and the greater of:
- * the Provincial Health Care Plan allowance, or
- * the amount the hospital charges for standard ward care.

The maximum amount eligible if confined in a private room is the amount that would be eligible if the person was in a semi-private room (but not more than the hospital actually does charge).

2. WHAT IS MEANT BY "REASONABLE AND CUSTOMARY" CHARGES?

These are the standard hospital charges for semi-private or standard ward care, as the case may be. If there are no "standard" charges, it means the average daily room and board charges made by the hospital.

3. SERVICES OUTSIDE THE PROVINCE

The maximum amount eligible if confined in a hospital outside the province of residence is the amount that would be eligible if confined in the employee's own province of residence.

4. HOW TO SEND IN A CLAIM

The hospital will usually send the claim directly to Equitable Life.

IMPORTANT: If your insurance terminates, or if the Hospital Benefit under this Policy terminates, or if this Group Policy terminates, all claims incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

HEALTH BENEFITS VISION CARE SERVICES

1. EYE GLASSES OR CONTACT LENSES OR LASER EYE SURGERY

Charges incurred for:

- * lenses and frames for eye glasses (including fitting, replacement or repair) or for contact lenses that aren't eligible under #3 below, as long as they're prescribed by a physician or optometrist, or
- * laser eye surgery to correct vision, if performed by a physician or ophthalmologist.

See the Schedule of Benefits for the **maximum amount** and **how often expenses are eligible** for you and your eligible dependents.

If the Schedule of Benefits indicates that Vision Care benefits are payable **in any period of "x" months** (such as any period of 12 months or any period of 24 months), and not by calendar years, the date used to determine if a claim is eligible is **the date the service (the eye glasses/contact lenses/laser eye surgery) is paid for**.

Example: If Vision Care is payable in any period of 24 months and the patient had paid for the services on October 5, 2013, the next time a claim will be eligible is October 6, 2015.

2. WHAT IS NOT COVERED?

Glasses used only for cosmetic reasons and safety glasses where a corrective prescription is not required are not eligible.

3. "SPECIAL" CONTACT LENSES

These are contact lenses prescribed by an ophthalmologist who certifies that they're medically necessary because of severe corneal astigmatism, corneal scarring, or as the result of surgery or treatment for keratoconus or aphakia. They are eligible only if vision can't be corrected to 20/40 or better with eye glasses. The maximum eligible for special contact lenses is shown in the Schedule of Benefits.

4. HOW TO SEND IN A CLAIM

The Health section in the Schedule of Benefits tells you if a change in prescription is required in order for benefits to be eligible under Vision Care.

If a change in prescription is required, use **Form #948 - Vision Care**. Follow the instructions on the form. Fill in:

- * the **Group Policy Number**
- * your **certificate number**
- * the **full birthdate (day/month/year)** if the claim is for a dependent
- * **all information on a dependent child**, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

If a change in prescription is not required, use **Form #466 - SUPPLEMENTARY MEDICAL BENEFITS**. Be sure all data listed above is completed on the form. If the claim is for Special Contact Lenses (#3 above), include the prescription or letter from your Ophthalmologist explaining the reason they are required.

Note: In all cases, the original receipt from the supplier which shows the patient's name and the service provided or item purchased (such as eyeglasses or contact lenses) must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

Claims must be submitted **within 90 days** of the date of treatment.

IMPORTANT: If your insurance terminates, or if the Vision Care Benefit under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

HEALTH BENEFITS

VISION CARE - EYE EXAMINATIONS

1. EYE EXAMINATIONS

Eye examinations are eligible, subject to the following:

- (a) the eye examination must be performed by an optometrist or ophthalmologist, and
- (b) eye examinations are eligible only if they are not listed under your Provincial Health Care Plan.

See the Schedule of Benefits page for the **maximum amount** and **how often expenses are eligible** for you and your eligible dependents.

2. HOW TO SEND IN A CLAIM

Use **Form #466 - SUPPLEMENTARY MEDICAL BENEFITS**. Follow the instructions on the form. Be sure to fill in:

- * the **Group Policy Number**
- * your **certificate number**
- * the **full birthdate (day/month/year)** if the claim is for a dependent
- * **all information on a dependent child**, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

Note: In all cases, the original receipt from the supplier which shows the patient's name and the service provided or item purchased (such as eyeglasses or contact lenses) must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

Claims must be submitted **within 90 days** of the date of treatment.

IMPORTANT: If your insurance terminates, or if the Vision Care (Eye Examination) Benefit under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

DENTAL BENEFITS GENERAL PROVISIONS

1. DESCRIPTION OF THIS BENEFIT

If you or your eligible dependents incur expenses described in the following pages while insured under this Group Plan, you'll be reimbursed for those charges.

The amount payable is subject to the **Co-Ordination of Benefits** (see #5 below) and any **Deductible Amount** and **Reimbursement Percentage** (see #3 and #4 below).

2. WHAT ARE THE ELIGIBLE EXPENSES?

These are the **reasonable and customary charges** made for required Dental treatment performed by a Dentist or, where allowed under the legislation of the province or territory, by an Independently Licensed Dental Hygienist, provided the **Schedule of Benefits** indicates the charges are included under this Group Plan and they are listed in the applicable Dental Fee Guide.

The maximum payable is the amount shown in the **Dental Fee Guide indicated in the Schedule of Benefits** for a General Practitioner.

3. WHAT IS THE "DEDUCTIBLE AMOUNT"?

This is the amount you must pay before any benefits become payable under the Group Plan. The Deductible Amount for your Plan is **shown on the Schedule of Benefits page**.

Note: If the Family Deductible Amount is greater than the Single Deductible Amount, no more than the Single Deductible Amount can be taken from any one family member towards satisfying the Family Deductible Amount.

Eligible claims incurred during October, November and December of a calendar year which satisfy the Deductible Amount for that year will also be used towards satisfying the Deductible Amount for the next calendar year.

4. WHAT IS THE "REIMBURSEMENT PERCENTAGE"?

This is the percentage (portion) of eligible expenses that is paid by the Company after any Deductible amount has been reached. The Reimbursement Percentage for this Group Plan is **shown on the Schedule of Benefits page**.

5. HOW DOES THE "COORDINATION OF BENEFITS" WORK?

If **you and your spouse** both have Family coverage under the Group Insurance Plans where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first insurance company.

Claims for **your dependent children** should first be submitted through the Group Plan of the parent with the earlier birthday (month/day) in the calendar year. Any balance is then submitted through the other parent's Group Plan.

For example, if your birthday is October 10 and your spouse's birthday is May 25, claims for your dependent children should be sent to your spouse's insurance company first (because your spouse's birthday is earlier in the year). Any unpaid balance would then be submitted to Equitable Life, along with a copy of what your spouse's insurer paid. **Total reimbursement for any claim cannot be more than 100% of the actual expense.**

DENTAL BENEFITS GENERAL PROVISIONS

6. WHAT ARE THE MAXIMUM AMOUNTS?

The **Annual Calendar Year Maximum Amount** is shown in the **Schedule of Benefits**. This is the total amount payable for each insured person in any calendar year and is automatically reinstated each January 1st.

If there is a **Lifetime Maximum Amount shown in the Schedule of Benefits**, this is the maximum amount payable for each insured person for the entire time they're covered under this Group Plan.

Note: If you and/or any of your dependent(s) are a "late applicant" (see #3 "How Do You Join?" under the General Provisions) and submit satisfactory evidence of insurability, Dental coverage for late applicants (if insured for Dental benefits) will be subject to a maximum of \$250 for all Dental expenses during the first 12 consecutive months of coverage under the Dental benefit.

7. PRE-DETERMINATION OF BENEFITS

If your Dentist suggests a course of treatment that costs **more than \$300**, a Treatment Plan and estimates of the charges should be sent to us **before** treatment begins. We'll then be able to tell you in advance how much will be eligible under the Group Plan.

8. ALTERNATE TREATMENT

If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this Group Plan is equal to the cost of the **less** expensive treatment. If you choose to proceed with the more expensive treatment, then **you're** responsible for the additional costs.

9. WHAT IS NOT COVERED?

Dental Benefits are not payable for expenses that result from the following:

- (a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)
- (b) active participation in a riot, rebellion or insurrection
- (c) war or hostilities of any kind (whether or not war is declared)
- (d) committing or attempting to commit a criminal offense
- (e) charges for un-kept appointments, telephone time, or to complete forms or reports
- (f) examinations for a third party
- (g) procedures that aren't approved by the Canadian Dental Association or that are experimental in nature
- (h) any condition where you or your dependents are entitled to benefits under any Workers' Compensation Act or law or similar legislation or service, or where benefits are payable under any other insurance policy issued by the Company
- (i) services performed by a person who usually lives in the patient's home or is related to the patient by birth or marriage, or related to the patient through the patient's spouse
- (j) cosmetic surgery or treatment
- (k) any expenses for on-going treatment if it started before your coverage under this Plan became effective
- (l) treatment performed or supplies delivered after your coverage under this Group Plan terminates (except for covered prosthetic appliances ordered and fitted before the date of termination and delivered within 31 days after the date of termination)
- (m) treatment for the purpose of altering vertical dimension, restoring occlusion, splinting (unless shown in the Schedule of Benefits) or replacing tooth structure lost because of abrasion or attrition (wearing away). Your Dentist should tell you if any of these conditions apply and explain them to you.
- (n) treatment for disturbances of the temporomandibular joint (TMJ), unless the Dental section in the Schedule of Benefits shows this is covered. Your Dentist should tell you if this condition applies and explain it to you.
- (o) services provided outside Canada, except for emergency treatment for an unexpected and unforeseen event (such as the loss of a filling or crown while outside Canada).

DENTAL BENEFITS GENERAL PROVISIONS

10. HOW TO SEND IN CLAIMS

If your Dentist* uses EDI (electronic Dental submission):

Your Dentist's* office will submit the claim electronically to Equitable Life.

If your Dentist* does not use EDI (electronic Dental submission):

When you go to your Dentist*, take a **Form #520 - Dental Claim Form** with you or get one from your Dentist's* office. The Dentist* fills in **Part 1** showing what was done and how much was charged. You may want to take this booklet with you when you go to the appointment in case the Dentist* wants to check what's covered.

* or, where applicable, Independently Licensed Dental Hygienist

Follow the instructions on the form. Be sure each form is **fully completed**, including:

- * the **Group Policy Number**
- * your **certificate number**
- * the **full birthdate (day/month/year) for your dependent**, if it's a Dental claim for your spouse or dependent child
- * **all information on a dependent child**, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.
- * **sign in Part 3 - Patient Information** on the back of the form.

If any of this information is missing, we'll have to return the form to you for completion and this will cause a delay in getting your payment.

Claims must be submitted **within 90 days** of the date of treatment.

IMPORTANT: If your insurance terminates, or if the Dental Benefits under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Dental Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

DENTAL BENEFITS

TYPE A - BASIC SERVICES

1. DIAGNOSTIC SERVICES

Services required to evaluate existing conditions, including:

- * consultations and biopsies
- * oral examinations **
- * bitewing x-rays **
- * complete mouth x-rays or panoramic films (once in any 24 months).

2. PREVENTIVE SERVICES

Services required to prevent dental disease, including:

- * dental cleaning **
- * oral hygiene instruction **
- * application of fluoride **
- * pit and fissure sealants for dependent children under age 18.

3. ROUTINE RESTORATIVE SERVICES

Services required for the treatment of dental cavities, including:

- * amalgam, acrylic or composite fillings
- * prefabricated metal or plastic restorations

4. ROUTINE SURGICAL SERVICES

Routine extractions (including wisdom teeth) and the anaesthesia required to do them are eligible.

5. WHAT IS NOT COVERED UNDER THE BASIC DENTAL SERVICES?

- * protective appliances (such as mouthguards) and space maintainers
- * all extensive restorative services
- * all major surgical services (other than the routine extractions in #4 above)
- * charges for specific and emergency examinations when performed in conjunction with any dental cleaning.

** See the **Recall Examination Period** in the Schedule of Benefits for how often a recall examination is eligible.

DENTAL BENEFITS

TYPE A - BASIC SERVICES - OPTIONS

The following Type A Basic Services Options are eligible **only if the Schedule of Benefits indicates they are eligible.**

SPACE MAINTAINERS OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for space maintainers if used as a preventative measure to maintain space. Space regainers used to move teeth or used for orthodontics are **not covered**.

MAJOR SURGICAL SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option covers major surgical services such as:

- * major oral surgery (other than routine extractions which are covered under the Routine Surgical Services of the Basic Dental Plan)
- * necessary sutures (stitches)
- * post-operative treatment and related general anaesthesia
- * alveoplasty, gingivoplasty, osteoplasty and frenectomy (your Dentist should tell you if any of these conditions apply and explain them to you).

Surgical services to prepare for orthodontics or major restorative services (other than fillings) are **not covered** under this Major Surgical Service option.

PERIODONTAL SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for services required to treat the soft tissues and bone that support the teeth, including gingivectomy and osseous surgery. Periodontal scaling is subject to the maximum number of units specified in the Dental section in the Schedule of Insurance.

ENDODONTIC SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option covers services required to diagnose or treat the following:

- * root canals
- * diseases of the tooth pulp
- * diseases of the periapical area.

DENTURE REPAIR SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for services that are required to:

- * rebase and reline removable full or partial dentures
- * repair broken dentures.
- * add teeth to partial dentures (provided the natural tooth is extracted while the insured person is covered under this Group Plan).

The making of dentures is **not covered** under Denture Repair Services option.

DENTAL BENEFITS

TYPE B - MAJOR RESTORATIVE SERVICES

(Dentures)

1. **DENTURES**

This Option covers services that are required to replace missing teeth by using either **partial or full removable dentures**. Eligible expenses include the laboratory charges for prosthodontic materials.

2. **EXCLUSIONS AND LIMITATIONS**

- (a) Replacement of lost or stolen dentures is not eligible.
- (b) Charges for duplicate dentures are not eligible.
- (c) Replacement of an existing denture is not eligible if the replacement is ordered within 5 years after the date of the initial placement or the last replacement if it was eligible for reimbursement under this Group Policy.
- (d) Replacement of an existing denture is eligible only if the existing denture can't be made serviceable. The replacement will be of the value and quality of the original denture (as determined by the Company).
- (e) Replacement of an existing temporary denture is eligible only if the insured person was covered under this Group Plan when the temporary denture was installed. If the temporary denture is more than a year old, it may be considered "permanent" and would then not qualify for replacement.
- (f) This Dental Plan includes an "**open space**" limitation. If the existing denture is not being replaced, charges for
 - * a complete or partial denture, or
 - * to add teeth to an existing dentureare eligible only to replace natural teeth that are extracted while the insured person is covered under this Group Plan. If the teeth were extracted prior to the effective date of the person's insurance under this Group Plan, complete dentures, partial dentures or the addition of teeth to dentures are **not eligible**.

DENTAL BENEFITS

TYPE B MAJOR RESTORATIVE SERVICES

(Services Other Than Dentures - implant crowns)

1. SERVICES OTHER THAN DENTURES OPTION

This Option covers major restorative services that are required to:

- * restore teeth or reconstruct a tooth, or
- * replace missing teeth by using fixed bridges.

Eligible expenses include:

- * crowns, including the crown only that is required as a result of Dental implant surgery (note that a crown following a root canal is not necessarily an eligible expense and we'll need a Pre-Determination in order to decide if it's payable)
- * fixed bridges (subject to #8 "Alternative Treatment" in the General Provisions for Dental)
- * inlays and onlays (subject to #8 "Alternative Treatment" in the General Provisions for Dental)
- * cast restorations
- * laboratory charges for prosthodontic materials.

Important: For any crown or bridge procedures, inlays or onlays, pre-treatment x-rays must be submitted to Equitable Life to be reviewed by our Dental Consultant.

2. EXCLUSIONS AND LIMITATIONS

- (a) Replacement of lost or stolen fixed bridgework is not eligible.
- (b) Replacement of an existing restoration is not eligible if the restoration is ordered within 5 years after the date of the initial placement or last replacement if it was eligible for reimbursement under this Group Policy. This time period doesn't apply if the replacement is required as a result of injuries caused solely through accidental, violent and external causes and the person is insured under this Group Plan at the time of the injury.
- (c) Replacement of an existing restoration is eligible only if the existing restoration can't be made serviceable. The replacement will be of the value and quality of the original restoration (as determined by the Company).
- (d) Full or partial dentures are not covered.
- (e) For bridges and crowns that are eligible on molar (back) teeth, only metal bridges and metal crowns are an eligible expense, not porcelain fused to metal.
- (f) This Dental Plan includes an "**open space**" limitation. If the existing fixed bridgework or cast restoration is not being replaced, charges for
 - * fixed bridgework (including crowns, inlays and onlays forming the abutments), or
 - * cast restorations, or
 - * crowns for Dental implantsare eligible only to replace natural teeth that are extracted while the insured person is covered under this Group Plan. If the teeth were extracted prior to the effective date of the person's insurance under this Group Plan, fixed bridgework or cast restorations are **not eligible**.
- (g) Dental surgery required in preparation for a Dental implant is not eligible.

SURVIVOR BENEFIT (PREMIUM WAIVED)

1. DESCRIPTION OF THIS BENEFIT

If you and your eligible dependents are insured under this Group Policy on the date of your death for the benefits included under the Survivor Benefit, those benefits will continue for your eligible dependents.

Premiums are "waived" (are not payable) once the Survivor Benefit begins.

2. WHAT BENEFITS ARE INCLUDED IN THE SURVIVOR BENEFIT?

The **Schedule of Benefits page** in this booklet shows:

- * what benefits are included
- * the **Maximum Period for Survivor Benefit** (the maximum length of time that the Survivor Benefit could be in effect)

3. WHEN DO THE SURVIVOR BENEFITS TERMINATE?

Survivor Benefits and the premium waiver terminate on the earliest of the following dates:

- * the date the Maximum Period for Survivor Benefit ends
- * the date your spouse or a dependent child becomes eligible for similar coverage somewhere else
- * the date a dependent child no longer meets the definition of an eligible dependent (as shown on the General Provisions for Dependents page and on the Schedule of Benefits page in this booklet)
- * the date your spouse remarries or qualifies as the spouse of another person
- * the date this Group Plan terminates.

