York Region District School Board

Employee Group Benefit Booklet

Elementary Teachers' Federation Of Ontario-York Region (ETFO)

Human Resource Services *January 01, 2016**

*Revised as at January 01, 2016
*Periodic Updates, if any, of this booklet will be posted on the bww.yrdsb.ca
*Divisions 01/51

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Introduction

Your hospital, major medical, vision care and dental benefits are provided directly by the York Region District School Board. Manulife Financial has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices as per the plan document. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

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

This booklet summarizes your Board-Sponsored Benefits Program. It provides excellent reference when planning your family's present and future benefit needs. This booklet outlines your protection:

- When you have health care expenses;
- When you have dental care expenses;
- In the event of your death.

Please read this booklet carefully and share the information with your family. If you have any questions, you may contact:

Manulife Financial	1-800-268-6195
Human Resource Services	905-727-0022 extension 2479

Disclaimer

In the event of a discrepancy between this booklet and the Plan document, the terms of the Plan document will apply. The booklet, either in its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations.

This booklet describes your benefit plan as of January 01, 2016 and may not reflect changes to the plan made subsequent to that date.

ETFO
Summary of Benefits

BENEFIT	Annual Deductible	Amount Reimbursed	Overall Maximum	Premium
Extended Health Care Plan (Plan Policy #83081)				
***Semi-Private Hospital**	Nil Yes	100%	Unlimited	100% Board Paid
***Prescription drugs**	$25.00 per person $50.00 per family	80—100% *refer to page 12	Unlimited	100% Board Paid
***Massage**	Yes	100%	Up to $750 every calendar year per person	100% Board Paid
***Hearing Aids**	Yes	100%	Up to $1,000 every 24 consecutive months	100% Board Paid
Vision Care	Nil	100%	Up to $500 every 24 consecutive months	100% Board Paid
Eye Examinations	Nil	100%	Basic eye examination every 24 consecutive months (adults), 1 per calendar year (children under the age of 18)	
*Annual deductibles may be taken from any one of these benefits to a maximum of $25/single or $50/family				
Dental Plan (Plan Policy #83082)				
Basic: examinations, fluoride treatment, fillings	Nil	100% of the current ODA fee guide	$5,000 per person per calendar year	100% Board Paid
Dental Rider (Major Restorative & Orthodontic Services)	Nil	50% of the current ODA fee guide	Major Restorative: $5,000 per person/calendar year combined maximum with Basic Orthodontic: $1,500 per person/calendar year, $3,000 per person/lifetime	100% Employee Paid
Basic Life Insurance (Plan Policy #16595), Optional Life Insurance (Plan Policy #35895) ***Combined (Basic Life & Optional) maximum coverage of $500,000 as provided under Manulife Financial Group Policy GL 16595 and 35895***				
Basic: 2x earnings (rounded up to the next higher $1,000)**	Nil	Upon Death 2x earnings (subject to maximum coverage)	Upon Death 2x earnings (subject to maximum coverage)	100% Board Paid
Optional Life: 1x earnings**	Nil	Upon Death 1x earnings (subject to maximum coverage)	Upon Death 1x earnings (subject to maximum coverage)	100% Employee Paid
AD&D: 2x earnings (rounded up to the next higher $1,000, to a maximum coverage of $500,000)	Nil	Upon Accidental Death 2x earnings (subject to maximum coverage)	Upon Accidental Death 2x earnings (subject to maximum coverage)	100% Board Paid

When Does Coverage Start?

The benefits program provides protection for you and your dependents, usually on the date of hire. If you are not at work on your date of hire, **coverage becomes effective on the first day you begin work**. If you cancel your coverage on your leave, coverage will become effective again, on the first day you return to work.

However, Manulife does not receive notification of benefit coverage until **4 to 6 weeks after your date of hire**.

You can still incur benefit costs, but your receipts should not be submitted until at least 6 weeks from your start date.

When Does Your Coverage Cease?

Your group coverage will terminate on the earliest of the following:

- the date you cease to be an eligible employee;
- the date you enter the armed forces of any country on a full-time basis;
- the date the Group Contract terminates;
- the date any required contribution is due for any ‘employee paid benefits’ but not paid;
- the date you die;
- the date you leave the Board;
- for Life and AD&D, the date you reach age 70;
- the date you retire. However if you retire before you reach age 65, you may continue your benefits to age 65 at your cost under the Board Retiree Plan.

Please note: You have **90 days** after the termination of your benefits to submit claims to Manulife Financial for reimbursement.

How to Submit Claims to Manulife

All claim forms, are available on the **BWW website**, Employee Self Serve, left hand side Employee Benefits or from your School office or on www.manulife.ca

Remember, always provide your Group Contract Number **(Medical 83081** and **Dental 83082)** and your Certificate Number (your employee ID#) to avoid any unnecessary delays in the processing of your claim.

If expenses relate to hospital confinement, the hospital and you should complete a claim form. Manulife will send out a questionnaire to you, that will need to be completed and returned to Manulife.

When claims forms are completed, forward it to Manulife together with all receipts, and doctors note. Claims must be submitted no later than the end of the calendar year following the year in which expenses were incurred. If your coverage terminates for any reason, proof of claim must be submitted within 90 days of the date your coverage terminates.

Claim Payments

Once the claim has been processed, Manulife Financial will send an Explanation of Benefits to you.

This document 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. This payment can be made to you in one of two ways:

1) By cheque or;
2) By Direct Deposit. - Instructions for how to register online with Manulife can be found on page 8.

Benefit Claim Reimbursement Timeline

All claims pertaining to extended health and dental benefits must be submitted to Manulife Financial no later than the end of the calendar year (Dec 31) *following* the year in which the expenses were incurred.

Enroll, Change, Cancel, or Transfer

To change your benefits, please complete a Benefit Change eForm found on the BWW website.

There are two options for selection:

- Change existing Benefit Plan Options Single/Family, etc. This option allows you to enroll, change, cancel, or transfer to spouse your benefit options;

- Dependent Benefit Changes. This option allows you to add/modify/remove a dependent, and update coverage for a child over age of 21.

Step 1. Employee Self Serve > My eForms Tab;

Step 2. eForm - Benefit Change Request;

Step 3. Click link to—Create a New Request;

Step 4. Reason for Change:
Change existing Benefit Plan options - single/family, etc. **OR**
Dependent Benefit changes;

Step 5. Submit eForm. You will receive an email once the eForm has been keyed by the Benefits Representative.

For further assistance, please refer to your Training Module/Tools— Submitting Benefit Change Request.

How to Register Online with Manulife

Step 1. Go to www.Manulife.ca / Sign In / Plan Member;
Step 2. Plan Contract # Medical 83081 or Dental 83082;
Step 3. Click Registration and complete the registration process;
Step 4. You will receive an activation key approximately, 3-5 business days after registration. It will be mailed to your home address.

Follow these simple steps to activate your account and complete the registration process. Once you have received your activation key from Manulife.

Step 1. Click login button;
Step 2. Enter your password;
Step 3. Enter the activation code you have received from Manulife (only use it the first time you login in).

Activating your account will complete the registration process. You will now be able to access all of the available online Plan features.

In order to **set up direct deposit for your claims**, you will need to be registered on the Manulife Group Benefit internet site. The address is www.manulife.ca.

From the Group Benefit internet site, choose sign in, my profile, banking information. Complete all the information including transit, institution and account number found on the bottom of your bank cheques, and press the submit button.

Once you have established the direct deposit, you can submit changes to your banking information at any time. You can even discontinue this payment method and revert to paper cheques.

If you have not received an activation key in the mail after 5 business days or you are having difficulty signing into the site please contact Manulife Group Benefits Customer Service Centre at 1-800-268-6195.

Who is Covered?

Your eligible dependents include your spouse, partner or common-law spouse (cohabits with the employee in a conjugal relationship for at least 12 months at the time a claim is incurred) unmarried children under age 21 (including adopted, foster and step-children). All Benefits are **terminated** when a child turns 21 years of age.

When your child turns 21 and is a full-time student at an accredited Canadian Institute of Learning, you (the Board employee), are responsible for completing a Benefit Change Request **eForm** on the BWW website to have your child's benefits reinstated with Manulife. The process is required every school year. The coverage continues to the age of 25.

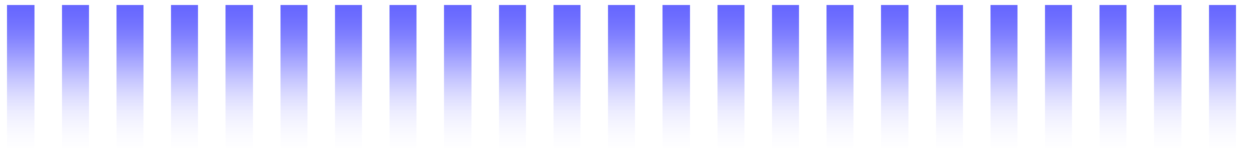
If you have a mentally or physically handicapped child, coverage continues beyond age 21, provided your child is incapable of self-sustaining employment and completely dependent upon you.

Out of Country Coverage

If you plan to travel outside of Canada we recommend you obtain private coverage, as **our Plan does not carry out of country coverage.**

Out of Province Coverage

If you require emergency medical services while out-of-province, the Plan will reimburse you up to amounts allowed under the applicable Ontario Fee Guide. You may wish to purchase additional private coverage when traveling out of province.



Coordination of Benefits

If you or your dependents are covered under more than one health plan, your benefits will be coordinated so the total amount reimbursed will not exceed the actual expenses incurred.

Please Note: There is no coordination of benefits between two Board Employees.

How Does Coordination of Benefits Work?

Claims for dependent children:

If the month and day of the Member's birth is….	Then claims should be submitted…. First to….	Then send the first claims statements….
Earlier than the Member's spouse's	The member's plan with Manulife	To the spouse's plan with the other insurance carrier
Later than the Member's spouse's	The spouse's plan with the other insurance carrier	To the member's plan with Manulife

Claims for dependent spouses:

If the claim is….	and….	The claim should be Submitted…. First to….	Then….
The Plan Member	The plan member is covered as a dependant under a spouse's plan	To the member's plan with Manulife	To the spouse's plan with the other insurance carrier
The Plan Member's spouse	The spouse is covered as an eligible dependant under the member's Manulife plan	To the spouse's plan with other insurance carrier	The member's plan with Manulife

Your Extended Health Care Plan, in combination with government-sponsored health care, provides valuable protection and peace of mind for you and your family.

When Coverage Begins:
You and your eligible dependents are covered under this Plan as of the date you commence employment.

If coverage is currently for yourself only and you later acquire a dependent; You will need to complete a Manulife Extended Health Care form (**section 2** Patient Information), and Manulife will add your dependents to the plan.

If your spouse is employed by the Board, there is no coordination of benefits between two Board employees. If you are covered under your spouse's health care plan, you are not required to apply for this Plan.

Semi Private Hospital Accommodation Plan Policy # 83081

The Plan pays 100% of the difference in cost between semi-private accommodation and ward coverage under OHIP.

Please note that if you are also covered by the major medical plan, you will be reimbursed for the cost of private hospital accommodation, should this be available. Semi Private and Private coverage is limited to “reasonable and customary” limits. If expenses relate to hospital confinement, the hospital and you should complete a claim form.

Manulife will send you a questionnaire that must be correctly completed, dated, and signed before Manulife will reimburse the hospital.

When completed, forward it to the insurer together with all receipts. Claims must be submitted no later that the end of the calendar year following the year in which expenses were incurred. If your coverage terminates for any reason, proof of claim must be submitted within 90 days of the date your coverage terminates.

The Plan pays 100% of many medical expenses for you and your dependents after you pay an annual deductible. The deductible of $25 per person (to a maximum of $50 per family) is the amount you must pay each year before the Plan starts reimbursing your costs.

The deductible is applied to the first expenses submitted during a 12-month calendar year period. For example if you submit $100 for drug expenses in January and $20 for vision expenses in June, the deductible will be taken from the payment for the drug expenses.

The Plan covers generic drugs available only by written prescription (no over-the-counter drugs are covered, even if prescribed).

Reimbursement shall be as follows:

1. 100% if an interchangeable generic product is available and has been substituted;
2. 100% for brand name drugs where an interchangeable generic product is not available;
3. 100% for brand name drugs where the prescriber has indicated that no substitution be made;
4. 80% if an interchangeable generic product is available and not dispensed and the prescriber did not indicate that no substitution be made.

Additional Coverage Includes:

- Fertility drugs – $15,000 Lifetime maximum per person;
- Smoking cessation products - $300 Lifetime maximum per person.

The Plan pays 100% of the cost of the following Podiatrist care services, providing a referral note from a licensed physician every calendar year. Services of a registered licensed podiatrist, up to $750 per practitioner per calendar year per person (less any provincial health insurance payments).

- Payments up to a total of $750 per person per calendar year, including non-surgery podiatry visits and x-rays;

- In addition, payment up to a total of $100 for the surgical removal of toenails or the excision of plantar warts by podiatrist. This is a separate maximum from the $750 calendar year maximum.

Orthotics
Plan Policy # 83081

Coverage for **one pair** of orthotics every three years, up to $500, when prescribed and dispensed by a medical doctor, podiatrist, chiropodist or orthopedic surgeon. Along with the claim form, you will need to provide (or have the orthotics supplier provide) the following documentation:

From your physician/practitioner:
1. Recommendation/referral from the prescribing physician, podiatrist/chiropodist, which includes the medical conditions) for which your orthotics are prescribed.

From the supplier:
1. Copies of the biomechanical examination and gait analysis performed;
2. Complete description of the process used to create the orthotics, including the casting technique and the raw materials used;
3. Confirmation that the orthotics have been paid in full (supporting receipt) or confirmation that the patient has received the appliances.

Please note: That any service or health care product not paid in full during the benefit coverage period will not be eligible for reimbursement by Manulife Financial.

For example: An eligible health care product is ordered at the beginning of the coverage period paying a deposit. However, since the payment is made in full outside the benefit coverage period, the claim will not be reimbursed by Manulife Financial.

If any of this information is missing, you or the orthotics supplier will be asked to provide it before the claim can be paid.

Paramedical Services
Plan # 83081

All of the paramedical services (with the exception of the naturopath services) will be eligible only with a written referral from a licensed physician. Referral letters are valid from January 1—December 31 of the current calendar year.

For any services which have a partial OHIP contribution, the difference between what OHIP covers and the total cost of the services is not eligible for reimbursement through the benefit plan. Until annual OHIP maximums are exhausted, the full payment is the responsibility of the patient. Any further expenses will then be considered for reimbursement through the plan.

- services of a registered **licensed naturopath** up to $750 per calendar year per person (effective October 1, 2007 a doctor's referral letter is not needed);
- services of a registered **licensed psychologist** (reimbursed at 50%), up to $1,000 per calendar year per person;
- services of a **licensed physiotherapist**, up to $750 per calendar year per person (less any provincial health insurance payments);
- services of a registered **licensed chiropractor**, up to $750 per calendar year per person. This coverage is in effect after the first five visits have been completed, and payment will begin on the sixth visit;
- services of a registered **licensed osteopath** and registered **licensed speech therapist**, up to $750 per practitioner per calendar year per person (less any provincial health insurance payments);
- services of a registered **licensed massage therapist**, up to $750 per calendar year per person;
- services of a registered **licensed family therapist**, up to $750 per calendar year, per family (less any provincial health insurance payments).

  A Family Therapist is a person who is one of the following:
  1. is a member of the Ontario Association For Marriage and Family Therapist;
  2. is a member of the Ontario College of Certified Social Workers;
  3. is a psychologist providing family therapy and/or marriage counseling;
  4. is a practitioner who holds a Ph.D. in psychology;
  5. is a practitioner who has been referred by an EAP provider (verify referred practitioner is eligible under the Plan).

Nursing
Plan Policy #83081

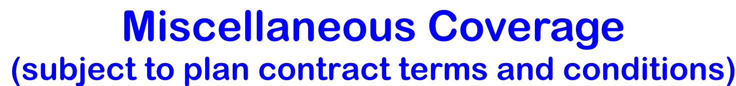
Services of a Registered Nurse, Registered Nursing Assistant (RNA) or Registered Practical Nurse (RPN) in the home if medically necessary and ordered by a physician (provided the care provider does not live with you) up to $25,000 per calendar year.

Contact Manulife for details regarding the eligibility and reimbursement of this benefit prior to incurring expenses.

Vision Care
Plan Policy #83081

Vision care expenses are eligible only when recommended by a physician (including an ophthalmologist) or an optometrist. The Plan pays 100% of the cost of the following vision care services and supplies:

- basic eye examination every 24 consecutive months (adults), 1 per calendar year for children under the age of 18;
- frames, lenses and fitting of prescription glasses, including prescription sunglasses and contact lenses, up to $500 every 24 months effective September 1, 2009;
- contact lenses prescribed for severe corneal astigmatism or scarring, keratoconus or aphakia, provided vision can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by regular glasses, up to a lifetime maximum of $200 per person;
- services for visual training or remedial exercises ocular examinations (including refraction) -- once in any calendar year for dependent children and once in any 24 consecutive months for you and your spouse;
- laser eye surgery shall be lifetime maximum coverage of $1500.00 effective September 1, 2009;
- once per Lifetime after cataract surgery or for patients lacking organic lenses. (contact Manulife for details regarding the eligibility and reimbursement of this benefit prior to incurring expenses).



Miscellaneous Coverage

(subject to plan contract terms and conditions)

Contact Manulife for details regarding the eligibility and reimbursement of these benefits prior to incurring expenses

- diagnostic procedures, radiology, blood transfusions and oxygen (including any equipment necessary for its administration);
- transportation by a licensed ground ambulance to and from a local hospital;
- includes transportation to and from the hospital and airport, at the points of arrival and departure;
- dental treatment to repair damage resulting from an accidental injury to natural teeth; treatment must occur within six months of the accident and your coverage must be in force;
- purchase of trusses, splints, braces, crutches, artificial limbs or eyes, prosthetic lenses and frames (once only for a patient who lacks an organic lens after cataract surgery);
- purchase of prostheses following surgery;
- rental, or at the insurer's option, purchase of a wheelchair, hospital bed or respirator/ventilator or other supportive devices;
- room, board and normal nursing care in a licensed nursing home or clinic (for convalescent or chronic care, but excluding custodial care), up to $20 per day;
- hospital outpatient charges for necessary medical or surgical treatment (excluding physicians' fees and special nurses' fees);
- hearing aids - maximum of $1,000 every 24 consecutive months effective September 1, 2009.

Please note: That any service or health care product not paid in full during the benefit coverage period will not be eligible for reimbursement by Manulife Financial.

For example: An eligible health care product is ordered at the beginning of the coverage period paying a deposit. However, since the payment is made in full outside the benefit coverage period, the claim will not be reimbursed by Manulife Financial.

Extended Health Care Expenses Not Covered

No payments will be made for expenses resulting from but not limited to the following:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which you are entitled to benefits under Workplace Safety & Insurance Board;
- charges by a physician or dentist for time spent traveling, broken appointments, transportation costs, room rental charges or for advice given by telephone (or other means of telecommunication);
- cosmetic surgery or treatment, unless such treatment is for accidental injuries and commences within 90 days of the accident;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- services, treatments or supplies covered under any government plan; the Plan pays only charges in excess of payments under government plans;
- examinations required for use of a third party;
- travel for health reasons;
- eyeglasses for cosmetic purposes;
- any charges for services, treatments or supplies for which there would be no charge except for the existence of coverage;
- drugs, sera, injectables and supplies not approved by Health & Welfare Canada (Food and Drugs) or experimental or limited in use;
- experimental medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society;
- sclerotherapy (treatment that bleaches spider veins);
- elastic support stockings;
- synvisc;
- drugs used for the treatment of sexual dysfunction.

Basic Dental Services
This Plan is your family's best defense against the rising costs of good dental care. You and your eligible dependents are each covered for up to $5,000 a calendar year in Basic Dental Services.

The Major Restorative/Orthodontic (Rider)
The Major Restorative/Orthodontic (Rider) benefit coverage is an optional coverage

- The premiums are 100% employee paid;
- The maximum reimbursement for this coverage is **50%**.

BENEFIT	LIMITATIONS	REIMBURSEMENT
Major Restorative	$5,000 per person per calendar year combined with basic dental coverage	Max 50%
Orthodontic	$1,500 per person per calendar year; $3000 per person/lifetime	Max 50%

If you **do not enroll** in this benefit when first offered and you choose to enroll in it at a later date, you will be under the **penalty** outlined below.

BENEFIT	PENALTY PERIOD	MAXIMUM REIMBURSE-MENT (During Penalty Period)
Major Restorative	1 year from your enrolment date	$100
Orthodontics	3 years from your enrolment date	$100

Please note: The alternate benefit clause is applied to all eligible expenses in the event that optional procedures are possible, the procedure involving the lowest fee will be considered – provided it is consistent with good dental care.

Proposed Dental Treatment

If you expect **Proposed Dental Treatment** to **cost more than $300**, you and your dentist should complete and submit a treatment plan to the insurer, outlining the services to be performed. The insurer will review the treatment plan and inform you of what costs, if any, you will be expected to pay.

What is Covered Under Dental Basic Services? Plan Policy # 83082

The Plan pays 100% of the cost based on the current Ontario Dental Association Fee Guide.

Diagnostic services/examinations:

- complete oral examinations (once every three years);
- recall oral examinations (once every six months);
- x-rays (some limitations apply);
- tests and laboratory examinations;
- treatment planning and consultations;
- bacteriologic cultures, caries susceptibility tests, cytological examinations, pulp vitality tests.

Preventive services:

- one unit of scaling and polishing (once every six months);
- fluoride treatment;
- oral hygiene instruction (once every six months);
- pain control;
- interproximal discing of teeth;
- pit and fissure sealants.

What is Covered Under Dental Basic Services? (cont'd)
Plan Policy # 83082

Restorative services:
- amalgam, acrylic, composite or silicate restorations;
- pin reinforcement;
- stainless steel or preformed plastic crowns (coverage for temporary usage ONLY).

Endodontic services (treatment of pulp):
- pulp capping and pulpotomy (removal of pulp);
- root canal therapy;
- Apexification;
- periapical services;
- root amputation and hemisection (removal of roots from a multi-rooted tooth);
- chemical bleaching;
- intentional removal, apical filling and reimplantation;
- other endodontic procedures preparing the tooth for treatment;
- emergency endodontic procedures.

Periodontal services (treatment of gum tissue):
- application of dressing, management of acute infections and oral lesions;
- desensitization of tooth surface;
- gingival curettage, gingivoplasty (shaping of gums), gingivectomy (removal of infected and diseased gum-tissue);
- osseous surgery (bone surgery);
- soft tissue grafts;
- vestibuloplasty, occlusal equilibration;
- adjunctive periodontal services, including splinting, scaling, root planing, periodontal appliances;
- maintenance, adjustments and repairs to periodontal appliances.

Denture adjustments:
- minor adjustments (after three months from insertion);
- denture repairs;
- denture rebasing and/or relining.

Other services:
- anesthesia, drug injections;
- consultation with another dentist or professional visits;
- drug injections.

What is Covered Under Dental Basic Services? (cont'd) Plan Policy # 83082

Other surgical services:

- removal of erupted or impacted teeth;
- removal of residual roots, fibrotomy;
- surgical exposure, transplantation or repositioning of teeth;
- enucleation of unerupted teeth and follicles;
- alveoplasty (preparation of the mouth for the fitting of dentures);
- gingivoplasty and/or stomatoplasty (plastic surgery of the mouth);
- osteoplasty;
- surgical excision or incision;
- fractures;
- frenectomy;
- additional miscellaneous surgical services.

Optional Dental Rider Plan Policy # 83082

The optional Dental Rider consists of two parts, Major Restorative Services and Orthodontic Services.

Please note: The alternate benefit clause is applied to all eligible expenses in the event that optional procedures are possible, the procedure involving the lowest fee will be considered – provided it is consistent with good dental care.

If you elect to pay a premium for coverage in addition to Basic Services, the Plan pays 50% of the cost of the following services based on the current Ontario Dental Association Fee Guide's and maximums specified on Page 18.

What is Covered Under the Optional Dental Rider Plan Policy # 83082

Restorative services:

- restorations using preformed stainless steel, metal, polycarbonate or plastic crown;
- retentive pins in inlays and crowns;
- porcelain inlays or onlays;
- crowns (acrylic, plastic, porcelain, metal, cast metal, porcelain fused to metal)
- cast post and cores;
- cast metal post and cores as a separate procedure.

Other restorative services:

- posts and cores (prefabricated metal, pin-reinforced amalgam, pin-reinforced composite), crowns made to existing partial denture.

Prosthodontic services -- general:

- replacement of existing fixed or removable dentures will be considered if;
- replacement if necessitated by extraction of additional natural teeth while covered under this policy;
- the existing denture is at least three years old and cannot be made serviceable;
- the existing denture is temporary and is replaced with a permanent denture within 12 months of installation of the temporary one;
- complete maxillary and/or mandibular denture;
- immediate complete denture;
- transitional complete or partial denture;
- removable partial denture (including cast, chrome, cobalt or gold).

Prosthodontic services -- fixed:

- evaluation of extensive or complicated restorative dentistry;
- metal, porcelain and acrylic pontics (individual artificial teeth);
- excision of hyperplastic tissue;
- in-office laboratory charges;
- metal inlays and onlays;
- acrylic, porcelain, metal and/or partial veneer crowns;
- retentive pins in abutments.

When Dental Benefits Are Not Payable

No payment will be made for expenses resulting from but not limited to the following:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which you are entitled to benefit under Workplace Safety & Insurance Board;
- charges of a physician or dentist for time spent traveling, broken appointments, transportation costs, room rental charges or for advice given by telephone (or other means of telecommunication);
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot services, treatments or supplies covered under any government plan. This Plan pays costs in excess of those covered under government plans, where permitted by law;
- examinations required for use of a third party;
- dental treatment received from a dental or medical department maintained by an employer, association or labour union;
- replacement of an existing dental appliance which has been lost, mislaid or stolen;
- dental services and supplies rendered for full-mouth reconstruction, vertical dimension correction or for a correction to temporomandibular joint dysfunction;
- any charges for services, treatments or supplies for which there would be no charge except for the existence of coverage;
- implants, or any service rendered in conjunction with implants;
- cosmetic surgery or treatment (when so classified by Manulife Financial) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident;
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.

When Your Coverage Begins

Basic Life Insurance and Accidental Death & Dismemberment benefits become effective on the date you commence employment. The Board pays 100% of the premium for this coverage.

You can also apply for Optional Life coverage. If you choose to apply for optional coverage you are responsible for 100% of the cost.

If You Become Disabled

If you become totally disabled and remain disabled for at least six months, your coverage will continue without payment of premiums (up to the earlier of recovery or age 65). You must submit satisfactory proof of your disability to the insurer within 12 months after your disability begins.

If You Leave the Board

If you terminate your employment, you can convert your Basic Life Insurance coverage to an individual life insurance policy within 31 days after your date of termination. The combined maximum you can convert is $200,000. If you apply within the 31-day period, you will not be required to provide medical evidence of insurability.

If you die within 31 days after termination, your full coverage will be paid to your spouse or beneficiary, even if you did not apply for conversion.

When Does Your Coverage Cease?

If you are actively employed at the Board when you reach age 70; life, optional (if applicable) and accidental death and dismemberment insurance will cease on your 70th birthday. Refer to page 5 of this booklet for additional termination of coverage details.

Basic Life Insurance
Plan Policy # 16595

In the event of your death , this Plan pays your beneficiary a death benefit equal to:

- two times your annual earnings, rounded to the next higher $1,000 to a maximum coverage of $500,000.00 (combined with Optional Life as provided under Manulife Financial Group Policy GL 35895).

Your earnings are your gross earnings excluding bonuses, commissions and overtime.

Accidental Death & Dismemberment (AD&D)
Plan Policy # 16595

This Plan provides additional benefits to your beneficiary if your death or dismemberment occurs as a result of an accident at any time, anywhere in the world (within 365 days after the accident).

Your coverage is equal to:

- two times your annual earnings, rounded to the next higher $1,000 to a maximum coverage of $500,000.00.

For injuries to the same limb resulting from one accident, only one of the amounts shown (the largest applicable) will be paid. The maximum payable for all losses sustained as a result of the same accident is 100% of your coverage.

Optional Life Insurance Plan Policy # 35895

You are able to purchase additional protection equal to 1x your annual earnings, rounded to the next higher $1,000. You pay a premium for this coverage through convenient payroll deduction.

If you elect this coverage, in the event of your death, this Plan pays your beneficiary a death benefit equal to **1 times your annual earnings** (combined with Basic Life to a maximum coverage of $500,000).

How to Claim Life Insurance Benefits
Basic Life and (AD&D) Plan Policy # 16595
Optional Life Insurance Plan Policy # 35895

Basic and Optional Life Claim:

- your beneficiary will receive the necessary claim forms from Human Resource Services. Proof of death should be submitted as soon as reasonably possible.

Accidental Dismemberment Claim:

- you will receive the necessary claim forms from Human Resource Services. Proof of claim must be submitted to Manulife Financial within 90 days after the date of loss.

The Amounts Payable in the Event of Loss are:

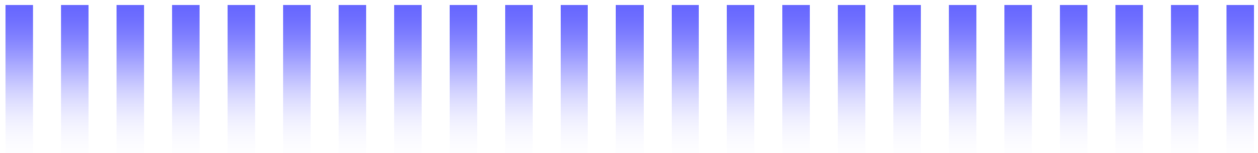
For loss of:	% Covered by Plan:
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye or one foot and sight of one eye	100%
Entire sight of one eye	100%
Hearing in both ears and speech	100%
Thumb and index finger of one hand	66 2/3%
Four fingers of one hand	66 2/3%
Hearing in one ear	50%
Loss of all toes of one foot	33 1/3%
Loss of one arm, or one leg, or one hand, or one foot	100%

Loss of use of:	% Covered by Plan:
Both hands or both feet	100%
One arm or one leg or one hand or one foot	100%
Thumb and index finger or at least four fingers on one hand	66 2/3%
Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	200%

When AD&D Benefits are Not Payable

No benefit will be payable for any claim arising as a direct or indirect result of one of the following:

- suicide, intentional self-inflicted injuries while sane, or self-inflicted injuries while insane;
- war or any act of war, whether declared or not;
- service in the armed forces of any country which is in a state of war;
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew;
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of the employer.



Long Term Disability

If you are at the Board when you reach age 65, long term disability benefits will cease on your 70th birthday. The LTD Cancellation Rules can be accessed on the BWW.