



## **Kawartha Pine Ridge District School Board**

### **Elementary Teachers**

Contract Numbers  
Claim Secure – 2747  
Manulife - 38122  
AIG - 9114600

Effective September 2008



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## General Information

***The information contained in this section applies only to benefits for which ClaimSecure is the insurer or “Plan Administrator”. Your employer is the Kawartha Pine Ridge District School Board “Kawartha Pine Ridge DSB” or “KPRDSB”).***

### **About this booklet**

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer’s group contract (the “Group Contract” or “Plan”) with ClaimSecure. The company previously mentioned is referred to as the “Benefits Carrier” or the “Plan Administrator” in this booklet.

Your group benefits may be modified or changed because of an amendment to the group contract, or because of a change in your age, class, earnings, dependent status, etc. The new benefits become effective on the date the change affecting your benefits occurred. The benefits outlined in this booklet are not guaranteed.

If your benefits change, payments for services and supplies received before the date of the change will always be based on plan benefits in effect before the change.

Kawartha Pine Ridge DSB reserves the right, through the process of negotiations, to amend, alter, or eliminate benefits offered under the group benefit plan, in whole or in part, from time to time without advance notice. If changes are made to the group benefit plan, they will be communicated to you as soon as possible after the changes have been finalized.

Notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If you have any questions about the information in this employee benefits booklet, you need additional information about your group benefits, please contact your employer.

This booklet is a summary of the principal features of the plan, but the ClaimSecure Master Application – Health & Dental Benefits, contract number 2747, issued to Kawartha Pine Ridge DSB by ClaimSecure is the governing document. In the event of any variation between the information provided in this summary and the provisions of the governing document, the latter will prevail.

All references to group contract in this booklet mean the “ClaimSecure Master Application Health and Benefits” contract.

**Eligibility**

To be eligible for group benefits, you must be a resident of Canada and meet the following:

- you are a permanent employee.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the schedule number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to three (3) months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

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

**Who qualifies as your eligible dependent**

Your eligible dependent must be your eligible spouse or your child and a resident of Canada.

Your eligible spouse means an individual who, at the time that the coverage is provided, is your legal spouse, or common-law spouse, as described below:

- A legal spouse is the person who is lawfully married to you according to applicable provincial legislation and who is living with you.
- A common-law spouse is a person of the same or opposite sex who is living with you in a conjugal relationship and who has been publicly represented as your spouse for at least nine (9) months.

You can only cover one spouse at a time. In case of conflict between the two, your legal spouse will be considered your eligible spouse over a common-law spouse.

Your children and your eligible spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an education institution recognized by the Canada Revenue Agency is also considered an eligible dependent as long as the child is under age 25 and dependent on you for financial support. Proof of full-time enrolment must be provided to the Benefits Department each school year to ensure uninterrupted benefit coverage.

If a child becomes handicapped before the limiting age, we will continue coverage and they will be considered an eligible dependent as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and

- the child depends on you for full financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify your employer.

In this booklet, "Participant" or "covered person" is defined as the individual entitled to benefit coverage pursuant to the terms of the ClaimSecure group contract and includes eligible spouse and dependent(s).

## Enrolment

You must enrol to receive benefit coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For an eligible dependent to receive coverage, you must request dependent coverage. Information concerning enrolment and dependent coverage can be obtained from your employer.

In both you and your spouse are employed by Kawartha Pine Ridge District School Board, you may both enrol for employee coverage under the External Health Care, Semi-private Hospital Care and Dental Care benefits or one of you can be enrolled as the dependent of the other. You cannot be enrolled as both an employee and a dependent. As well, all eligible dependent children must be registered under either yourself or your spouse to be eligible for dependent child coverage.

If you or your dependents are covered for comparable Extended Health Care, Semi-private Hospital Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

Should you wish to enrol for benefit coverage you may do so within the first 31 days of becoming eligible for benefit coverage. If you fail to enrol within this time limit, you will have to wait until the next open enrolment period, which is September and February of each year and you may have to provide proof of good health at your own expense.

## When coverage begins

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

## Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contact. Any resulting change in the coverage will take effect on the date of the change in circumstances.

You may request a change within 31 days of a change such as:

- an increase in the hours worked per week;
- your dependent status, such as acquiring a spouse or child, or;
- losing comparable coverage through your spouse's plan.
- if you are not actively working when the change occurs, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the coverage occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

#### **Updating your records**

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of eligible dependents
- change of spousal status
- change of name
- change of beneficiary

It is your responsibility to ensure that your benefit enrolment information is current.

#### **When coverage terminates**

As an employee, your coverage terminates on the earlier of the following dates:

- the date your employment ends for any reason other than retirement pension;
- the date you are no longer actively working;
- the date you no longer satisfy the eligibility conditions under the group contract;
- the end of the period for which premiums have been paid to KPRDSB for your coverage;
- the date the group contract terminates.

Your dependent's coverage terminates on the earlier of the following dates:

- the date your coverage terminates; or

- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage outlined above may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefit booklet. In the event that you require further clarification, please contact your employer.

If you die while covered by this plan, coverage for your eligible dependents will continue until the earlier of the following dates:

- the last day of the second month following the date of your death;
- the last date of the month in which your spouse reaches age 65;
- the date the person would no longer be considered your eligible dependent under this plan if you were still alive; or
- the date the benefit provision under which the eligible dependent is covered terminates.

### **Replacement Coverage**

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

### **Continuation of coverage and premium payment**

When coverage terminates because your employment ends or you are no longer actively at work, the KPRDSB may continue coverage for you in the following circumstances provided within KPRDSB procedure and/or the terms of the Collective Agreement.

- if you are absent from work due to illness, coverage may be continued until the expiry of sick leave credits.

Also, your coverage under this contract may be continued:

- during pregnancy, maternity/parental leave;
- during the statutory notice period for termination of employment as required by relevant legislation or during additional notice periods as determined by the KPRDSB;
- for employees who are employed on a continuous 10 month basis, during the employee's schedule summer lay-off. However, benefits may not continue for more than 3 months during the lay off; or
- during any period you are on approved leave of absence.

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An employee who is on an approved leave of absence and is not continuing to receive remuneration from KPRDSB, may be provided with an election to participate in continued benefit coverage. If the employee elects to continue benefit coverage they will be expected to provide the premium payment for the benefits as directed by the KPRDSB.

**Note:** If continuing coverage is elected, premium payments are the sole responsibility of the employee. KPRDSB will not contribute to the premium payments.

### **Making claims**

The Plan Administrator is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim. All claim forms are available on myKPR. There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. All claims must be made in writing on forms approved by the Plan Administrator.

No legal action may be brought by you more than two years after the date we must receive your claim forms or more than one year after we stop paying disability benefits.

### **Coordination of benefits**

If you are covered for Extended Health Care, Semi-private Hospital Care or Dental Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

- you and your spouse should first submit your own claims through your respective employer's plan.
- if you are claiming expenses for your eligible dependent children, and both you and your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year (the year of birth is not considered). For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- you may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan. The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

Your employer can help you determine which plan you should claim from first. If any claims are eligible for reimbursement from any government or automobile insurance plan, claims should first be submitted to that plan. The balance of the claim may be submitted to this plan as described above.

### **Medical examination**

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefits.

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<b>Recovering overpayments</b>	We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.
<b>Definitions</b>	Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.
<b><i>Accident</i></b>	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
<b><i>Appropriate treatment</i></b>	Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when the Benefits Carrier believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.
<b><i>Basic earnings</i></b>	Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.
<b><i>Doctor</i></b>	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
<b><i>Illness</i></b>	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person, which causes total disability is an illness.
<b><i>Retirement date</i></b>	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.
<b><i>We, our and us</i></b>	We, our and us means Current Benefits Provider.

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## Extended Health Care

**Plan Administrator**

*This benefit is administered by ClaimSecure.*

**General description of the coverage**

Extended Health Care Benefits coverage provides protection against the cost of those medically necessary services and supplies for which there is only partial or no reimbursement from provincial health plans. The coverage provided covers only those expenses which are considered reasonable and customary for the service provided in the geographic area where the expense occurred.

The following services and supplies are included in your coverage where permitted by law and to the extent they are not covered under your Provincial Medicare Plan.

The Plan Administrator shall pay reasonable and customary charges in the geographic area where the claim occurs subject to the provisions of the group contract. Services, supplies and equipment will be covered if:

- Ordered by a physical or other health care provider. A physician means a doctor of medicine who is legally qualified to practice medicine and is licensed by the appropriate board in the jurisdiction where his or her services are rendered. A health care provider is defined as a licensed certified, registered or chartered practitioner licensed to practice in the jurisdiction where the services are provided.
- Medically necessary services are defined as service, equipment or supplies consistent with the diagnosis and treatment of the condition and in accordance with the standards of good medical practice. The order, recommendation or approval of a physician does not make the service medically necessary. Final determination of what is considered medically necessary shall be made by the Plan Administrator in conjunction with the terms of the group contract.
- Amounts are still payable after all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance specified in the group contract have been applied.
- You are eligible for the benefit coverage.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchase or rented.

In this section, *you* means the employee and all eligible dependents covered for Extended Health Care benefits.

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The benefit year is from January 1 to December 31.

**Deductibles** The deductible is the portion of the claims you submit that you are responsible for paying.

For prescription drugs there is a deductible of \$0.50 for each prescription or refill.

For other expenses, there is a deductible of \$10 each benefit year for each person up to a minimum of \$20 per family. After this deduction has been paid, claims will be paid up to the maximum percentage of coverage applicable to you based on your benefit coverage.

**Prescription drugs** We will cover 100% of the cost of drugs or supplies listed in the Kawartha Pine Ridge District School Board Benefits Carrier Formulary, which have a Drug Identification Number (DIN) and are prescribed in writing by a doctor or dentist and are obtained from a pharmacist. For these expenses you should use your drug card.

***The Kawartha Pine Ridge District School Board Benefits Carrier Formulary*** A list of eligible drugs (and supplies) which is at least equal to the Ontario Drug Benefit Plan (ODB), where the products are determined, subject to the terms of the Collective Agreement, to be therapeutically useful and cost effective. If you are unsure about what drugs are covered under your benefit coverage please consult your Plan Administrator.

Notwithstanding the foregoing, the following drugs or supplies are also covered, however, you must submit a claim to the Plan Administrator for reimbursement. These drugs and supplies are not subject to the prescription deductible.

- vaccines and compound serums that legally require a prescription.
- colostomy supplies.
- varicose vein injections, if medically necessary.

For the above items, payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period, or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor provided such drugs continue to be on the Kawartha Pine Ridge District School Board Managed Health Care Formulary.

***Drug Exception Process*** In the event that the Kawartha Pine Ridge District School Board Benefits Carrier Formulary does not contain any acceptable substitute with equivalent therapeutic value, a claim for the additional 30% reimbursement for the prescription drug that is required may be submitted manually with a Drug Exception Request Application.

You may make a written request to your employer through the Plan Administrator for the additional 30% reimbursement for the prescription drug you are requesting with this application.

The coverage under this Application is limited to legally prescribed drugs. The relevant sections of the Drug Exception Request Application must be completed explaining why the prescription should be filled as written. The Drug Exception Request Application will be submitted to the Plan Administrator for review and adjudication.

Approval for coverage of the drug will depend on the following criteria:

- the drug must have been an eligible expense under the drug plan prior to the change to a Managed Formulary;
- there is no reasonable substitute that would be an effective treatment; and
- other therapeutic alternatives have been tried and proven ineffective.

The Plan Administrator will provide you with a written decision. If the drug is approved, you will be reimbursed for up to 100% of its costs. This drug will be added to your drug card for future purchases and you will not have to seek approval for the drug again. The Plan Administrator will endeavour to have the matter resolved within twenty (20) working days after your initial written request.

If the Plan Administrator is unable to provide a decision on your application within twenty (20) working days you will be entitled to 100% reimbursement, provided the delay is not caused in any part by missing information on your application form.

***Ineligible drug expenses*** The KPRDSB will not pay for the following drugs, even when prescribed by a doctor or medical practitioner:

- any drug charge not listed on the Kawartha Pine Ridge DSB Managed Formulary on the date the expense is incurred (unless it is exempted as described in the section above);
- any charge for drugs not covered under the Pay Direct Drug Benefit in effect on July 1, 1992, under this plan, whether or not such medication is listed on the Kawartha Pine Ridge DSB Managed Formulary;
- any charge for **over the counter drugs**, whether or not prescribed in writing by a doctor, dentist or medical practitioner;
- drugs for the treatment of infertility, whether or not they require a prescription;
- products to help you quit smoking, whether or not they require a prescription;
- treatments for weight loss, including drugs, proteins, food or dietary supplements;
- Viagra or other erectile dysfunction drugs; and

- Vitamin B6/B12 compound(s).

Also, KPRDSB will not pay for any drug charge, including dispensing fee, for a person age 65 or over as they are eligible for coverage under the Ontario Drug Benefit Program.

**Generic limit** Any charge in excess of the cost of the lowest priced interchangeable generic product is considered an ineligible expense, regardless of the product actually dispensed, unless otherwise provided within the terms of the Collective Agreement.

**Other health professionals allowed to prescribe drugs** KPRDSB will reimburse certain drugs prescribed by other qualified health professionals, in the same way it would if a doctor or dentist prescribed the drugs, provided the applicable provincial legislation permits them to prescribe those drugs.

**Hospital expenses in your province** KPRDSB will cover 100% of the costs for hospital care in the province of your permanent residence. The deductible does not apply to these expenses.

KPRDSB will cover out-patient services in a public or private hospital and the difference between the cost of a semi-private hospital room and a private hospital room.

KPRDSB will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least three (3) consecutive days of in-patient hospitalization,
- it begins within forty-eight (48) hours of release from the hospital, and
- it is for rehabilitation and not primarily for custodial care.

The maximum period of coverage for treatment in a convalescent hospital of an illness due to the same or related causes is 180 days.

For purposes of this group contract, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are actually ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse or the use of beds set aside in an institution for any of these purposes.

**Expenses out of your province** KPRDSB will cover emergency medical services while you are outside the province of your permanent residence. KPRDSB will also cover referred services.

An *emergency* is an acute, unexpected condition, illness, disease or injury that requires immediate medical assistance. KPRDSB will pay 100% of the reasonable cost of qualified emergency services.

**Referred services** will be covered as below:

Reasonable and customary medical and transportation expenses for the insured person and an approved escort to a lifetime maximum of \$50,000, for a pre-approved medical referral, subject to the following conditions:

- The treatment must be unavailable where the insured person resides and where services are rendered in Canada, located at least five hundred (500) kilometres from where the insured person resides.
- The insured person’s attending physician and a specialist from a related medical field must recommend the treatment.
- The insured person’s Government Health Insurance Plan must agree to reimburse eligible medical expenses.
- Medical services and travel must take place within thirty (30) days of receiving approval from the insured person’s Government Health Insurance Plan, unless the earliest possible treatment date exceeds thirty (30) days from the date of approval.
- All medical referrals must be submitted in writing to, and pre-approved by Global Excel, along with supporting documentation.

For out of county medical coverage please see the Travel Medical Emergency Insurance Section.

***Emergency and referred services out of your province***

Expenses incurred for emergency and referred services outside the province where you live are subject to a lifetime maximum of \$1,000,000 per person or, if lower, any other applicable lifetime maximum.

**Medical Equipment/Supplies**

The following medical equipment and supplies are covered when prescribed by a medical doctor. Such equipment must be required for therapeutic use. The following coverage for supplies and equipment is available only on a rental basis. However, some equipment and/or supplies may be purchased at the discretion of the Plan Administrator. Pre-approval must be obtained by the Plan Administrator prior to the rental of any equipment or supplies.

Equipment that can be rented or purchased for temporary therapeutic use and is usually to be found in a hospital may be considered. You may be required to complete a questionnaire provided by the Plan Administrator.

**Note:** Provincial assistive device program maximums will be taken into consideration where applicable.

***Breathing Equipment***

- Continuous Positive Airway Pressure Machine (CPAP)
- CPAP Supplies replaceable every 12 months or sooner in the case of humidifier:
  1. filter (once every 12 months)
  2. Humidifier (as needed )
  3. mask (once every 12 months)

4. gel cushion for mask (once every 12 months )
5. nasal pillow --- examples of brand names: Mirage Activa Cushion (once every 12 months)
6. mouthpiece (once every 12 months )
7. tubing/headgear/chin strap (once every 12 months \*)

**Note:** One (1) CPAP machine per lifetime per Participant.

- Oxygen and the oxygen equipment needed for its administration
- Breathing unit (respirator)
- Apnea Monitors for respiratory dysrhythmia
- Aerochamber
- Tracheostoma tubes

#### ***Orthopaedic Equipment***

- Braces  
**Note:** Braces are wearable, orthopaedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body in the correct position.  
Exclusions: Elastic supports and foot orthotics and dental braces are not considered as an orthopaedic appliance.
- Splints: Including splints attached to a brace (Dennis Brown Splint)  
Exclusions; Intra-oral splints attached to a brace.
- Casts: Fibreglass, air and walking casts
- Cervical Collars

#### ***Prosthetic Equipment***

- External Breast Prosthesis  
**Note:** Required due to a total or radical mastectomy.
- Standard Artificial Limbs  
Exclusions: Myoelectric limbs.
- Artificial Eyes including repair and replacement.
- Stump Socks  
**Note:** Maximum of five (5) pairs per person per benefit year.

#### ***Mobility Aids***

- Standard Wheelchair, or where medically required electric wheelchairs. Maximum benefit of \$3,000.00 every sixty (60) consecutive months per Participant.  
**Note:** Pre-approval required from ClaimSecure.  
Exclusions: Wheelchair cushions
- Canes

**Other Medical  
Equipment**

- Crutches
- Walkers
- Supports
- Blood Glucose Monitoring Machines (glucometers), including reagent strips, prescribed by a dialectologist or a specialist in internal medicine. Maximum benefit is one (1) machine every sixty (60) consecutive months per Participant.
- Insulin Infusion Sets.  
Exclusions: Insulin Infusion Pump
- Surgical Brassieres  
Maximum benefit four (4) pairs per benefit year per Participant.  
**Note:** Following a mastectomy.
- Support Hose and Compression Stockings.  
Maximum benefit two (2) pairs per benefit period per Participant.
- Transcutaneous Nerve Stimulators for the control of chronic pain (Tens machine).  
**Note:** A Doctor's order is required.
- Cystic fibrosis equipment.
- Bone stimulator
- Supports: abdominal, back, spinal and wrist
- Colostomy and Ileostomy Supplies
- Custom-Made Burn Garments
- Urethral Catheters
- Plasma and blood transfusions
- Molded ear plugs when recommended by a Doctor
- Wigs  
Maximum benefit is \$200.00 per Participant per lifetime.  
**Note:** Available only to cancer patients undergoing radiation therapy or chemotherapy. Wigs do not require a doctor's order.

Exclusions: The medical equipment benefit does not include charges for the maintenance of medical equipment, rented or purchased. Rental costs may not exceed the purchase price.

**Excluded Medical Equipment**

As well, the following items are specifically excluded from your benefit coverage:

- Intermittent Positive Pressure Breathing Machines (IPPBs);
- Mist tent and Nebulizers;
- Shoulder Harnesses;
- Intra-uterine Contraceptive Devices (IUDs);
- Bed rails;
- Custom-made pressure supports for lymphedema;
- Head halters;
- Traction apparatus;
- Trapeze bars;
- Sanatorium treatment and facilities for treatment of drug and alcohol abuse;
- Orthopaedic mattresses; and
- Whirlpools.

**Private Duty Nursing**

Services of a Registered Nurse, Licensed Practical Nurse, or Registered Nursing Assistant, will be covered to a maximum Benefit amount of \$35,000 per benefit year per covered person covered under the plan.

**Note:** The Nursing Provider listed above may not reside in the Participant's home or be related to the Participant's family.

Services must be determined to be medically necessary by a medical doctor and must be provided in a Participant's home. Services rendered must require the skill of a Registered Nurse, Licensed Practical Nurse or Registering Nursing Assistant. Services must be pre-approved by the Plan Administrator with such approval being subject to periodic reassessment.

**Ambulance Service**

Charges for transportation of a licensed Ground and Air Ambulance Service to the nearest Hospital or other medical facility capable of providing the required care will be covered. Emergency transportation by rail and/or water is not covered by this group contract. Emergency Air Ambulance services do not require pre-approval. However, non-emergency Air Ambulance transportation does require pre-approval from the Plan Administrator.

**Accidental Dental**

Charges for the services of a licensed dental provider for the repair or replacement, including braces and splints, of sound natural teeth when caused by an external force or accident are covered. Services rendered must be within thirty-six (36) months of the date of the accident. We will not cover more than the fee stated in the current Dental Association Fee Guide for a general practitioner in the province of your permanent residence at the time that treatment is received.

**Note:** Prior to receiving treatment for accidental dental coverage, pre-approval must be obtained from the Plan Administrator. Please contact the Plan Administrator for more details.

**Hearing Aids**

The purchase of a new hearing aid(s) or repair of an existing hearing aid(s), up to a lifetime maximum of \$200 per person.

**Effective September 1, 2010**

The purchase of a new hearing aid(s) or repair of an existing hearing aid(s), \$500 per insured individual per 48 month period. For family members under eighteen (18) years or age, the coverage will be \$500 per 24 month period.

**Note:** A doctor or Audiologist's referral is required for the purchase of a hearing aid. Provincial assistive devices program maximums will be taken into consideration where applicable.

Exclusions: Hearing tests, batteries and ear moulds are not covered under the group contract.

- Orthotics** Custom Moulded Orthotics
- One (1) pair every twelve (12) months per Participant covered under Plan.

**Note:** Physician's or Chiropracist/Podiatrist's referral required. The referral must include the diagnosis of the condition and the symptoms, a gait analysis/biochemical exam, description of how the orthotic was constructed and the raw materials used. The orthotics must be dispensed by a licensed provider and the invoice must include the name and license number of the provider.

- Custom Made Orthopaedic Shoes/Boots and Orthopaedic Modifications** Custom Fitted Orthopaedic Shoes/Boots
- Note: Physician's or Chiropracist/Podiatrist's referral required. The referral must include the diagnosis of the condition and the symptoms, a gait analysis/biochemical exam and a description of how the custom-made shoe was constructed and the raw materials used. The shoes must be dispensed by a licensed provider and the invoice must include the name and license number of the provider.

- Off the Shelf Orthopaedic Shoes and Modifications** Off the shelf orthopaedic shoes and or modifications.
- Note: Physician's or Chiropracist/Podiatrist's referral required. The referral must include the diagnosis of the condition and the symptoms, a gait analysis/biochemical exam and a description of the modifications made to the shoes including a breakdown of the costs and the brand name of the shoe. The shoes must be dispensed by a licensed provider and the invoice must include the name and license number of the provider.

Combined maximum benefit \$150.00 per benefit period per covered person.

Orthopaedic shoe(s) or permanent modification of a regular shoe. Modifications may include sole buildups, lifts, wedges, steel plates, calliper plates, stirrups to accommodate braces and self-adhesive closures for each participant covered under the plan.

Exclusions: The Orthopaedic Shoe Benefit does not include purchase of shoes or shoes purchased only to accommodate orthotics or comfortable walking shoes such as Birkenstock, Nike, Brooks, Rockport, etc.

**Diagnostic Services** Diagnostic laboratory and x-ray procedures, which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examination performed are covered when coverage is not available under the provincial government plan. Diagnostic testing must be requested by a medical doctor or licensed medical practitioner as defined in this booklet. Tests performed by a doctor's office or pharmacy are not covered.

Treatment of an illness by the user of radiotherapy.

**Vision Care Services**

Frames and prescriptions lenses and tinting, or prescription contact lenses, laser eye surgery, and eye examinations with a maximum of \$50.00 per exam per participant.

- Maximum benefit is \$300 every twenty-four (24) consecutive months per participant and every twelve (12) consecutive months per participant under the age of eighteen (18) years.

**Effective September 1, 2010**

Frames and prescriptions lenses and tinting, or prescription contact lenses, laser eye surgery, and eye examinations with a maximum of \$100.00 per exam per participant.

- Maximum benefit is \$500 every twenty-four (24) consecutive months per participant and every twelve (12) consecutive months per participant under the age of eighteen (18) years.

**Note:** An ophthalmologist or licensed optometrist prescription is required and frames and lenses must be obtained from an ophthalmologist, licensed optometrist or optician.

Exclusions:

- Refractions required by KPRDSB, government body or other third party.
- Safety glasses or safety goggles.
- Replacement of lost, stolen or broken lenses or frames
- Duplicated or spare eyeglasses.
- Intra-ocular les implants.
- Prescription or non-prescription sunglasses.
- Magnifying glasses.

**Paramedical services**

Services provided by the following licensed, certified or registered professional Paramedical Practitioners, so long as the services being provided are within the scope of their profession. KPRDSB will cover 100% of the cost of treatment up to annual maximum, after you pay deductible, for each category of Paramedical Practitioners listed below:

Category 1:           • licensed physiotherapists, when order by a doctor.

Category 2:           • licensed speech therapists or psychologists, when ordered by a doctor, up to a maximum of \$200 per Participant per benefit year.

**Effective September 1, 2010**

- licensed speech therapists or psychologists, when ordered by a doctor, up to a maximum of \$500 per Participant per benefit year
- Category 3:
- licensed osteopaths, chiropractors, podiatrists/chiropractists, naturopaths, massage therapists (when ordered by a doctor) or Christian Science Practitioners.

Maximum benefit for all such services listed in Category 3, including the services of massage therapists, is \$200 per Participant per benefit year.

**Note:**

- Payment for the services of massage therapists is limited to \$7 per visit, up to a maximum of twelve (12) visits per person per benefit year.

**Effective September 1, 2010**

- licensed osteopaths, chiropractors, podiatrists/chiropractists, naturopaths, massage therapists (when ordered by a doctor) or Christian Science Practitioners up to a maximum of \$500 per participant per benefit year.

**Note:**

- X-ray examination provided by a licensed chiropractor, osteopath practitioner, chiropractist and podiatrist are eligible and included in the benefit maximum. Maximum of one x-ray examination for Paramedical Practitioners per benefit year.

Exclusions: Occupational therapy, homeopathy and acupuncture treatments are not covered. Supplements and remedies ordered by Paramedical Practitioners are not covered.

We will not pay for the cost of services rendered by a podiatrist in Ontario unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

**When coverage ends**

For active employees retiring on June 30:  
Extended Health Care coverage will end on August 31<sup>st</sup> which coincides with or follows the date the employee reaches age 70 or retires (unless the employee elects early retiree coverage), whichever is earlier.

For all other active employees:  
Extended Health Care coverage will end on the last day of the month in which the employee reaches age 70 or retires (unless the employee elects early retiree coverage) whichever is earlier.

For employees who elect early retiree coverage:  
Extended Health Care coverage will end on the last day of the month in which the employee reaches age 65.

**General  
Limitations &  
Exclusions for  
Extended Health  
Benefits**

In addition to the limitations and exclusions of this benefit plan, and those limitations and exclusions contained in the description of the benefits, the Extended Health Benefits do not cover services, supplies or equipment that are primarily intended to facilitate:

- Expenses that private insurers are not permitted to cover by law.
- Services or supplies the person is entitled to without charge by law or for which a charge is made only because the person had insurance.
- Services and supplies that do not represent reasonable treatment.
- Services or supplies associated with: services rendered for cosmetic reasons, exercise, weight loss, physical fitness or sports, environmental or atmospheric control in the home or workplace.
- The diagnosis or treatment of infertility.
- Services or supplies associated with covered items, unless specifically listed as a covered expense.
- Extra medical supplies that function as spares or alternatives.
- Services or supplies received outside Canada except as provided under the Travel Medical Emergency Insurance.
- Services covered by any Workplace Safety and Insurance Board unless prohibited by law.
- Services and supplied not covered in the master contract between KPRDSB and ClaimSecure.
- Expenses for services, treatment or supplies, which are considered experimental in nature.
- Health care services or supplies required as a result of war, terrorism, rebellion or hostilities of any kind, whether or not the covered person is a participant.
- Health care services or supplies required as result of participant in a riot or civil disturbance.
- Health care services or supplies due to intentional self-inflicted injury.

**When and how to  
make a claim**

To make a claim, complete the claim form that is available on myKPR.

In order for you to receive benefit we must receive the claim no later than one year from the date the expense is incurred or thirty (30) days from the date your extended health coverage ends.

All Claim forms and pre-approvals should be mailed to:

ClaimSecure  
43 Elm Street  
Suite 200  
Sudbury, ON  
P3C 1S4

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## Travel Medical Emergency Insurance

**Plan Administrator**

*This benefit is administered by ClaimSecure.*

**General description of the coverage**

Claim Secure Travel Plan is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provision of the policy, the provisions of the Travel Plan Policy shall govern.

Claim Secure has contracted Global Excel to provide medical assistance services and pay claims under the Travel Plan Policy Coverage Period: sixty (60) days per trip.

The Travel Plan Policy covers expenses that are:

- Incurred outside the province or territory of residence of the Participant.
- Medically necessary.
- Reasonable and customary.
- Incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period.
- In excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage, and
- Legally insurable.

Subject to a maximum total benefit of \$5,000,000 per Participant. In the event of an emergency, you must call Global Excel immediately. The following emergency telephone numbers are also shown on the back of the travel card provided along with this booklet.

- From Canada and U.S., call toll-free .....1-877-566-8276
- From anywhere else, call collect .....1-819-566-8276

If you incur any expenses without prior approval by Global Excel, such expenses may be covered, except where the Policy booklet expressly requires prior approval or authorization of Global Excel.

Please refer to the Travel Plan booklet for details of benefits covered under this policy. You received this booklet when you first enrolled for benefits.

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## Semi-Private Hospital Coverage

***This benefit is administered by ClaimSecure.***

### General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Your current benefits carrier only acts as administrator on behalf of the contractor holder.

In this section, *you* means the employee and all dependents covered for the Semi-Private Hospital benefit.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

An expense must be claimed for the benefit year in which the expenses is incurred. You incur an expense on the date the service is received.

The benefit year is from January 1 to December 31.

### Hospital expenses in your province

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

#### ***Semi-Private Hospital***

We will cover out-patient services in a hospital and the difference between the cost of a ward and a semi-private hospital room.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

### When coverage ends

Semi-private Hospital coverage will end when the employee retires or reaches age 70, whichever is earlier.

**Payments after coverage ends**

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within ninety (90) days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

For the purpose of this provision, a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

**What is not covered**

We will not pay for the costs of:

- services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees and extra billing if the legislation allows private plans to cover the user fees and extra billing.

## Dental Care

**Plan administrator  
General description of the coverage**

***This benefit is administered by ClaimSecure***

ClaimSecure Dental Care coverage provides protection against the cost of dental services which are often significant and unexpected. To be considered a covered expense, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred and will be limited to the maximum fee level of the current Dental Fee Schedule for your province of residence. The service must be incurred while you are eligible for benefits under the plan.

Dental Fee Schedule means the schedule of fees approved and published by a provincial dental association and stipulated for use under this benefit plan in the master contract. When treatment outside Canada is necessary, the approved fee schedule used will be the fee schedule of the province in which the Participant resides.

Dental coverage covers necessary dental treatment by a dentist or physician or by other qualified personnel under the direct supervision of the dental or medical profession (e.g., dental assistants or dental hygienists) and will also cover necessary services rendered by dental mechanics, denturologists, and denturists where they are permitted by law to deal directly with the public.

Where alternative forms of treatment are available, covered expenses will be limited to the reasonable and customary charge for the least expensive form of treatment consistent with generally accepted dental practice.

The specialist dental fee schedule option is not included. Services rendered by a Dental Specialist will be paid in accordance with the suggested provincial fee schedule for general practice Dentists.

When deciding what we will pay for a procedure, we will first find out if other or alternative procedures could have been done. These alternative procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternative procedure.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

**Deductible** There is no deductible for coverage listed in this section.

<b>Benefit year maximum</b>	<p>Level 1 &amp; 2 services – 100% coverage based on the current Dental Fee Schedule.</p> <p>Level 3 services – 70% reimbursement to an annual maximum of \$1,500 per Participant.</p> <p><b>Effective September 1, 2010</b></p> <p>Level 3 services – 70% reimbursement to an annual maximum of \$2,100 per Participant.</p> <p>TMJ and Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.</p> <p>If your coverage starts in the second half of a benefit year, the maximum amount for the benefit year will be reduced by 50%.</p>
<b>Lifetime maximum</b>	<p>Level 4 services – 70% reimbursement to a lifetime maximum of \$2,000 per Participant.</p> <p><b>Effective September 1, 2010</b></p> <p>Level 4 services – 70% reimbursement to a lifetime maximum of \$2,500 per Participant.</p> <p>TMJ Appliances and Procedures – 70% reimbursement to a lifetime maximum of \$1,000 per covered person.</p> <p><b>Note:</b> Temporomandibular (TMJ) joint is your hinge joint to your jaw.</p>
<b>Predetermination</b>	<p>When a planned course of dental treatment is expected to exceed \$500 or more, it is highly recommended that ClaimSecure receive a predetermination of benefits from the attending dental provider. This predetermination should include a description of the proposed treatment, an estimate of the charges for services and dental radiographs where applicable. ClaimSecure will determine and confirm the amount of approved benefits. The predetermination must be submitted manually on a dental claim form and mailed to ClaimSecure.</p>
<b>Level 1 Services</b>	<p>Level 1 services include Diagnostic, Preventive, Minor Restorative, Minor Oral Surgical, Prosthetic Denture Maintenance, Denture Maintenance, and Adjunctive Services.</p> <p><b>Diagnostic Services</b> are services to diagnose a dental condition.</p> <p>The following diagnostic services are covered:</p> <ul style="list-style-type: none"> <li>• Complete examination A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, pulp vitality tests, recording history, treatment planning, case presentation and consultation with the patient. <i>Limitation:</i> One (1) complete examination every thirty-six (36) consecutive months.</li> </ul>

- Recall examination  
*Limitation:* One (1) recall examination every nine (9) months for adults and every six (6) months for children under 18.
- Specific examination  
*Limitation:* One (1) specific examination every recall exam.  
Recall and specific examination include a complete examination of the hard and soft structures, checking occlusion, pulp vitality tests and consultation with the patient.

**\*Please note: Any of the above (3) three examinations must be separated from any other examination by at least 6 months for children up to age 18 or at least 9 months for any other person.**

- Periodontal specialty examinations to a maximum of one (1) examination every thirty-six (36) consecutive months.
- Prosthodontic examinations  
*Limitation:* One (1) examination every thirty-six (36) months.
- Oral Surgical Specialty Examinations to a maximum of one (1) examination every thirty-six (36) consecutive months.
- Endodontic Specialty Examinations to a maximum of one (1) examination every thirty-six (36) consecutive months.
- Emergency examinations  
An emergency examination includes an evaluation for acute pain or infection, and pulp vitality tests.
- Complete series of radiographs or panoramic radiograph  
A complete series of x-rays is 10-14 individual x-rays, including bitewings, showing all the teeth in the mouth. A panoramic radiograph is a large panoramic view of the entire mouth.

*Limitation:* One (1) complete series or panoramic radiograph every thirty-six (36) consecutive months.

- Extra-oral radiographs limited to two (2) radiographs every twelve (12) consecutive months.
- Bite-wing radiographs  
Bite-wing radiograph is a routine check-up x-ray used to detect decay in molar teeth.  
*Limitation:* Four (4) every twelve (12) consecutive months.  
**Note:** No electronic claim submission.
- Occlusal radiographs  
*Limitation:* Two (2) every twelve (12) consecutive months.

- Periapical radiographs  
X-ray of single teeth, called periapical x-rays  
*Limitation:* Four (4) periapical radiographs every two (2) consecutive months.
- Cytological tests
- Bacteriological tests/analyses
- Histopathological tests/analyses
- Microbiological tests/analyses
- Unmounted diagnostic casts  
*Limitation:* one (1) every thirty-six (36) consecutive months

**Preventive Services** are services to prevent future dental problems.

The following preventive services are covered:

- Fluoride  
*Limitation:* One (1) fluoride treatment every recall period, nine (9) months for adults and six (6) months for children under age 18.
- Oral hygiene instruction  
Instruction on how to brush and floss.  
*Limitation:* One (1) occurrence every thirty-six (36) months.
- Polishing  
*Limitation:* One (1) unit of polishing every recall period, nine (9) months for adults and six (6) months for children under age 18.
- Scaling/root planning  
Scaling means removing calcium deposits above and below the gum line. Root planning is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.  
*Limitation:* Eight (8) units per Participant per benefit year.
- Interproximal diskings  
*Limitation:* Coverage for eligible dependent children under age nineteen (19) only.
- Pit and fissure sealants  
This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Only children under 19 are covered for this treatment. A child is covered for one (1) treatment per permanent molar tooth.  
*Limitation:* One (1) treatment per permanent molar teeth for eligible dependent children under age nineteen (19).  
**Note:** No electronic claim submission.

- Space maintainers & maintenance of space maintainers  
You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

You can only have one (1) appliance per quadrant unless another tooth in that quadrant is subsequently lost. Teeth are divided into four (4) quadrants: upper right, upper left, lower right and lower left.

This procedure includes the design, separation, fabrication, insertion, cementation, removal and six (6) months follow-up care.

Maintenance includes adjustments and recementation, addition of clasps or activating wires, repairs and recementation, and six (6) month follow-up care.

*Limitation:* Limited to primary teeth only

**Note:** No electronic claim submission.

**Minor Restorative services** are services to repair teeth.

The following minor restorative services are covered:

- Amalgam and composite or acrylic restorations  
An amalgam filling (silver) procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling.  
  
A composite or acrylic (white) filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.  
*Limitation:* You are covered for composite fillings on front teeth only.
- Bonded amalgam restorations.
- Prefabricated restorations (prefabricated crowns)  
This coverage is only available when a permanent crown is not being installed. You are covered for pre-fabricated metal or plastic restorations, including stainless steel crown.  
This procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, and cementation of crown.  
*Limitation:* Replacement every thirty-six (36) months.  
**Note:** No electronic claim submission.
- Tooth coloured restorations  
*Limitation:* To anterior and bi-cusped teeth only. Tooth coloured restorations performed on molar teeth are reduced to the cost of non-bonded amalgam restorations.

- Caries, trauma and pain control  
You are covered for sedative fillings that are applied to very deep cavities to reduce pain. This procedure includes local anaesthesia, removal of decay or removal of existing restoration, occlusal adjustment, pulp cap and placement of sedative filling.

**Minor Oral Surgical services** include oral surgery services.

Oral surgery includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation. A surgical site will be considered a sextant unless specified as a quadrant.

The following minor oral surgical services are covered:

- Alveoplasty  
This procedure includes remodelling, excision, removal and reduction of bone.
- Antral surgery  
Extractions and residual root removal
- Frenectomy
- Hemorrhage control
- Mucous Fold Extension\*
- Repairs of Lacerations\*
- Remodelling floor of mouth\*  
*Limitation:* Frequency limitation of relining and rebracing dentures to combine every thirty-six (36) consecutive months.
- Stomatoplasty\*
- Surgical excision
- Surgical exposure
- Surgical incision
- Surgical removal of Foreign Bodies
- Treatment of salivary glands
- Vestibuloplasty

**Denture Maintenance services** includes services for the repair of prosthetic appliances.

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The following maintenance services are covered:

- Denture rebase or reline  
Rebasing dentures means fitting dentures with a new base. Relining dentures means adding material so that the dentures fit properly. These services include six (6) months follow-up care.  
*Limitation:* One (1) reline or rebase every twelve (12) consecutive months.
- Denture repairs  
Repairing dentures means fixing broken or damaged dentures. This procedure includes six (6) months follow-up care.
- Bridge reconstruction

**Adjunctive services include services that are not classified elsewhere.**

The following adjunctive services are covered:

Related surgical services

The following services only when you have eligible complicated oral surgery:

- Deep sedation
- General anaesthesia, including pre-anaesthetic evaluation and post-anaesthetic follow-up: general anaesthesia, deep sedation and provision of dental and anaesthetic facilities, equipment and supplies.
- Nitrous oxide
- Parenteral conscious sedation, including conscious sedation: inhalation technique, intravenous sedation, intramuscular injections of sedative drugs; and combined techniques of inhalation plus intravenous or intramuscular injections.
- Provision of anaesthetic facilities, equipment and support
- Therapeutic injections: administration of intramuscular drug injections
- Neuroleptanalgesia.

**Level 2 Services** Level 2 Services include Endodontics and Periodontics Services.

**Endodontic services** include services to treat the pulp chamber of the tooth. Endodontics is root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

The following endodontic services are covered:

- Root canal therapy  
This procedure includes treatment plan, pulp vitality test, opening and drainage, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, relieving occlusion, smoothing tooth, and follow-up care.

If, root canal therapy is performed on the same tooth by the same dentist within three (3) months of opening and drainage, pulpotomy or pulpectomy, the amount payable is reduced by the amount previously paid for such opening and drainage, pulpotomy or pulpectomy.

*Limitation:* Routine initial root canal therapy. Complicated root canal therapy reduced to cost of routine root canal therapy. Retreatment of root canal is covered by only if at least sixty (60) consecutive months have elapsed from the date of the initial root canal therapy.

**Note:** No electronic claim submission.

- **Apexification**  
This procedure includes treatment plan, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, placement of dentogenic media, and follow-up care. You are only covered for permanent teeth.  
*Limitation:* To permanent teeth only.  
**Note:** No electronic claim submission.
- **Apicoectomy**  
This procedure includes treatment plan, local anaesthesia, clinical procedure with appropriate x-rays, root resection, apical curettage, and follow-up care.
- **Hemisection**
- **Pulpotomy**  
This procedure includes treatment plan, local anaesthesia, clinical procedure and appropriate x-rays, and follow-up care.
- **Retrofilling**  
This procedure includes apicoectomy, curettage and root-end filling.
- **Root amputation**  
This procedure includes recontouring tooth and furca.  
*Exclusion:* Bleaching of endodontically treated teeth, intentional removal and implantation of teeth, open and drain pulpetomy.

**Periodontic services** include services to treat the tissue supporting the teeth. Periodontics is the treatment of bone and gum disease.

The following periodontic services are covered:

- **Periodontal appliances and maintenance**  
A periodontal appliance is used to treat gum diseases. Includes impression, insertion and adjustments within six (6) months of insertion. Periodontal appliance adjustment or reline is also covered.  
*Limitation:* One (1) adjustment or reline every twelve (12) consecutive months. One appliance per arch every twelve (12) consecutive months
- **Occlusal equilibration**  
This treatment is only available when you have gum surgery or temporomandibular joint (TMJ) treatment  
*Limitation:* One (1) unit per visit and two (2) units per twelve (12) months.

- Periodontal abscess or periocoronitis  
This procedure includes lancing, scaling, curettage, medication, or surgery.  
*Limitation:* One (1) unit per treatment to a maximum of two (2) units every twelve (12) months.

If you have surgery, coverage depends on how many teeth are involved. You are covered for each type of surgery once every twelve (12) months on the same surgical site.

Periodontal surgery includes local anaesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant. The mouth is divided in six (6) sextants. The allowance for fewer teeth may be prorated. Periodontal surgery includes the following procedures:

- Periodontal surgery – flap approach  
*Limitation:* One (1) flap approach surgery per site every twelve (12) months.
- Periodontal surgery – gingival curettage  
Surgical procedure performed by the dentist under local anaesthesia.  
*Limitation:* One (1) gingival curettage per site every twelve (12) months.
- Periodontal surgery – gingivoplasty  
*Limitation:* One (1) gingivoplasty per site every twelve (12) months.
- Periodontal surgery – gingivectomy  
*Limitation:* 1 gingivectomy per site every 12 months
- Periodontal surgery – grafts – pedicle, free soft tissue, lateral sliding and rotated.  
This procedure includes local anaesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. You are covered for one (1) graft per site every twelve (12) months.
- Proximal wedge  
This procedure includes local anaesthesia, management of infection, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant.  
Exclusion: Management of oral disease.

Related Periodontal services which includes the following procedures:

- Provisional splinting  
This procedure includes tooth preparation, acid etch, wire replacement, acrylic or composite filling, occlusal adjustment, and three (3) month follow-up care.  
*Limitation:* One (1) unit per joint; replacements must be separated by twenty-four (24) months.  
**Note:** No electronic claim submission.

**Level 3 Services** Level 3 services include Major Restorative and Major Oral Surgical Services. Some examples are crowns, dentures or bridges.

*General Limitation:* Coverage for porcelain crowns, inlays, onlays, pontics and retainers are limited to anterior and bi-cuspid teeth only.

**Note:** No electronic claim submission.

### **Inlays / Onlays / Crowns**

Inlays and onlays are metal or porcelain fillings placed on the surface of tooth. Inlays, onlays or gold foil restorations are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

Inlays and onlays include treatment planning, occlusal records, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation.

**Note:** Replacements must be separated by at least five (5) years.

#### *Inlays*

- Inlays – metal, composite or porcelain  
Inlays are only covered when x-rays indicate a crown will be required.

#### *Onlays*

- Onlays – metal, composite or porcelain  
Onlays are limited to teeth with extensive incisal or cusp damage.

#### *Crowns*

This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It does not include porcelain or porcelain fused to metal for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

The following crowns are covered:

- Acrylic crowns
- Cast metal crowns
- Porcelain/ceramic crowns
- $\frac{3}{4}$  cast metal crowns
- $\frac{3}{4}$  porcelain/ceramic crowns
- repairs of inlays/onlays or crowns
- Gold foil restorations  
Gold foil restorations include treatment planning, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, insertion, occlusal adjustments, and gold material.
- Cores-amalgam and tooth coloured
- Prefabricated metal or plastic post  
(prefabricated post, prefabricated post and core – manufactured metal post – manufactured metal post and core). This procedure is for teeth which have had root canal therapy.
- Retentive pins for inlays, onlays and crowns  
This procedure is for the retention and preservation of the tooth.  
*Limitation:* Maximum three (3) retentive pins (for amalgam and composite fillings) per tooth.

- Recementing for inlays, onlays and crowns  
*Limitation:* One (1) unit for fifteen (15) minutes per tooth every six (6) months.

**Dentures**

- Complete Standard dentures  
This procedure includes treatment plan, initial and final impressions, jaw relations records, try-in insertion, occlusal equilibration, and follow-up care and adjustments for six (6) months following insertion.
- Standard immediate dentures.  
This procedure includes treatment plan, impressions, jaw relations records, tissue conditioner, insertion, occlusal equilibration, and follow-up care and adjustments for six (6) months following insertion.  
*Limitation:* Standard complete/immediate dentures.  
**Note:** Replacements must be separated by at least five (5) years.
- Cast partial dentures including partial dentures with clasps and/or rests.
- Remake partial dentures  
You are only covered when a replacement partial denture would be covered.
- Remake partial dentures
- Denture adjustments
- Over dentures and complicated dentures reduced to the cost of standard dentures.
- Partial acrylic dentures including partial dentures with clasps and/or rests.  
This procedure includes treatment plan, mouth preparation, initial and final impressions, jaw relations records, connectors, rests, clasps, and bases, framework try-in, try-in evaluation, insertion, occlusal equilibration, and follow-up care and adjustments for six (6) months following insertion.
- Crowns for partial dentures  
*Limitation:* When the related crown would be covered.
- Tissue conditioning

**Bridgework**

The alternate benefit provision may be applied, we will only pay for the least expensive alternate procedure when considering the cost of a bridge.

- Cast metal pontics
- Porcelain/ceramic pontics
- Acrylic retainers
- Porcelain/ceramic retainers
- Cast metal retainers
- $\frac{3}{4}$  cast metal retainers
- Metal, composite and porcelain inlay retainers
- Metal, composite and porcelain onlay retainers
- Retentive pins for inlay/onlay retainers

- Fixed Bridges
  - Initial bridges. Limited to teeth extracted while you are covered under this plan until you have been covered for twelve (12) consecutive months.
  - This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, splinting and intraoral indexing for soldering purposes, insertion, occlusal adjustments, and cementation. Does not include porcelain or porcelain fused to metal abutments or pontics for molar teeth.

*Limitation:* Alternative Benefit clause may be applied.
- Retention pins for fixed bridge  
This procedure is for the retention and preservation of the tooth.  
*Limitation:* Three (3) per tooth.
- Replacement bridges
  - limited to teeth extracted while you are covered under this plan until you have been covered for twelve (12) consecutive months.
  - after you have been covered for twelve (12) consecutive months, replacement bridges are covered provided the existing bridges are at least 10 years old.
- Repairing of bridgework
- Recementing of bridgework

### Major Surgery services

The following major oral surgery services are covered:

- Reconstruction.

**TMJ treatment** The hinge joint of the jaw is called the temporomandibular joint or TMJ. You are covered for TMJ appliances, including a maximum of two (2) TMJ x-rays in any twelve (12) month period. You are not covered for appliances for tooth movement or tooth guidance.

**Miscellaneous**

- diagnostic casts – unmounted for prosthetic dentistry. You are covered for one (1) diagnostic cast every thirty-six (36) months.
- laminates or veneers – for teeth which have extensive incisal or cusp damage and cannot be restored by a composite filling. Replacement applications must be separated by at least thirty-six (36) months.
- cast metal post and core – custom made casting includes cast core. This procedure is for teeth which have had root canal therapy. You are covered for one (1) post and core per tooth.

- amalgam and pin crown build-up, composite and pin crown build-up. This procedure is for the retention and preservation of the tooth.
- repair of inlay, onlays or crowns.
- recement inlays, onlays or crowns. You are covered for one (1) unit of fifteen (15) minutes per tooth every six (6) months.

**Exclusions** The following treatments are excluded under Level 3 Dental coverage:

- Equilibration casts
- Crown lengthening
- Mandibulectomy
- Maxillectomy
- Sequestrectomy
- Surgical movement of teeth

**Level 4 Services** Level 4 Services include Orthodontics. Orthodontic procedures used to treat misaligned or crooked teeth.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- Cephalometric radiographs
- Diagnostic photographs
- Complete radiograph series or panoramic film
- Facial and intraoral photographs
- Consultations and case presentation
- Full orthodontic treatment
- Hand and wrist radiographs
- Interpretation from other source
- Monthly payments
- Orthodontic examinations  
This procedure includes diagnostic casts, complete radiograph series or panoramic film, cephalograms, facial and intraoral photographs, consultations and case presentations.
- Orthodontic casts
- Surgical exposure of impacted tooth. This procedure is covered for orthodontic purposes.
- Tracing and interpretation
- Orthodontic band splints

**Exclusions**

- Enucleation
- Other oral surgery
- Experimental treatment

- Procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).

**General  
Limitations &  
Exclusions for  
Dental Benefits**

In addition to the limitations and exclusions outlined in this section of the benefit booklet and those limitations and exclusions contained in the outlined description elsewhere in this booklet, the dental benefits do not cover the following:

- Charges for services provided for cosmetic reasons only, except for orthodontic services when such services are included in the orthodontic services benefit in the schedule of dental benefits and orthodontic services are included under the benefit plan.
- Charges for missed or cancelled appointments, completion of forms, communications, or any other non-treatment services.
- Charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice.
- Charges which may be covered elsewhere in this benefit plan
- shall not be covered under dental benefits.
- Replacement of lost or stolen prostheses or appliances.
- Protective appliances for athletic purposes or supplies usually intended for sport or home use, for example, mouthguards.
- Implants and any dental services associated with implants.
- Services covered by any Workplace Safety and Insurance Board unless prohibited by law.
- Services and supplies not shown in the include list of benefits.
- Dental services or supplies required as a result of war, terrorism, rebellion or hostilities of any kind, whether or not the covered person is a participant.
- Dental services or supplies required as a result of participation in a riot or civil disturbance.
- Dental services or supplies due to intentional self-inflicted injury.
- Charges for completing claim forms.
- Teeth malformed at birth and during development.

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer (see myKPR). The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive a claim no one year from the date on which the expense is incurred or thirty (30) days from the date your dental coverage ends.

ClaimSecure can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

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## Accidental Death and Dismemberment

### Why You Need Personal Accident Insurance

A serious accidental injury or death can have tremendous consequences, even for a two income family. You may not have sufficient financial resources to pay for the care you or a loved one may require. Without a reliable source of income, you may not be able to make home mortgage payments, cover college costs or save for retirement.

Now your employer is offering you, through the benefit of group buying power, the opportunity to purchase simple and affordable Personal Accident Insurance coverage underwritten by American Home Assurance (the "Company"), a member of the AIG Companies®, for you and your eligible dependents. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you or your eligible insured dependents should suffer loss of life, or 'living benefits' should a covered accident result in paralysis, or the loss of or loss of use of a limb, sight, speech or hearing.

### How It Works

You choose a Principal Sum amount for yourself, which is set out in your application to enroll. If you elect family coverage, your Spouse's Principal Sum will equal 50% of your Principal Sum and each of your eligible Dependent Children will be covered for 15% of your Principal Sum. If you do not have any eligible Dependent Children, your Spouse will be covered for 60% of your Principal Sum. If you do not have a Spouse, your eligible Dependent Children will be covered for 20% of your Principal Sum.

### Enrolling is Easy

You're eligible to enroll if you are an Elementary Teacher of Kawartha Pine Ridge District School Board and under the age of 70.

To learn more about this valuable benefit offering or if you're ready to enroll, contact your Human Resources Department today.

### Here's What You Get

**Broad Accident Insurance Coverage** - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

**Amount of Coverage Available** - You are covered for half, one times or one and a half times your annual earnings to a maximum of \$500,000.00 in combination with your basic plan.

**Guaranteed Acceptance** - Coverage is provided regardless of your health history.

**24/7 Worldwide Coverage** - Your coverage is in force around-the-clock - at work, at home or at play, anywhere in the world.

**Economical Cost** - Group buying power allows you to purchase coverage at reduced rates, well below that of an individual policy.

**Convenient Payroll Deductions** - For your convenience, the insurance premiums are automatically deducted.

### Definitions

**"Insured Person"** means you, if you are an active full-time employee of the Policyholder who is under the age of 70.

“**Spouse**” means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

“**Dependent Child**” means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

**Beneficiary Designation**

You may designate a beneficiary to receive the amount payable under this policy in case of your accidental death. If there is no written designation then the benefit will be paid to your estate. The amount payable for the loss of life of your insured dependents is payable to you. All other benefits will be payable to you.

**Benefits and Coverages**

**Accidental Death, Dismemberment, Paralysis and Loss of Use**

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

**Table of losses**

Loss of life.....	The Principal Sum
Loss of both hands or both feet .....	The Principal Sum
Loss of entire sight of both eyes .....	The Principal Sum
Loss of one hand and one foot .....	The Principal Sum
Loss of one hand and the entire sight of one eye .....	The Principal Sum
Loss of one foot and the entire sight of one eye .....	The Principal Sum
Loss of one arm or one leg .....	Four-fifths of the Principal Sum
Loss of one hand or one foot .....	Three-quarters of the Principal Sum
Loss of the entire sight of one eye .....	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand .....	One-third of the Principal Sum
Loss of speech and hearing.....	The Principal Sum
Loss of speech or hearing .....	Three-quarters of the Principal Sum
Loss of hearing in one ear .....	Two-thirds of the Principal Sum
Loss of four fingers of one hand .....	One-third of the Principal Sum
Loss of all toes of one foot.....	One-quarter of the Principal Sum

**Loss of Use**

Loss of use of both arms or both hands .....	The Principal Sum
Loss of use of one hand or one foot .....	Three-quarters of the Principal Sum
Loss of use of one arm or one leg .....	Four-fifths of the Principal Sum

**Paralysis**

Quadriplegia (total paralysis of both upper and lower limbs).....	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs).....	Two times The Principal Sum up to a maximum of one million dollars

Hemiplegia (total paralysis of upper and lower limbs of one side of the body).....Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint; "Thumb and Index Finger" means the complete severance through or above the first phalange; "Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; "Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. "Loss" when used herein may also include "Loss of Life".

**Rehabilitation Benefit**

Reimburses your expenses for occupational training to a maximum of \$15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

**Home Alteration and Vehicle Modification Benefit**

Pays a benefit of up to \$15,000 for modification to your home or vehicle if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

**Workplace Modification and Accommodation Benefit**

Pays a benefit of up to \$5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with the Policyholder.

**Psychological Therapy**

Pays a benefit of up to \$5,000 if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

**In-Hospital Benefit**

Pays a benefit of (i) 1% of the Principal Sum to a maximum of \$2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30<sup>th</sup> of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

**Family Transportation**

Pays a benefit of up to \$15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

**Repatriation Benefit**

Pays a benefit of up to \$15,000 to cover the expenses to return your body to your city of residence if you or your eligible insured dependents suffer a covered accidental death while at least 50 kilometres from home.

**Identification Benefit**

Pays a benefit of up to \$5,000 for the transportation of an immediate family member to identify your body if you or your eligible insured dependents suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

**Seat Belt Benefit**

Pays an additional benefit of 10% of the Principal Sum to a maximum of \$50,000 if you or your eligible insured dependents suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

**Day Care Benefit**

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of \$5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

**Dependent Child Educational Benefit**

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of \$5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

**Spousal Educational Benefit**

Pays a benefit of up to \$15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

**Funeral Expense**

Pays a benefit of up to \$5,000 to reimburse funeral expenses if you or your eligible insured dependents suffer a covered accidental death.

**Bereavement Benefit**

Pays a benefit of up to \$1,000 if you have selected single coverage and you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

**Felonious Assault Benefit**

Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, other than an act of a fellow employee or a member of your family or household.

**Waiver of Premium**

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

**Continuance of Coverage**

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

**Conversion Privilege Benefit**

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

**Policy Exclusions**

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- (a) suicide or any attempt thereat by you or your insured eligible dependents while sane;
  - (b) self inflicted injury or any attempt thereat by you or your insured eligible dependents while sane or insane;
  - (c) declared or undeclared war or any act thereof;
  - (d) sickness, disease, mental incapacity or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
  - (e) injury sustained while you or your insured eligible dependents are undergoing the medical or surgical treatment of sickness, disease, or mental infirmity;
  - (f) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
  - (g) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you or your insured eligible dependents are:
    - I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    - II. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    - III. riding as a passenger in an aircraft owned or leased by the Policyholder;
  - (h) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
  - (i) injury sustained if you or your insured eligible dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you or your insured eligible dependents are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
  - (j) any attempt at self-asphyxiation whether with intent to harm oneself or not.
-

**Aggregate Limit Per Accident**

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the Policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

**Effective Date**

Coverage for an Insured Employee, begins on the latest of: (1) the policy effective date; (2) the first day of the month following receipt of your completed application by your Human Resources Department; or (3) the date such person satisfies the definition of "Insured Employee".

**Termination Date**

Coverage for an Insured Employee, ends on the earliest of:

(1) the date the policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date such person no longer satisfies the definition of Insured Employee, or (4) the first day of the month following the date the Insured Employee no longer belongs to an Eligible Class of Employees as set out in the Policy.

**Benefit Cost**

The monthly cost for shown Principal Sums is as follows:

PRINCIPAL SUM	MONTHLY COST Employee Only
\$ 50,000.00	\$ 0.60
\$ 100,000.00	\$ 1.20
\$ 150,000.00	\$ 1.80
\$ 200,000.00	\$ 2.40
\$ 250,000.00	\$ 3.00
\$ 300,000.00	\$ 3.60
\$ 400,000.00	\$ 4.80
\$ 500,000.00	\$ 6.00

Please note this program provides accident insurance only.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by American Home Assurance Company.

# Benefit Summary

This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

**This version of the Benefit Summary redrafted:** January 8, 2009

## Employee Life Insurance

**Benefit Amount**-2.5 times your annual earnings, rounded to the next higher \$1,000, if not already a multiple thereof, to a maximum of \$500,000 combined with Employee Optional Life

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

## Employee Optional Life Insurance

**Benefit Amount** -an election of 0.5, 1, or 1.5 times your annual earnings, rounded to the next higher \$1,000, if not already a multiple thereof, to a maximum of \$500,000 combined with Employee Life

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

## Dependent Life Insurance

**Benefit Amount** - \$1,000 spouse; \$500 each dependent child

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

*Employee Life Insurance*

*Employee Optional Life Insurance*

*Dependent Life Insurance*

# Benefit Summary

## Long Term Disability

### *Long Term Disability*

**Benefit Amount** -60% of monthly earnings, to a maximum of \$3,500

**Qualifying Period** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Maximum Benefit Period**

- a) If your disability begins before your 63rd birthday, payments end on the earlier of:
  - i) the date you are no longer disabled,
  - ii) age 65, or
  - iii) the date you are first eligible for a pension equal to or more than 66.67% of a full pension
- b) If your disability begins after your 63rd birthday, payments end on the earlier of:
  - i) the date you are no longer disabled,
  - ii) 24 months benefits payments,
  - iii) age 70, or
  - iv) the date you are first eligible for an unreduced pension equal to or more than 66.67% of a full pension

**Termination Age** -age 70 less the Qualifying Period or retirement, whichever is earlier

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# How to Use Your Benefit Booklet

**Your Benefit Booklet  
includes...**

***Designed with Your Needs in Mind***

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

Explanation of Common Insurance Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet  
a clear, concise explanation of your Group Benefits  
information you need, and simple instructions, on how to submit a claim

***Important Note***

***Important Note***

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of Kawartha Pine Ridge District School Board. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy (both available from your employer), the terms of the Group Policy will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

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

## Explanation of Common Insurance Terms

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

**Birth** *Birth* the complete live delivery of a child from its mother.

**Dependent** *Dependent* your Spouse or Child who is insured under the

### **-Spouse**

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 9 months. You can only cover one spouse at a time.

### **-Child**

- your natural or adopted child, or stepchild, who is: -unmarried -under age 21, or under age 25 if a full-time student -not employed on a full-time basis, and -not eligible for insurance as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been insured under this Benefit Program immediately prior to that date.

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

Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible
- a newborn child shall become eligible from the moment of birth

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

## Explanation of Common Insurance Terms

### *Earnings*

**Earnings** your regular rate of pay from your employer (prior to deductions), excluding regular bonuses, regular overtime pay and regular commissions. Earnings may include other income as agreed to in writing by your employer and Manulife Financial.

If you do not work in the second semester, your annual rate of pay will be 50% of salary earned in the first semester.

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

-the amount reported on your claim form, or

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

### *Non-Evidence Limit*

**Non-Evidence Limit** you must submit satisfactory medical evidence to Manulife Financial for Benefit Amounts greater than this amount.

### *Provincial Plan*

**Provincial Plan** any plan which provides hospital, medical, or dental benefits established by the government in the province where the insured person lives.

### *Qualifying Period*

**Qualifying Period** a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

### *Take Home Pay (Net Earnings)*

**Take Home Pay (Net Earnings)** your earnings, less deductions normally made for federal and provincial income tax.

### *Waiting Period*

**Waiting Period** - none

## Why Group Benefits?

### *Why Group Benefits?*

In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance. But government plans provide only basic coverage. A disability can create financial hardship for you and your family. Private disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by Kawartha Pine Ridge District School Board, in partnership with The Manufacturers Life Insurance Company.

### ***Your Plan Administrator***

#### *Your Plan Administrator*

Your Plan Administrator is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by submitting all required premiums, reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your Plan Administrator with the necessary information to perform such duties.

Your Plan Administrator is \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Please record the name of your Plan Administrator and the contact number in the space provided.*

### ***Applying for Group Benefits***

#### *Applying for Group Benefits*

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your Plan Administrator. Your Plan Administrator then forwards the application to Manulife Financial.

### ***Making Changes***

#### *Making Changes*

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

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

To make such changes, you must contact the Plan Administrator for the appropriate form.

## The Claims Process

### *How to Submit a Claim*

#### ***How to Submit a Claim***

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed.

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

## Who Qualifies for Coverage?

### **Eligibility**

#### **Eligibility**

You are eligible for Group Benefits if you:

- are a permanent employee of Kawartha Pine Ridge District School Board and work at least the Required Number of Hours,
- are younger than the Termination Age, and
- are residing in Canada.

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

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

### **Required Number of Hours**

#### **Required Number of Hours**

For Employee Life, Employee Optional Life and Dependent Life: no minimum work schedule requirement

For Long Term Disability:

Full-time employee -actively working for your employer

Part-time employee -actively working for your employer at least 25% of a normal full-time schedule

Semester employee -working at least one out of every two semesters

### **Effective Date of Coverage**

#### **Effective Date of Coverage**

If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are Eligible.

If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

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

Your dependent's insurance becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Manulife Financial, whichever is later.

Your dependent's insurance will not be effective prior to the date your insurance becomes effective.

## Who Qualifies for Coverage?

### *Termination of Insurance*

### ***Termination of Insurance***

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- for Optional Life benefits, the date that employee contributions are required and are not paid
- the date you reach the Termination Age
- the date of your death

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

## Your Group Benefits

### Employee Life Insurance

#### *Employee Life Insurance*

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

#### *The Benefit*

#### *Employee Life -The Benefit*

**Benefit Amount** -2.5 times your annual earnings, rounded to the next higher \$1,000, if not already a multiple thereof, to a maximum of \$500,000 combined with Employee Optional Life

**Non-Evidence Limit** -\$500,000

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

**Waiting Period** - none

#### *Submitting a Claim*

#### *Employee Life Insurance -Submitting a Claim*

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

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

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

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

A completed claim form must be submitted within 180 days from the end of the qualifying period.

#### *Waiver of Premium*

#### *Employee Life Insurance – Waiver of Premium*

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

# Your Group Benefits

## *Definition of Totally Disabled*

*Employee Life Insurance  
-Totally Disabled*

For Employees with less than 35 years of employment, Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period

- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

For Employees with 35 or more years of employment, Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

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

If you must hold a government permit or licence to perform the duties of your job, you will be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed for up to a maximum of 12 months following the qualifying period.

## *Entitlement Criteria*

*Employee Life Insurance  
-Entitlement Criteria*

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

- you must be continuously Totally Disabled throughout the Qualifying Period.

For Employees with less than 35 years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

- your own occupation, during the Qualifying Period and the following 2 years,  
and

- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

For Employees with 35 or more years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation

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

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

## Your Group Benefits

### *Termination of Waiver of Premium*

*Employee Life Insurance  
Termination of Waiver  
of Premium*

Your Waiver of Premium will cease on the earliest of:

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

For Employees with less than 35 years of employment, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:

-your own occupation, during the Qualifying Period and the following 2 years, and

-any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

For Employees with 35 or more years of employment, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of your own occupation

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

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

-the date of your death

-the date that Long Term Disability benefit payments cease

### *Recurrent Disability*

*Employee Life Insurance  
-Recurrent Disability*

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

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

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

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

## Your Group Benefits

### *Conversion Privilege*

#### *Employee Life Insurance -Conversion Privilege*

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

For more information on the conversion privilege, please see your Plan Administrator.

## Employee Optional Life Insurance

#### *Employee Optional Life Insurance*

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

#### *The Benefit*

#### *Employee Optional Life Insurance -The Benefit*

**Benefit Amount** -an election of 0.5, 1, or 1.5 times your annual earnings, rounded to the next higher \$1,000, if not already a multiple thereof, to a maximum of \$500,000 combined with Employee Life

**Non-Evidence Limit** -All amounts are subject to Evidence of Insurability.

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

**Waiting Period** - none

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

For details on Submitting a Claim and Conversion Privilege, please refer to Employee Life Insurance.

## Your Group Benefits

### **Waiver of Premium**

#### **Employee Optional Life Insurance -Waiver of Premium**

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

### **Exclusions**

#### **Employee Optional Life Insurance -Exclusions**

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

## Dependent Life Insurance

#### **Dependent Life Insurance**

If one of your dependents dies while insured, the amount of this benefit is paid to you.

### **The Benefit**

#### **Dependent Life -The Benefit**

**Benefit Amount** -\$1,000 spouse; \$500 each dependent child

**Qualifying Period for Waiver of Premium** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

**Termination Age** -your benefit amount terminates on the last day of the month in which you reach age 70 or retirement, whichever is earlier. However, if you retire on June 30th, your benefit amount terminates on August 31st or age 70, whichever is earlier.

**Waiting Period** - none

### **Submitting a Claim**

#### **Dependent Life Insurance - Submitting a Claim**

To submit a Dependent Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

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

### **Waiver of Premium**

#### **Dependent Life Insurance - Waiver of Premium**

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

# Your Group Benefits

## Conversion Privilege

**Dependent Life Insurance**  
**-Conversion Privilege**

If your spouse's life insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator.

## Survivor Extended Benefit

**Survivor Extended Benefit**

If you die while your dependents are covered under this Group Benefit Program, Manulife Financial will continue the Dependent Life benefits without payment of premium, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Common Insurance Terms)
- the date similar coverage is obtained elsewhere
- the date which is the end of the second month after your death, or
- the date the Group Policy terminates

## Long Term Disability

**Long Term Disability**

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Manulife Financial will pay a disability benefit.

### Definition of Totally Disabled

**Long Term Disability**  
**Definition of Totally Disabled**

For Employees with less than 35 years of employment, Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

-your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period

-any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

For Employees with 35 or more years of employment, Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.

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

If you must hold a government permit or licence to perform the duties of your job, you will be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed for up to a maximum of 12 months following the qualifying period.

# Your Group Benefits

## *The Benefit*

### *Long Term Disability The Benefit*

**Benefit Amount** -60 % of monthly earnings, to a maximum of \$3,500

**Non-Evidence Limit** -\$3,500

**Qualifying Period** -uninterrupted period of 90 working days or, if later and you so elect, expiration of your sick leave credits

Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.

You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

### **Maximum Benefit Period**

- a) If your disability begins before your 63rd birthday, payments end on the earlier of:
  - i) the date you are no longer disabled,
  - ii) age 65, or
  - iii) the date you are first eligible for a pension equal to or more than 66.67% of a full pension
  
- b) If your disability begins after your 63rd birthday, payments end on the earlier of:
  - i) the date you are no longer disabled,
  - ii) 24 months benefits payments,
  - iii) age 70, or
  - iv) the date you are first eligible for an unreduced pension equal to or more than 66.67% of a full pension

**Termination Age** -age 70 less the Qualifying Period or retirement, whichever is earlier

**Waiting Period** - none

# Your Group Benefits

## Entitlement Criteria

### Long Term Disability Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period.
- For Employees with less than 35 years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:
  - your own occupation, during the Qualifying Period and the following 2 years, and
  - any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above
- For Employees with 35 or more years of employment, Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

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

## Periods for Which You are Not Entitled to Benefits

### Long Term Disability Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial
- receiving Employment Insurance maternity or parental benefits
- on a maternity or parental leave of absence. However, Manulife Financial will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth. Long-term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been Totally Disabled for the Qualifying Period, provided your coverage has been continued
- on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law

## Your Group Benefits

-receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan

-working in any occupation, except as provided for under the Rehabilitation Assistance provision

-incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

### ***Amount of Disability Benefit Payable***

***Long Term Disability  
Amount of Disability  
Benefit Payable***

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans, excluding dependent benefits
- compensation or profit from any occupation engaged in by you while benefits, other than rehabilitation, are payable

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings (or 80% of your net earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

- any group, association or franchise plan
- any retirement or pension plan
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law
- earnings or payments from any employer, including severance payments and vacation pay
- any Criminal Injuries Compensation Act or similar law, where allowed by law
- any government plan, excluding Employment Insurance Benefits
- Canada or Quebec Pension Plans including dependent benefits

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

# Your Group Benefits

## **Benefit Calculation Rules**

### **Long Term Disability Benefit Calculation Rules**

Manulife Financial will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial
- subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established
- benefits payable under individual disability income insurance will not be taken into account
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial, and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid

## **Subrogation**

### **Long Term Disability Subrogation**

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

## **Tax Status of Benefits**

### **Long Term Disability Tax Status**

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

## **Payment of Disability Benefits**

### **Long Term Disability Payment of Disability Benefits**

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

## Your Group Benefits

### **Rehabilitation Assistance**

#### **Long Term Disability Rehabilitation Assistance**

Once Manulife Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife Financial will take into account:

- the nature, extent and expected duration of your disability your level of education, training or experience
- the nature, scope, objectives and cost of a Vocational Plan

### **-Vocational Plan**

#### **-Vocational Plan**

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife Financial will provide a structured Vocational Plan that will prepare you for a return to work, either:

- with your employer
- with an alternate employer
- in a self-employed capacity

#### **-Disability Benefits During Rehabilitation**

### **-Disability Benefits During Rehabilitation**

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings; net earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife Financial will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

## Your Group Benefits

### *Termination of Benefit Payments*

*Long Term Disability  
Termination of Benefit  
Payments*

Your disability benefit payments will cease on the earliest of:

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

For Employees with less than 35 years of employment, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:

-your own occupation, during the Qualifying Period and the following 2 years,

and

-any occupation for which you are qualified, or may reasonably become

qualified, by training, education or experience, after the 2 years specified above

For Employees with 35 or more years of employment, the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of your own occupation

- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit
- the date of your death

### *Recurrent Disability*

*Long Term Disability  
Recurrent Disability*

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

### *Waiver of Premium*

*Long Term Disability  
Waiver of Premium*

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

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## Your Group Benefits

### *Submitting a Claim*

#### *Long Term Disability Submitting a Claim*

To submit a claim, you must complete the Long Term Disability claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

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

### *Exclusions*

#### *Long Term Disability Exclusions*

*No benefits are payable for any disability related to:*

- self-inflicted injuries or illnesses
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit an assault or criminal offence
- a Pre-Existing Condition which causes disability within the first 6 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which drugs were prescribed prior to the effective date of your coverage. However, once you have worked 90 days continuously (not including an absence of up to 3 days) and have not been treated or attended by a physician, or by any medical personnel working under the direction of a physician, for any illness or injury, this limitation will not apply. If you have returned to work after an approved Leave of Absence, the 6 months shall be deemed to commence on the date of return to active employment.

