

Class: 32 – Chief of Staff

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Date: December 1, 2013

Bruyère Continuing Care

Class: 32 – Chief of Staff

Welcome to Your Group Benefit Program

Group Policy Effective Date: November 01, 1996

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

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

Your Human Resources Department can answer any questions you may have about your benefits.

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Benefit Summary

Employee Life Insurance

Benefit Amount - 2 times your annual earnings, to a maximum of \$500,000

Termination Age - your benefit amount reduces by 50% on April 1st coinciding with or next following attainment of age 65, and is further reduced to \$1,000 on April 1st coinciding with or next following attainment of age 70, and terminates upon your retirement

Employee Optional Life Insurance

Benefit Amount - increments of \$10,000 to a maximum of \$500,000

Termination Age - age 65 or retirement, whichever is earlier

Dependent Optional Life Insurance

Benefit Amount - Spouse - increments of \$10,000 to a maximum of \$500,000

Benefit Amount - Child - an election of one of the following amounts:

- \$5,000
- \$10,000
- \$15,000
- \$20,000

Termination Age - employee's age 65 or retirement, whichever is earlier

Benefit Summary

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$10 Individual, \$20 Family, per calendar year(s)

Not applicable to:

Hospital Care

Medical Services & Supplies

Orthopaedic Shoes

Professional Services

Vision

Drug Dispensing Fee Maximum - \$6.54 per prescription

Benefit Percentage -

100 % for - Drugs - Hospital Care - Medical Services & Supplies – Professional Services - Vision

Termination Age - employee's age 70 or retirement, whichever is earlier

Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs or medicines for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist (charges for anti-smoking drugs are not covered)
- oral contraceptives
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)
- Charges for drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home are not covered.

Benefit Summary

- Drug Maximum

Fertility drugs - \$2,500 per calendar year

Viagra - 8 pills per month

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

Covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this benefit, the full cost of the prescribed product is covered.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

- Prescription Quantity

The maximum quantity of drugs or medicines that will be payable for each prescription will be limited to the lesser of:

- a) the quantity prescribed by your physician or dentist, or
- b) a 34-day supply

A quantity of up to a 100-day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Benefit Summary

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

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

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, once every 2 calendar years to a maximum of \$75
- purchase and fitting of prescription eyeglass lenses - one pair every 2 calendar years or elective contact lenses - one claim every 2 calendar years

Note: Eyeglass lenses and contact lenses will be reimbursed on the basis of reasonable and customary charges.

- repairs, replacement glasses or frames for glasses to a maximum of \$60 during any 2 calendar years
- elective laser vision correction procedures to a maximum of \$250 during any 2 calendar years

Benefit Summary

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$500 per calendar year(s)
- Osteopath - \$500 per calendar year(s)
- Podiatrist - \$500 per calendar year(s)
- Chiropodist - \$500 per calendar year(s)
- Massage Therapist - \$500 per calendar year(s)
- Naturopath - \$500 per calendar year(s)
- Speech Therapist - \$1,000 per calendar year(s)
- Physiotherapist - Unlimited
- Psychologist - \$1,000 per calendar year(s)
- Acupuncturist - \$500 per calendar year(s)

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for the Province in which the services are rendered

If the services are rendered in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment.

Benefit Percentage (Co-insurance) -

100% - Basic Services

100% - Supplementary Basic Services

100% - Dentures

50% - Major Restorative Services

50% - Orthodontics

Benefit Summary

Benefit Maximums

Unlimited for Basic Services

Unlimited for Supplementary Basic Services

Unlimited for Dentures

\$1,000 per calendar year for Major Restorative Services

\$1,000 per lifetime for Orthodontics

Termination Age - employee's age 70 or retirement, whichever is earlier

Long Term Disability

Benefit Amount - 66.7% of your monthly earnings, subject to a minimum of \$50 and a maximum of \$11,000

Qualifying Period - 119 days

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

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

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Common Insurance Terms, which provides a brief explanation of the insurance 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

The purpose of this booklet is to outline the benefits for which you are eligible as an Employee of Bruyère Continuing Care. 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 (available from your Human Resources Department), 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 insured. 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.

Your Group Benefit Card

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

The Group Policy Number and your Certificate Number are also necessary for ALL correspondence with your Plan Administrator.

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

Explanation of Common Insurance Terms

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses payable.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable.

Dependent

your Spouse or Child must be insured under the Provincial Plan.

- Spouse

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

- Child

- your unmarried natural or adopted children, or stepchildren living in your home, who are:
 - under age 21, or under 26 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 insurance 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 handicap.

Written proof of the child's condition may be required as often as may reasonably be necessary.

- for Dependent Optional Life Insurance a child must be at least 24 hours old to be eligible.
- a stepchild must be living with you to be eligible.

Drug Dispensing Fee

of the total prescription drug cost, that portion charged for the pharmacist's professional services for filling a prescription.

Explanation of Common Insurance Terms

Drug Dispensing Fee Maximum

the maximum amount that is covered by your plan for a drug dispensing fee.

Earnings

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

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.

Immediate Family Member

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

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Non-Evidence Limit

you must submit satisfactory medical evidence to your Plan Administrator for Benefit Amounts greater than this amount.

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

a period of continuous and total disability which you must complete in order to qualify for disability benefits.

Take Home Pay (Net Earnings)

your earnings, less deductions normally made for federal and provincial income tax.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Human Resources Department

Your Human Resources Department 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 by keeping all records up to date.

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

Your Human Resources Department contact
is _____

Phone Number: (_____) _____ - _____

Please record your Human Resources Department contact and contact number in the space provided.

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed [Enrolment or Reinstatement Application form](#), available from your Human Resources Department. Your Human Resources Department then forwards the application to the Plan Administrator, Cowan.

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 Human Resources Department. Such changes could include:

change in Dependent Coverage change of Beneficiary

change in Name applying for coverage previously waived

To make such changes, you must complete the [Application for Change form](#), available from your Human Resources Department.

The Claims Process

How to Submit a Claim

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

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

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, a Claim Statement will be sent to you.

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

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

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

Co-ordination of Extended Health Care and Dental Care Benefits

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

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs;
- any other arrangement of coverage for individuals in a group; and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

The Claims Process

Order of Benefit Payment

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

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.
 - For Claims incurred by you or your Dependent Spouse:

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

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

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

- For Claims incurred by your Dependent Child:

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

However, if you and your Spouse are separated or divorced, the following order applies:

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

The Claims Process

- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the insured person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a full-time employee of Bruyère Continuing Care and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

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

Your dependents are eligible for insurance 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

Full-time employee - 37.5 hour(s) per week

Evidence of Insurability

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

Medical evidence is also required for all benefits, except Dental insurance, **when you make a Late Application for insurance on any person.**

Who Qualifies for Coverage?

Late Application

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 31 days ; or
- re-apply for insurance on any person whose insurance had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for insurance more than 31 days after the date benefits terminated under your spouse's plan; or
- apply for insurance and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the [Evidence of Insurability form](#), available from your Human Resources Department. Further medical evidence may be requested.

Late Dental Application

If you apply for coverage for Dental insurance for yourself or your dependents late, insurance will be limited to \$250 for each insured person for the first 12 months 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, 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 evidence of insurability on the dependent is approved, whichever is later.

Your dependent's insurance will not be effective prior to the date your insurance becomes effective. (This does not apply to Dependent Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.)

Who Qualifies for Coverage?

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 insurance on the class to which you belong terminates,
- the date you reach the Termination Age, or
- 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

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

The Benefit

Benefit Amount - 2 times your annual earnings, to a maximum of \$500,000

Non-Evidence Limit - \$500,000

Termination Age - your benefit amount reduces by 50% on April 1st coinciding with or next following attainment of age 65, and is further reduced to \$1,000 on April 1st coinciding with or next following attainment of age 70, and terminates upon your retirement

Waiting Period

first of the month coincident with or next following 3 months for employees hired on or prior to the Group Policy Effective Date

first of the month coincident with or next following 3 months for all other employees

Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the [Life Claim form](#) which is available from your Human Resources Department.

Documents necessary to submit with the form are listed on the form. Upon completion of the form, the necessary documents should be attached and the form returned to your Human Resources Department for mailing to Manulife Financial.

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

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 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 contact your Plan Administrator.

Your Group Benefits

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

Benefit Amount - increments of \$10,000 to a maximum of \$500,000

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

Qualifying Period for Waiver of Premium - 6 months

Termination Age - age 65 or retirement, whichever is earlier

Waiting Period

first of the month coincident with or next following 3 months for employees hired on or prior to the Group Policy Effective Date

first of the month coincident with or next following 3 months for all other employees

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your Human Resources Department.

For details on Submitting a Claim and Conversion Privilege, please refer to 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 Optional Life Insurance will continue without payment of premium.

Definition of Totally Disabled

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

- your own occupation, during the Qualifying Period and the 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

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

Your Group Benefits

Entitlement Criteria

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

- you must be continuously Totally Disabled throughout the Qualifying Period. If your disability is not continuous, Manulife Financial will apply separate periods of disability towards satisfying the Qualifying Period, provided:
 - no interruption between periods of disability is longer than 3 weeks, and
 - the disabilities are due to the same or related illness or injury.
- 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.
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit.
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:
 - your own occupation, during the Qualifying Period and the following 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.
- 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 independent expert chosen by Manulife Financial.
- the date of your 65th birthday.
- the date of your death.

Your Group Benefits

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.

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than 2 years will not be payable.

Dependent Optional Life Insurance

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

The Benefit

Benefit Amount - Spouse - increments of \$10,000 to a maximum of \$500,000

Benefit Amount - Child - an election of one of the following amounts:

- \$5,000
- \$10,000
- \$15,000
- \$20,000

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

Termination Age - employee's age 65 or retirement, whichever is earlier

Your Group Benefits

Waiting Period

first of the month coincident with or next following 3 months for employees hired on or prior to the Group Policy Effective Date

first of the month coincident with or next following 3 months for all other employees

To apply for Dependent Optional Life Insurance you must complete the Application for Optional Life form which is available from your Human Resources Department.

Submitting a Claim

To submit a Dependent Optional Life Insurance claim, you must complete the [Life Claim form](#) which is available from your Human Resources Department. 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

Please refer to Employee Optional Life Insurance for details on the Waiver of Premium provision.

- Exception

If you are not insured for Employee Optional Life, the Waiver of Premium provision will not apply to your spouse's Dependent Optional Life Insurance, unless:

- at the time you applied for Dependent Optional Life Insurance on your spouse, you also provided Manulife Financial with evidence of insurability for yourself, and
- Manulife Financial approved your evidence of insurability

Conversion Privilege

If your spouse's insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Application for the individual policy must be made, and the first monthly premium paid, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Optional 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 contact your Plan Administrator.

Exclusions

If death results from suicide any amount of Dependent Optional Life Insurance that has been in effect for less than 2 years will not be payable.

Your Group Benefits

Basic Accidental Death and Dismemberment Insurance

This benefit is insured by SSQ Financial Group. The wording for this benefit has been provided by SSQ Financial Group who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them.

Eligibility

If you are an active, full-time employee under the age of seventy and participate in your Employer's Basic Group Life Insurance program, you are automatically insured under this program.

Amount of Principal Sum

The Principal Sum is equal to the amount of insurance under your Basic Group Life Insurance program.

Definitions

Wherever used in this Booklet:

"You" and "Your", means the Eligible Employee who has purchased this Insurance and who is employed by the Employer.

"Policy", means the Group Policy #9223356 which is on file with the Employer.

"Program", means the Policy.

"Injury", means bodily Injury caused by an Accident occurring while your coverage is in force under the Policy, and resulting directly and independently of all other causes in Loss covered by the Policy, 24 hours a day, anywhere in the world.

"Principal Sum", means an amount equal to your Basic Group Life Insurance.

"Employer", means Bruyère Continuing Care.

"Insured Person", means an Employee insured under the Policy.

"Member of the Immediate Family", means a person at least 18 years of age, who is your son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother.

"Spouse" means an individual under the age of 70;

a) to whom you are legally married,

b) with whom you have continuously cohabited and who has been publicly represented as your spouse for a minimum of one (1) year immediately before a Loss is incurred under the Program.

Only one (1) individual will qualify as a spouse.

Your Group Benefits

If the insured Employee is legally married but is also cohabiting with an individual as described under section (b) above, the insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the Spouse will be the individual to whom the insured Employee is legally married.

Benefits

Specific Loss Accident Indemnity

If Injury results in any of the following Losses within three hundred and sixty-five (365) days after the date of the Accident, benefits will be paid according to the following Schedule of Losses.

For Loss of

- Life - The Principal Sum
- The Entire Sight of Both Eyes - The Principal Sum
- Speech and Hearing in Both Ears - The Principal Sum
- One Hand and the Entire Sight of One Eye - The Principal Sum
- One Foot and the Entire Sight of One Eye - The Principal Sum
- The Entire Sight of One Eye - Two-Thirds of the Principal Sum
- Speech - Two-Thirds of the Principal Sum
- Hearing in Both Ears - Two-Thirds of the Principal Sum
- Hearing in One Ear - One-Third of the Principal Sum
- All Toes of One Foot - One-Quarter of the Principal Sum

For Loss or Loss of Use of

- Both Hands - The Principal Sum
- Both Feet - The Principal Sum
- One Hand and One Foot - The Principal Sum
- One Arm - Three-Fourths of the Principal Sum
- One Leg - Three-Fourths of the Principal Sum
- One Hand - Two-Thirds of the Principal Sum

Your Group Benefits

- One Foot - Two-Thirds of the Principal Sum
- Thumb and Index Finger or at Least Four Fingers of One Hand - One-Third of the Principal Sum

For Total Paralysis of

- Both Upper and Lower Limbs (Quadriplegia) - Two Times the Principal Sum
- Both Lower Limbs (Paraplegia) - Two Times the Principal Sum
- Upper and Lower Limbs of One Side of Body (Hemiplegia) - Two Times the Principal Sum

“Loss” as used above with reference to:

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: means the Complete Severance of one entire phalanx of the thumb;

finger: means the Complete Severance of two entire phalanges of the finger;

toe: means the Complete Severance of one entire phalanx of the big toe and all phalanges of the other toes;

eye: means the Irrecoverable Loss of the entire sight thereof;

speech: means the Complete and Irrecoverable Loss of the ability to utter intelligible sounds;

hearing: means the Complete and Irrecoverable Loss of hearing;

quadriplegia, paraplegia, and hemiplegia: means the Complete and Irreversible Paralysis of such Limbs;

“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 at the end of such period. Indemnity provided under this section will not be paid under any circumstances for more than one (1) of the losses, the greatest, sustained for multiple injuries to the same limb by any one (1) Insured Person as the result of any one (1) accident.

Indemnity provided under this section for all Losses sustained by any one (1) Insured Person as the result of any one (1) accident will not exceed the following:

- a) with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- b) with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within ninety (90) days after the date of the accident.

Your Group Benefits

In no event will indemnity payable for all Losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

Repatriation *

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under this program, repatriation benefits up to \$10,000 will be paid for expenses incurred for the return home of your body (including preparation charges for transportation). The death must occur at least 50 kilometres from your residence.

Education *

If you sustain Accidental Loss of Life which becomes payable under the Program, up to 5% of your Principal Sum (maximum \$5,000 which maximum is in combination with the Education Benefit maximum provided under any other policy issued to the Policyholder by the Insurer) will be payable for each qualifying Dependent Child for post-secondary education expenses provided the Child (i) is already enrolled full-time in an institution of higher learning or (ii) is at a secondary school level but will enroll, as a full-time student in a post-secondary education program within 365 days of your death.

This is payable annually for each year for up to 4 consecutive years. No payment will be made for expenses incurred prior to your Death nor will payment be made for room, board or other ordinary living, travelling or clothing expenses.

If your Dependent Child satisfies the above requirements, any benefits payable will be paid to such Child. If none of your Dependent Children satisfy the above requirements or the requirements as shown under "Day-Care Benefit", an amount equal to five percent (5%) of your Principal Sum or two thousand and five hundred dollars (\$2,500), whichever is less, will be paid to your beneficiary. This amount will only be paid under one (1) of the Policies issued to your Employer by the Insurer.

"Institution of Higher Learning" includes any university, college, CEGEP or trade school.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are unmarried, under twenty-six (26) years of age and dependent upon the Insured Person for maintenance and support.

Day-Care **

If you sustain Accidental Loss of Life which becomes payable under the Program, up to 5% of your Principal Sum (Maximum \$5,000 which maximum is in combination with the Day-Care Benefit maximum provided under any other policy issued to the Policyholder by the Insurer) will be payable for each qualifying Dependent Child for Day-Care expenses provided the Child (i) is enrolled in a legally licensed Day-Care Centre on the date of the accident, or (ii) enrolls in a legally licensed Day-Care Centre within 365 days after the date of your Death and (iii) is under 13 years of age.

Your Group Benefits

This is payable annually for each year for up to 4 consecutive years. No payment will be made for expenses incurred prior to your Death nor will payment be made for room, board or other ordinary living, travelling or clothing expenses.

If a Dependent Child does satisfy the requirements indicated above, the Day-Care Benefit will be payable to the surviving Spouse if the Spouse has custody of the Child. If there is no surviving Spouse or the Child does not reside with the Spouse, benefits will then be paid to the child's legally appointed Guardian. If none of your Dependent Children satisfy the above requirements or the requirements as shown under "Education Benefit", we will pay an amount equal to five percent (5%) of your Principal Sum or two thousand and five hundred dollars (\$2,500), whichever is less, to your beneficiary. This amount will only be paid under one (1) of the policies issued to your Employer by the Insurer.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are under thirteen (13) years of age and dependent upon the Insured Person for maintenance and support.

Rehabilitation *

If you sustain any Loss which becomes payable under the Program and such Loss requires you to participate in a rehabilitation program in order to qualify to engage in an occupation in which you would not have engaged except for such Loss, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the Accident to a maximum of \$10,000. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Occupational Training *

If you sustain Accidental Loss of Life, Paralysis or Loss of entire sight of both eyes or Loss of use of both hands or Loss of use of both feet which becomes payable under the Program, this benefit will refund expenses incurred for your Spouse to engage in a formal occupational training program in order to upgrade his/her employment qualifications, to a maximum of \$10,000 within 3 years from the date of the Accident. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Family Transportation *

If any specific loss covered under this program confines you to a hospital or if any other injury confines you to a hospital for 4 days and such hospital is located at least 150 kilometers from your residence, this benefit will refund expenses incurred by a member of your immediate family for hotel accommodation and transportation (via the most direct route) to your bedside, to a maximum of \$5,000. Private transportation expenses are limited to \$0.20 per kilometer travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Your Group Benefits

Identification *

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under this program, and identification of your body is required by the police or a similar law enforcement agency having authority over such matters, this benefit will refund expenses actually incurred by a member of your immediate family for lodging and board (maximum of 3 consecutive nights) and transportation (via the most direct route) to the city or town where your body is located (location of the body must be at least 150 kilometres from the family member's normal place of residence), to a maximum of \$5,000. Private transportation expenses are limited to \$0.20 per kilometre travelled.

Seat Belt **

If, at the time of the Accident, you or your Insured Dependent(s) were wearing a properly fastened seat belt and driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs (unless taken as prescribed by a physician), and a Loss becomes payable under the Program, the applicable amount of Principal Sum will be increased by 10% for those wearing a seat belt, subject to a maximum of fifty thousand dollars (\$50,000), which maximum is in combination with the Seat Belt Benefit maximum provided under any other policy issued to the Policyholder by the Insurer.

"Intoxicated and being under the influence of drugs" is as defined by the jurisdiction in which the Accident occurs.

"Vehicle" means a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

Home Alteration and Vehicle Modification *

If you or your Insured Dependent(s) sustains the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity is payable under the policy, and subsequently requires the use of a Wheelchair to be Ambulatory, we will pay the reasonable and necessary expenses actually incurred within 3 years of the date of the Accident causing such Loss for:

- a) the cost of Alterations to your Principal Residence to make it wheelchair accessible, and/or
- b) the cost of Modifications to 1 Motor Vehicle utilized by you to make it wheelchair accessible when such modifications are approved by licensing authorities where required.

Payment by the Insurer for the total of all expenses incurred by or for any Insured Person will not exceed \$10,000 as the result of any one Accident.

Your Group Benefits

Hospital Indemnity *

A daily benefit of 1/30th of 1% of your Principal Sum, to a maximum of \$2,500.00 per month, which maximum is in combination with the Hospital Indemnity Benefit maximum provided under any other policy issued to the Policyholder by the Insurer, will be payable to you when you or your Insured Dependent(s) are in Hospital and under the care of a Physician, but only if the period of Hospitalization is uninterrupted, results from an Injury and begins while insurance under the Policy is in force.

Such daily benefit will be paid from the first day of Hospitalization if Hospitalized:

- a) due to a Loss payable under the "Schedule of Losses", or
- b) due to an Injury which requires Hospitalization for at least 4 consecutive days; but in no event for more than 365 days per Injury.

If a particular condition causes more than one period of Hospitalization due to the same or related causes, then the maximum benefit (365 days in a Hospital) will be reinstated, provided a period of 183 days has elapsed between periods of Hospitalization.

Note: Benefits marked with an asterisk (*) are only payable under one of the policies issued to your employer by SSQ Financial Group.

Benefits marked with 2 asterisks (**) are subject to a combined maximum with similar benefits provided under any other policy issued to your employer by SSQ Financial Group.

Aircraft Coverage

You are covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, leased, operated by or on behalf of your employer) and flown by a licensed pilot. Coverage also applies while flying as a passenger in a military aircraft and while boarding or alighting from any aircraft or being struck by any aircraft.

Exposure and Disappearance

If, by reason of an Accident covered by this Program, an Insured Person is unavoidably exposed to the elements and such Exposure results in a covered Loss, such Loss will be covered.

If any Insured Person is not found within one year of the disappearance, sinking or wrecking of a conveyance in which he/she was riding at the time of the Accident, it will be presumed the Insured Person has suffered Loss of Life resulting from bodily Injury caused by an Accident.

Your Group Benefits

Waiver of Premium

If you become totally disabled and remain so for at least 6 consecutive months, you need not pay any further premiums under the policy, until the earliest of the following dates:

1. the date this program terminates;
2. the date you reach age 65;
3. the date you cease to be totally disabled; or
4. Omission to provide us with satisfactory proof of continuance of total disability within 90 days of request or refusal to submit to medical examination.

All terms and provisions of this program will apply during the period your premiums are waived, including provisions relating to reduction in amounts of insurance.

Continuation of Coverage

Subject to payment of premium, coverage will be continued for a period of up to 12 months during any approved leave of absence, temporary lay-off or maternity leave. For disability leave, coverage provided under this section will terminate when You reach age 65, qualify for a Waiver of Premium clause or when You return to work, whichever is earliest.

All terms and provisions of the Policy apply during the period of the leave, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of Your leave.

Conversion Privilege

If Your insurance is terminated due to

1. termination of employment,
2. cessation of eligibility for insurance under the Policy or
3. cessation of total disability after which You did not return to work for the Employer, and the Policy is still in effect, You may convert Your own insurance without evidence of insurability, into an individual accident policy.

You must apply prior to attainment of age 70 and within 31 days of the termination of Your insurance.

Your Group Benefits

The benefits provided are a Specific Loss schedule available from SSQ Financial Group at the date of conversion. The amount of insurance that may be converted cannot exceed the amount then in effect on the date of termination (total aggregate of \$200,000 for all conversions with Us). The premium is calculated at SSQ Financial Group manual premium rates in force at the date of conversion.

Premiums are payable annually in advance and the individual accident policy issued on an annually renewable basis.

Exclusions

The Program does not cover any loss, fatal or non-fatal, caused or contributed to by:

1. intentionally self-inflicted injury while sane or self-inflicted injury while insane;
2. declared or undeclared war or any act thereof;
3. active full-time service in the armed forces of any country;
4. riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage".

To Whom are Benefits Paid?

Your accidental death benefit will be paid to the beneficiary designated on your Basic Group Life Insurance Enrollment Card. Any other benefits payable will be paid to you.

Claim Procedures

You or your beneficiary must notify your employer immediately.

In the event of a claim, written notice of injury must be given to SSQ Financial Group within 30 days after the date of the accident and written proof of loss must be submitted to SSQ Financial Group within 90 days after the date of such loss.

Failure to provide such notice or proof within such time will not invalidate nor reduce any claim, if it is shown not to have been reasonably possible to provide such notice or proof and that such notice or proof was provided as soon as was reasonably possible, but in no event later than one year after the date of the accident.

This booklet/certificate summarizes in non-technical language the terms and conditions of this accident insurance program and should be preserved for reference. All rights and obligations are determined in accordance with the Group Policy #9223356 and not this booklet/certificate. For detailed information, please contact the Human Resources Department of your Employer.

Your Group Benefits

Extended Health Care

If you or your dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$10 Individual, \$20 Family, per calendar year(s)

Not applicable to:

Hospital Care

Medical Services & Supplies

Orthopaedic Shoes

Professional Services

Vision

Drug Dispensing Fee Maximum - \$6.54 per prescription

Benefit Percentage -

100 % for - Drugs - Hospital Care - Medical Services & Supplies – Professional Services - Vision

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

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

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

Your Group Benefits

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, provided they are:

- medically necessary for the treatment of sickness or injury and recommended by a physician
- incurred while you are insured under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable

Note: The term sickness as used above does not include infertility.

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time, except for covered drug expenses.

Hospital Care

The maximum amount payable to you on and after the first day of the year in which you attain age 65 is \$500, less the total paid during the 3 preceding calendar years

- charges, in excess of the hospital's public ward charge, for private accommodation, provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- private accommodation for confinement in a palliative or rehabilitative care facility, up to a maximum of 180 days per disability
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Nursing Home

Private accommodation for each day the insured person is residing in a Nursing Home and is eligible to receive extended care benefits under the Health Insurance Act of Ontario, subject to Physician's recommendation, up to a maximum reimbursement of \$200 per day, for up to 120 days, for one period of confinement.

All confinements due to same or related cause will be considered as one continuous period of confinement, unless separated by 30 days for an Employee, or 180 days for a Dependent.

Your Group Benefits

Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs or medicines for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist (charges for anti-smoking drugs are not covered)
- oral contraceptives
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)
- Charges for drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home are not covered.

- Drug Maximum

Fertility drugs - \$2,500 per calendar year

Viagra - 8 pills per month

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

Covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this benefit, the full cost of the prescribed product is covered.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum and the Co-insurance of 100%.

Your Group Benefits

- Prescription Quantity

The maximum quantity of drugs or medicines that will be payable for each prescription will be limited to the lesser of:

- a) the quantity prescribed by your physician or dentist, or
- b) a 34-day supply

A quantity of up to a 100-day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

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

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Your Group Benefits

Vision Care

- eye exams, once every 2 calendar years to a maximum of \$75
- purchase and fitting of prescription eyeglass lenses - one pair every 2 calendar years or elective contact lenses - one claim every 2 calendar years

Note: Eyeglass lenses and contact lenses will be reimbursed on the basis of reasonable and customary charges.

- repairs, replacement glasses or frames for glasses to a maximum of \$60 during any 2 calendar years
- elective laser vision correction procedures to a maximum of \$250 during any 2 calendar years

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - \$500 per calendar year(s)
- Osteopath - \$500 per calendar year(s)
- Podiatrist - \$500 per calendar year(s)
- Chiropodist - \$500 per calendar year(s)
- Massage Therapist - \$500 per calendar year(s)
- Naturopath - \$500 per calendar year(s)
- Speech Therapist - \$1,000 per calendar year(s)
- Physiotherapist - Unlimited
- Psychologist - \$1,000 per calendar year(s)
- Acupuncturist - \$500 per calendar year(s)

Recommendation by a physician for Professional Services is not required.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Your Group Benefits

Private Duty Nursing

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

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

Covered Expenses are subject to maximums of 90 eight-hour shifts per person, \$175 per day, and \$15,750 per calendar year

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

A detailed treatment plan should be submitted with cost estimates before Private Duty Nursing services begin. The Plan Administrator will then advise you of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available, including attendant if transportation is not by a licensed service

Medical Equipment

- rental or, when approved by the Plan Administrator, purchase of:
 - Mobility Equipment: crutches, canes, walkers, wheelchairs and electric wheelchairs due to medical necessity; and
 - Durable Medical Equipment: manual hospital beds, electric hospital beds due to medical necessity, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Your Group Benefits

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- charges for myoelectrical limbs
- charges for initial pair of eyeglasses or contact lenses following cataract surgery or when the insured person does not have an organic lens
- surgical stockings, up to a maximum of 6 pairs per calendar year
- surgical brassieres, up to a maximum of 2 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear, up to a maximum of 2 pairs (maximum of \$225 per pair) per calendar year(s) (recommendation of either a physician or a podiatrist is required)
- custom-made shoes which are constructed by a Certified Orthopaedic Footwear Specialist (C.O.F.S.) and are required because of a medical abnormality, up to a maximum of 1 pair per calendar year
- casted, custom-made orthotics, up to a maximum of 2 pairs (maximum of \$225 per pair) per calendar year(s) (recommendation of either a physician or a podiatrist is required)
- cost, installation, repair and maintenance of hearing aids (including charges for batteries), to a maximum of \$500 every 5 calendar year(s)

Other Supplies and Services

- glucometers, 1 per 4 calendar years in the case of insulin dependent diabetes
- the cost of tracheotomy supplies, urinary kits and respirators
- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$1,500 per lifetime
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec

Your Group Benefits

- charges for oral surgery or treatment with removal of malignant tumours
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 90 days of the accident and is completed within 1 year. Injuries due to biting or chewing are excluded. Covered expenses will be subject to a maximum of \$2,500 per accident

Submitting a Claim

To submit an Extended Health Care claim, you must complete an [Extended Health Care Claim form](#), Claim forms are available from your Human Resources Department or on Cowan's website at www.cowangroup.ca.

All applicable receipts must be attached to the completed claim form when submitting it to your Plan Administrator.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Subrogation (Third Party Liability)

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

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

Your Group Benefits

Exclusions

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic

Your Group Benefits

Dental Care

If you or your dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners for the Province in which the services are rendered

If the services are rendered in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus inflationary adjustment.

Benefit Percentage (Co-insurance) -

100% - Basic Services

100% - Supplementary Basic Services

100% - Dentures

50% - Major Restorative Services

50% - Orthodontics

Benefit Maximums

Unlimited for Basic Services

Unlimited for Supplementary Basic Services

Unlimited for Dentures

\$1,000 per calendar year for Major Restorative Services

\$1,000 per lifetime for Orthodontics

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

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

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

Your Group Benefits

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of an insured person while insured under this benefit
- are incurred for services provided by a dentist, a dental hygienist working under the supervision of a dentist, or a denturist working within the scope of his license
- are reasonable, taking all factors into account, and
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges, if the expenses are not listed in the Dental Fee Guide.

Basic Services

- complete oral exam, one per 2 calendar years
- full-mouth x-rays and panoramic x-rays, once every 36 months
- one unit of light scaling and one unit of polishing twice per calendar year, when the service is performed outside Quebec, or prophylaxis (light scaling and polishing) twice per calendar year, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction
- fillings and retentive pins. Replacement fillings are covered provided:
 - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
 - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pit and fissure sealants are limited to one application per tooth, for dependent children under the age of 16
- pre-fabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)

Your Group Benefits

- consultations, anaesthesia, and conscious sedation
- denture repairs, relines and rebases, once every 36 months
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

Supplementary Basic Services

- surgical procedures not included in Basic Services (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - scaling not covered under Basic Services, and root planing, up to a combined maximum of 16 units per calendar year;
 - provisional splinting;
 - occlusal equilibration, up to a maximum of 8 units per calendar year; and
 - bruxism appliances
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
 - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
 - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Dentures

- initial provision of full or partial removable dentures, including transitional dentures and over-dentures
- replacement of removable dentures, provided the dentures are required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable;
 - the existing appliance is at least 60 months old and cannot be made serviceable; or
 - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

Your Group Benefits

Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:
 - a natural tooth is extracted and the existing appliance cannot be made serviceable;
 - the existing appliance is at least 60 months old and cannot be made serviceable; or
 - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

Orthodontics

- orthodontic services (for dependent children only, provided treatment commences prior to reaching age 18)

Late Entrant Limitation

If you or your dependents become insured for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to \$250 for each insured person.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed \$500, it is recommended that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Dental Care Benefit) are payable, provided the expense is incurred within 30 days after your benefit terminates.

Submitting a Claim

To submit a claim, you and your dentist must complete a [Dental Claim form](#) which is available from your Human Resources Department.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Your Group Benefits

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, the Plan Administrator may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses. On settlement or judgement of your legal action, you will be required to reimburse the Plan Administrator those amounts you recover which, when added to the payments you received from the Plan Administrator, exceed 100% of your incurred expenses.

Exclusions

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of insurance
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges

Your Group Benefits

Survivor Extended Benefit

If you die while your dependents are insured under this Group Benefit Program, the Extended Health Care and Dental Care benefits will continue 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 2 years from your death, or
- the date the Group Policy terminates.

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

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

The Benefit

Benefit Amount - 66.7% of your monthly earnings, subject to a minimum of \$50 and a maximum of \$11,000

Non-Evidence Limit - \$11,000

Qualifying Period - 119 days

- 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.

Your Group Benefits

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period

first of the month coincident with or next following 3 months for employees hired on or prior to the Group Policy Effective Date

first of the month coincident with or next following 3 months for all other employees

Entitlement Criteria

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

- you must be continuously Totally Disabled throughout the Qualifying Period. If your disability is not continuous, Manulife Financial will apply separate periods of disability towards satisfying the Qualifying Period, provided:
 - no interruption between periods of disability is longer than 3 weeks, and
 - the disabilities are due to the same or related illness or injury.
- 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.
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial.

Where there is a dispute over the nature and extent of your disability and/or the appropriateness of the care and treatment being provided to you, Manulife Financial may require an examination by an independent expert.

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 lay-off during which you become Totally Disabled
- 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

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any amount 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
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law

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

a) any amount you receive or are entitled to receive from:

- any group, association or franchise plan
- any retirement or pension plan
- earnings or payments from any employer, including severance payments and vacation pay
- self-employment
- any government plan, excluding Employment Insurance Benefits

b) any amount of Canada or Quebec Pension Plan benefits which another member of your family receives or is entitled to receive by reason of your disability

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

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

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

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

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

Once Manulife Financial determines that you are Totally Disabled, if appropriate, you will 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; and
- the nature, scope, objectives and cost of a 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

Manulife Financial may require that you be examined by an independent expert to assist in determining the appropriateness and structure of your Vocational Plan.

- 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

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit.
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:
 - your own occupation, during the Qualifying Period and the following 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.
- the date you do not attend an examination by an independent expert chosen by Manulife Financial.
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit.
- the date you reach the Termination Age for this benefit.
- the date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months of cessation of your Long Term Disability benefit payments, Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period. 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 cessation of benefit payments, 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

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

Your Group Benefits

Submitting a Claim

To submit a claim, you must complete the [Long Term Disability claim form](#) which is available from your Human Resources Department. 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

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.
- medical or surgical care which is not medically necessary.
- the committing of or the attempt to commit an assault or criminal offence.
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial.