EMPLOYEE GROUP HEALTH BENEFITS (INCLUDING VISION CARE)*

DENTAL BENEFITS

FOR

ELIGIBLE EMPLOYEES OF

SEVEN OAKS SCHOOL DIVISION

490 Dutton Drive, Suite B6, Waterloo, Ontario
Toll Free: (800) 265-2178 Fax: (519) 747-5323
www.pwi-insurance.ca info@pwi-insurance.ca

Modified Health Benefits (including Vision Care) are available to retired employees,and are described herein. Dental Benefits terminate at retirement.

EQUITABLE LIFE POLICY #97822

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

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

We encourage you to read and understand the benefits that your Employer is providing for you. If you have any questions, please contact PWI Insurance Services (Agency) Ltd. who administers your Group Benefits Plan.

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

IMPORTANT

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

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THIS GROUP INSURANCE PLAN HAS BEEN ARRANGED AND IS ADMINISTERED BY:

PWI Insurance Services (Agency) Ltd.
490 Dutton Drive, Suite B6, Waterloo, Ontario N2L 6H7
1-800-265-2178

The Employee Benefit Specialists

GENERAL INFORMATION

The Plan described in this booklet was effective on April 1, 2005, and reflects amendments dated July 1, 2006, September 1, 2006, December 1, 2009, October 1, 2010, January 1, 2012, September 1, 2012, September 1, 2013, and October 1, 2014.

In this booklet "the Company", "we" and "us" means The Equitable Life Insurance Company of Canada.
The Plan Administrator for these benefits is PWI Insurance Services (Agency) Ltd.

CLASSIFICATION

All eligible employees of:
- Educational Assistants
- Trustees
- SOTA
- Manitoba Association of School Superintendents
- CUPE 2348
- Superintendents & Divisional Administration Employees

GENERAL INFORMATION

Maximum Age for Dependent Children:
Under age 21 but under age 25 if in school full-time

Co-Habitation Requirement for Partners *(see **General Provisions for Dependents page** for more information on coverage for your eligible dependents)***:**
12 consecutive months

Maximum Age for Coverage *(see **5. When Does Your Insurance Terminate? on the General Provisions page** for more information)***:**
Health Benefits and Dental Benefits terminate at retirement – modified Health Benefits may be continued in retirement – see paragraph below.

Modified Health Benefits in Retirement:
A modified Health Benefit is available to you (and your eligible dependents) upon your retirement provided you apply no later than 15 days following your retirement date.

Participation:
Compulsory for all permanent part-time and permanent full-time employees. Opting out is not allowed under the Health Benefits and Dental benefits.

Waiting Period *(see **2. When Am I Eligible to Join the Group Insurance Plan - Is There a Waiting Period? on the General Provisions page** for more information):*
Nil

GENERAL PROVISIONS

1. **WHO IS ELIGIBLE TO JOIN THE GROUP PLAN?**

You are eligible if you:
* live in Canada, and
* actively and regularly work for this Employer on a permanent part-time or permanent full-time basis (including term positions of at least 5 months), and
* if employed in a part-time or term position work at least 30% of a full-time position, and
* belong to the classification shown on the General Information page.

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

You are eligible to apply for coverage under this Group Plan from the date that you are appointed to a position by the Division. There is no waiting period.

Notwithstanding the above,

* if you are employed in a definite term position of at least 5 months, you are eligible for Extended Health Care and Dental benefits from the date that you are appointed to that definite term position. Notwithstanding the above, if an eligible contract employee is appointed to a definite term contract for a full school term, but that school term is less than 5 months, such employee will be eligible for Extended Health Care and Dental benefits from the effective date of such contract.

* if you are appointed to an indefinite term position, Extended Health Care and Dental benefits commence 6 months following the date that you are appointed to that indefinite term position.

Coverage is compulsory for all eligible employees.

3. **HOW DO YOU JOIN?**

* fully complete a **Group Insurance Enrollment Card**

4. **WHEN DOES YOUR INSURANCE COVERAGE BECOME EFFECTIVE?**

Your coverage becomes effective on the date you become eligible. You'll be given a **Group Insurance Certificate** showing the Effective Date of your entry into the Group Plan.

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

5. **WHEN DOES YOUR INSURANCE TERMINATE?**

Your insurance terminates on the earlier of the following dates:
* on the date of your retirement (modified Health Benefits are available to you upon retirement provided you apply before, or within 15 days following, your retirement date.)
* on the date you are no longer employed by the Employer
* on the date your Employer terminates your coverage
* on the date this Group Policy terminates
* on the date you no longer qualify for coverage
* on the date you reach the ***Maximum Age for Coverage on the General Information page***

GENERAL PROVISIONS FOR DEPENDENTS

1. **WHO ARE ELIGIBLE DEPENDENTS?**

Eligible dependents must **live in Canada** and include:

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

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

* your **natural child, adopted child, stepchild or child of your spouse**. They must be unmarried, normally live with you or your spouse, be supported by you, and not be working on a full-time basis. See the ***Maximum Age for Dependent Children on the General Information page***.

* your **developmentally or physically disabled natural child, adopted child, stepchild or child of your spouse**. To be eligible, the child must be unmarried and we must have a Doctor's certificate stating he/she is incapable of self-sustaining employment and chiefly dependent upon you for support. (Please note that a dependent who has not been supported by you, is over age 21, and becomes disabled, is not eligible for coverage under the plan.)

2. **HOW TO APPLY TO COVER YOUR DEPENDENTS**

If you have any eligible dependents fully complete a **Group Insurance Enrollment Card.**

If you don't have any eligible dependents when you join the Group Plan, please advise PWI Insurance Services as soon as you do acquire a dependent (when you get married, start living with your partner*, or have a child). Complete the required forms so your spouse or child can be included. *Remember that when you start living with your partner, there is a 12-month co-habitation period.

3. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?**

If you applied for dependent coverage when you joined the Group Plan, coverage for your dependents is effective on the date your own coverage is effective.

4. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?**

* on the **date your own coverage terminates**
* on the **date the dependent no longer qualifies** as an eligible dependent as described in 1. above

SCHEDULE OF BENEFITS
EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Deductible Amount per Calendar Year:
Nil

Reimbursement Percentage:
Vision: 100%
Ambulance, including Medical Transfer Service and Hostel Accommodation : 100%
Out-of-Province/Canada, including Travel Assist: 100%
All other benefits: 80%

Benefits:
Pay-Direct Drug Plan #88 Generic (Note: The Pay-Direct Drug Plan provider is Emergis Inc.)
Maximum dispensing fee: The maximum amount eligible is the cost of the drug plus a dispensing fee up to a maximum of $6.00 per prescription
Major Services, including Travel Assist
Vision Care *(see **Vision Care Services pages** for more information)*:
Eye Glasses or Contact Lenses or Laser Eye Surgery. Maximum: $400
This maximum applies in any period of 24 months for adults and for dependent children.
One eye examination every 24 months for each insured individual is included in the Vision Care maximum.

Employees Who Have Not Registered with Manitoba Pharmacare:
If you have not provided confirmation of your registration with Manitoba Pharmacare, your drug coverage is limited to $750 per family per calendar year until proof of your Manitoba Pharmacare registration is received.

Lifetime Maximum Amount per insured person:
Unlimited, except in respect of services rendered outside the province of residence the maximum is:
i. $5,000,000 lifetime in respect of actively-working employees under age 70 and their eligible dependents, and
ii. $1,000,000 lifetime in respect of actively-working employees age 70 and over and their eligible dependents

Lifetime Maximum in respect of Eligible Retired Employees and each of the eligible dependents of that employee:
Unlimited, except there is a $1,000,000 Lifetime Maximum for services rendered outside the province of residence.

See ***Summary of Health Benefit Maximums page, Services Outside the Province: Time Limit for Commencement of Emergency Treatment*** for more information.

See ***Health Benefits - Major Services page, 7. Services Outside the Province*** for the definition of "emergency treatment"

SURVIVOR BENEFIT
Maximum Period for Survivor Benefit: 2 years

SUMMARY OF HEALTH BENEFIT MAXIMUMS

THE FOLLOWING MAXIMUMS APPLY TO ITEMS COVERED UNDER THE MAJOR SERVICES PORTION OF THE HEALTH BENEFITS:

Note: The numbers at the left refer to the corresponding item number on the Health pages in this booklet. Please see ***Health Benefits - Major Services pages*** for more information about these benefits.

#1 **Maximum Payable for Convalescent Home Services**:
$20 per day for a maximum of 180 days per disability

#3 **Maximum Amount Payable for Nursing Care Services**:
$5,000 per insured person per calendar year

#4(a) **Maximum Period for Rental of Equipment:**
6 months

#4(c) **Maximum for Breast Prosthesis and Surgical Brassiere(s)**:
one breast prosthesis per affected breast per calendar year
two surgical brassieres per calendar year

#4(e) **Maximum for Hearing Aids**:
$1,000 in any period of 36 consecutive months

#4(f) **Maximum for Orthotics and Orthopaedic Shoes**:
Custom-made Orthotics: $350 per calendar year
Custom-made Orthopaedic Shoes: $500 per calendar year

#4(h) **Maximum for Wigs and Hairpieces (after chemotherapy or radiation therapy)**:
$300 lifetime maximum

#4(i) **Maximum for Glucometers**
1 glucometer per insured person per lifetime

#4(j) **Maximum for Laboratory Services and PSA Testing:**
$200 per calendar year for Laboratory Services (excludes Genetic Testing) and $250 per calendar year for PSA Testing

#4(k) **Maximum for Surgical Stockings/Support Hose, and Stump Socks:**
2 pairs per calendar year for each

SUMMARY OF HEALTH BENEFIT MAXIMUMS

MAXIMUMS UNDER THE MAJOR SERVICES PORTION OF THE HEALTH BENEFITS (Continued)

#6 **Maximums for Paramedical Services**:

Audiologist	$850 per insured person per calendar year
Certified Athletic Therapist	$850 per insured person per calendar year
Chiropractor	$850 per insured person per calendar year
Dietician	$850 per insured person per calendar year
Massage Therapist	$850 per insured person per calendar year
Naturopath	$850 per insured person per calendar year
Osteopath	$850 per insured person per calendar year
Physiotherapist	$850 per insured person per calendar year
Podiatrist/Chiropodist	$850 per insured person per calendar year
Psychologist (including MSW/Clinical Counsellors)	$850 per insured person per calendar year
Specialist in Acupuncture	$850 per insured person per calendar year
Speech Therapist	$850 per insured person per calendar year

Please note: a physician's prescription (referral) is not required for Paramedical Services.

#7 **Services Outside the Province:**

Time Limit for Commencement of Emergency Treatment (see 7. (b) under ***Health Benefits - Major Services page***):
90 days for active employees under age 70, and each eligible dependent; 60 days for active employees age 70 to 79, inclusive, and each eligible dependent; 30 days for active employees age 80 and older, and each eligible dependent; 30 days for retired employees, regardless of age, and each eligible dependent.

#8 **Maximum Payable for Cardiac Rehabilitation:**
$300 lifetime maximum

HEALTH BENEFITS - GENERAL PROVISIONS

1. **DESCRIPTION OF THIS BENEFIT**

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

2. **WHAT IS THE "DEDUCTIBLE AMOUNT"?**

This is the amount you must pay before any benefits become payable under the Group Plan. See the ***Employee and Dependent Health Benefits box on the Schedule of Benefits page for the Deductible Amount.***

3. **WHAT IS THE "REIMBURSEMENT PERCENTAGE"?**

This is the percentage (portion) of eligible expenses that is paid by the Company after any Deductible Amount has been reached. See the ***Employee and Dependent Health Benefits box on the Schedule of Benefits page for the Reimbursement Percentage.***

4. **HOW DOES THE "COORDINATION OF BENEFITS" WORK?**

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

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

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

5. **WHAT ARE THE OVERALL MAXIMUM AMOUNTS?**

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

HEALTH BENEFITS - GENERAL PROVISIONS

6. **DEFINITION OF "PRACTITIONERS"**

In the ***Summary of Health Benefit Maximums page***, we refer to various practitioners. Below is the definition for these practitioners (the qualifications they must have for claims to be eligible):
Paramedical practitioners:

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

Other practitioners:

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

7. **RECURRENT DISABILITY**

This can apply to those Health Benefits which include a maximum period of time during which benefits are payable for any one disability or period of disability (such as ***Convalescent Home Services Health Benefits - Major Services page***) .

If **you** return to active work after being disabled due to illness or accident and you then become disabled again within 14 days from the same or related causes, it will be assumed that the original disability has continued.

If **one of your eligible dependents** is disabled due to sickness or accident and recovers but then becomes disabled again within 90 days from the same or related causes, it will be assumed that the original disability has continued.

8. **WHAT HAPPENS IF YOUR HEALTH BENEFITS TERMINATE?**

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

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

provided we receive proof that is acceptable to the Company that the person is totally disabled.

9. **WHAT IS NOT COVERED?**

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

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

10. **HOW TO SUBMIT CLAIMS**

Look on the following benefit descriptive pages to see what claim forms are needed. Claims must be submitted within 365 days following the calendar year in which the claim was incurred. However, please note that **if your insurance terminates or if the Health Benefits under this Policy terminate or if this Group Policy terminates, all claims incurred prior to the date of termination must be submitted to the Company within 90 days of the date of termination.**

HEALTH BENEFITS – PAY-DIRECT PRESCRIPTION DRUG PLAN #88 Generic

This is a Pay-Direct Drug Plan **administered by Emergis Inc.**

NOTE: This is a Generic Drug Plan and the maximum that will be reimbursed is an amount equal to the lowest priced substitutable drug as provided for in the Provincial Drug Benefit Formulary, unless the physician has noted "no substitution" on the prescription.

1. **WHAT IS COVERED?**

(a) **prescribed drugs and medicines** if they're dispensed by a pharmacist and which:
- * bear a Drug Identification Number (DIN) and are listed as "prescription requiring" in Federal or Provincial Drug Schedules
- * are injectable drugs, injectable vitamins, and allergy extracts which bear a Drug Identification Number (DIN)
- * are extemporaneous preparations or compounds where one of the ingredients is an eligible benefit
- * are "non-prescription requiring drugs" with a Drug Identification Number (DIN) in the following categories: antimalerials, fibrinolytics, nitroglycerin, potassium replacements, single entity iron salts, single entity fluorides, topical enzymatic debriding agents, thyroid agents

(b) **insulins**, disposable needles (including disposable needles only, for non-disposable insulin delivery devices), disposable syringes, lancets and chemical reagent testing materials used for monitoring diabetes

(c) **birth control pills**

(d) **all preventive immunization vaccines and toxoids**

2. **MAXIMUM SUPPLY**

The maximum eligible at any one time is a **1-month supply**, except a 3-month supply is allowed for the following drugs and medicines used for maintenance or long-term therapy: antiasthmatics, antibiotics for acne, anticoagulants, anticonvulsants, antihypertensives, antiparkinson, antituberculosis, cardiacagents, estrogens, thyroid agents, glaucoma, hypoglycemics, oral contraceptives, potassium replacements.

3. **EXCLUSIONS**

The following are not eligible under the Drug Plan:

(a) drugs used to enhance fertility (even if prescription requiring)

(b) all smoking cessation products, whether prescribed or not

(c) proprietary medicines bearing a GP (general product) number, as defined in Division 10 of the Food and Drug Act; Homeopathic preparations

(d) atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as a Glucometer®), non-disposable insulin delivery devices (such as Novolin Pen®), delivery or extension devices for inhaled medications (such as Rotohaler®, Diskhaler® or Aerochamber®), spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, or supplies and accessories for these. NOTE: Some of these items may be covered under Major Services.

(e) oral vitamins, minerals, dietary supplements, infant formulas, or injectable total parenteral nutrition (TPN) solutions, whether or not such a prescription is given for a medical reason, except where Federal or Provincial law requires a prescription for their sale

(f) diaphragms, condoms, contraceptive jellies/foams/sponges/suppositories, intrauterine devices (IUD's), contraceptive implants, or appliances normally used for contraception, whether or not a prescription is given for a medical reason. NOTE: IUDs are covered under Major Services

(g) prescriptions dispensed by a physician, clinic, dentist or in any non-accredited hospital pharmacy, or for treatment as an inpatient or outpatient in a hospital, including investigational status drugs and emergency status drugs, unless otherwise approved by Emergis Inc.

(h) all allergy extracts, compounded in a lab, and not bearing a Drug Identification Number (DIN)

(i) items deemed cosmetic or hygienic by Emergis Inc. or the Company (even if a prescription is legally required), such as topical minoxidil, sunscreens, or contact lens care products, whether or not a prescription is given for medical reasons
(j) any medication which the person is eligible to receive under the applicable Provincial Drug Benefit Plans
(k) costs of administration
(l) illegal or experimental drugs

4. **<u>OUT-OF-PROVINCE EXPENSES</u>**

The maximum amount eligible will be an amount up to (but not more than) the following:
(a) if the drug was purchased at a pharmacy that has signed an agreement with Emergis Inc. for the direct submission and payment of drugs, payment will be made for reasonable and customary charges and eligible expenses of the province in which the drug was purchased, or
(b) in all other circumstances, payment will be made according to the reasonable and customary charges and eligible expenses allowed in your province of residence.

<u>Please note:</u>

If your pay-direct drug card is not accepted by a pharmacy (for any reason), you will have to pay for your prescription in full. Please “paper” claim this expense using **Form 466 – Supplementary Medical Benefits Claim Form*.**

Form 466 can be picked up at your worksite office, or downloaded from Equitable Life's website www.equitable.ca (click on 'Group Benefit Forms' under 'Making a Claim?').

HEALTH BENEFITS - MAJOR SERVICES

The following pages describe the expenses eligible under the Major Services benefit.

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

1. **CONVALESCENT HOME SERVICES**

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

* a sanitarium
* a skilled nursing home
* a special wing of a hospital which has a transfer agreement with a hospital

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

Services are eligible as long as:

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

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

2. **AMBULANCE SERVICES**

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

MEDICAL TRANSFER SERVICE

Charges for "non-emergency" transport by an approved medical transfer service are covered up to a lifetime maximum of $250 per person.

HOSTEL ACCOMMODATION

Payment of the reasonable and customary per diem charge for in-province hostel accommodation if you require diagnostic testing or treatment, on the recommendation of a medical practitioner, at a hospital located more than 60 km from your home, and you are placed in a recognized medical hostel associated with the hospital.

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

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

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

4. **APPLIANCES AND SUPPLIES**

Eligible expenses include the following, provided they are prescribed by a physician (we'll need a copy of the Doctor's written prescription), performed in the province of residence, and not covered by the provincial medical health plan:

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

provided the rental is for therapeutic use only subject to the ***Maximum Period for Rental of Equipment shown on the Summary of Health Benefit Maximums page***
(Rental of other durable medical equipment may be considered if required for therapeutic use.)

(b) reasonable and customary charges for the purchase of:
- * casts, splints, trusses, crutches, canes, walkers
- * orthopaedic braces that are required for medical reasons (note that we may ask for additional information), including over-the-counter braces that have rigid supports, provided they are prescribed by a physician
- * artificial limbs, artificial eyes, or laryngeal speaking aids

provided they are required due to a disability which occurred while the person was insured under this Plan
The following are not covered:
- * replacement or repair (except for replacement or adjustments that are required because of pathological changes)
- * charges for the purchase of devices used primarily to allow the person to participate in sports
- * elastic supports

(c) purchase of a breast prosthesis and surgical brassiere(s) required as the result of a mastectomy, subject to the ***Maximum for Breast Prosthesis and Surgical Brassiere(s) shown on the Summary of Health Benefit Maximums page***

(d) reasonable and customary charges for the purchase of ileostomy or colostomy supplies

(e) purchase or repair of hearing aids (not including batteries) obtained on the written prescription of a certified otolaryngologist up to the ***Maximum for Hearing Aids shown on the Summary of Health Benefit Maximums page***

(f) purchase of orthotics which are specially constructed for the patient and prescribed by a physician, chiropractor or podiatrist, subject to the ***Maximum for Orthotics and Orthopaedic Shoes shown on the Summary of Health Benefit Maximums page***. "Orthotics" includes the following:
- * orthopaedic shoes (note that it does not include orthopaedic shoes that can be bought and worn without modification, such as Dr. Scholl's, Birkenstock, etc.)
- * lifts, wedges, flares or similar shoe modifications
- * foot orthotics

(g) reasonable and customary charges for oxygen (with a physician's prescription)

(h) wigs and hairpieces required as a result of chemotherapy received while insured under this Group Plan, subject to the ***Maximum for Wigs and Hairpieces (after chemotherapy or radiation therapy) shown on the Summary of Health Benefit Maximums page***

(i) standard syringes, needles and diagnostic test material, including glucometers, required to treat diabetes. The ***Maximum for Glucometers is shown on the Summary of Health Benefit Maximums page***. However, for Pay-Direct Drug Plans, disposable needles (including disposable needles only, for non-disposable insulin delivery devices), disposable syringes, lancets and chemical reagent testing materials used for monitoring diabetes are eligible under the Pay-Direct Drug Plan.

(j) reasonable and customary charges for diagnostic services, such as laboratory services, x-ray services, and PSA testing where medically necessary, subject to the ***Maximum for Laboratory Services and PSA Testing shown on the Summary of Health Benefit Maximums page***

(k) purchase of surgical stockings/support hose, and stump socks subject to the ***Maximum for Surgical Stockings/Support Hose, and Stump Socks shown on the Summary of Health Benefits Maximums page*** (with a physician's prescription)

(l) IUDs, if prescribed by a physician

5. **DENTAL ACCIDENT**

This section of the Major Services covers reasonable and customary charges for treatment by a Dental Surgeon for:
* a fractured jaw, or
* injuries to sound natural teeth

that result from an accident which occurs while insured under this Group Plan. The accidental injuries must be caused by external, violent and accidental means and does not cover injuries caused by an object placed in the mouth (even while eating or drinking).

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

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

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

6. **PARAMEDICAL SERVICES**

The following practitioners are covered under your Group Plan:

Audiologist
Certified Athletic Therapist
Chiropractor
Dietician
Massage Therapist
Naturopath (covers the office visit but excludes charges for such things as tests, supplements and remedies)
Osteopath
Physiotherapist
Podiatrist/Chiropodist
Psychologist/Master of Social Work (MSW)/Clinical Counsellor
Specialist in Acupuncture
Speech Therapist

See the ***Maximums for Paramedical Services on the Summary of Health Benefit Maximums page***. These are the maximums for each practitioner in any calendar year. See ***6. Definition of "Practitioners" Health Benefits - General Provisions page*** for the definition/qualifications of the various practitioners.

7. SERVICES OUTSIDE THE PROVINCE

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

(a) The services are covered under the employee's Provincial Health Care Plan

(b) The services are for **emergency treatment** (see definition of "emergency" below) for an injury or illness which occurs within the number of days shown under **Time Limit for Commencement of Emergency Treatment** shown in the Summary of Health Benefit Maximums after the insured person begins a temporary absence from the employee's province of residence, or

(c) The services (or similar services) are not available in the employee's province of residence but they are available elsewhere in Canada. If the services aren't available in Canada, services performed outside Canada will be eligible. In either case, we require the written referral of the insured person's regular physician in the province of residence and confirmation from the Provincial Health Care Plan that the services are not available in that province.

"**Emergency**" means a sudden, unexpected, acute illness or accidental injury that requires immediate medically necessary treatment, prescribed by a doctor. An emergency ends when the insured person is deemed medically stable to return to his province of residence. When an insured person has a chronic condition, emergency services do no include treatment provided as part of an established management program that existed prior to the person leaving their province of residence.

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

(a) services by a physician or surgeon

(b) charges for daily room and board in a public ward of a hospital (or for a semi-private or private room if shown on the Schedule of Benefits page); the maximum payable for any period of disability is 180 days of confinement

(c) hospital charges for medically necessary services and supplies for an in-patient, as long as these charges aren't included in the daily room and board rate; the maximum payable for any period of disability is an amount equal to 30 times the hospital's standard public ward rate

(d) professional ambulance services (including air ambulance if medically necessary) to the nearest hospital where the required treatment can be provided

(e) other charges for out-of-province services are included only up to the amount that would have been payable under this Group Plan if the service had been performed in the employee's province of residence.

HEALTH BENEFITS - MAJOR SERVICES

The following limitations and exclusions shall apply:

(a) where a person is resident outside Canada, no benefit is payable under this section in respect of any services received outside Canada; however, an eligible dependent child will be eligible for benefits payable under this section only for emergency treatment (as defined in this Policy) received outside Canada for an injury or disease which occurs while the child is a student enrolled in and attending an accredited educational institution on a full-time basis outside Canada for the purpose of attaining a post-secondary degree or diploma, provided that:

- (i) the Company receives a letter from the post-secondary institution at the beginning of each school term confirming the enrolment and attendance of the student. A school term will include a co-op work term placement outside Canada, which is part of the degree or diploma program, and
- (ii) the Company receives a letter from the Provincial Health Care Plan of the student's province of residence, confirming that coverage for the student will continue under that Plan while attending school outside Canada, and
- (iii) the student immediately contacts Allianz Global Assistance Assistance when the student incurs an eligible expense while outside Canada, and
- (iv) other than drugs, the emergency treatment services must be eligible under the Provincial Health Care Plan of the student's province of residence, and
- (v) coverage for benefits is subject to the provisions of this Policy, including the Limitations and Exclusions provisions in this Policy, except that the maximum time period for emergency treatment shown on the Summary of Health Benefit Maximums shall not apply, and
- (vi) coverage for benefits is provided only during a school term, and
- (vii) coverage for benefits shall not be provided during holidays or student absences which occur during or between school terms that exceed one month in duration, and
- (viii) coverage for benefits will not be provided if the student is in a country that is deemed to be high risk for travel on the date the school term begins as determined by Canadian Foreign Affairs.

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

8. **CARDIAC REHABILITATION**

Eligible expenses incurred for cardiac rehabilitation, on the written prescription of a physician, provided the cardiac rehabilitation is:

(a) provided by a therapist who is qualified and properly certified in advanced Cardio Pulmonary Resuscitation (CPE), and

(b) performed under the direct supervision of a physician duly trained or experienced in the delivery of the service.

See the ***Summary of Health Benefit Maximums page for the Maximum Payable for Cardiac Rehabilitation.***

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

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

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

Remember to attach all receipts, written prescriptions, referral letters, etc. Claims must be submitted within 365 days following the calendar year in which the claim was incurred. However, please note that ***if your insurance terminates or if the Health Benefits under this Policy terminate or if this Group Policy terminates, all claims incurred prior to the date of termination must be submitted to the Company within 90 days of the date of termination.***

Form 466 can be picked up at your worksite office, or downloaded from Equitable Life's website www.equitable.ca (click on 'Group Benefit Forms' under 'Making a Claim?').

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

1. **Assistance Services**

(a) access to multilingual help by telephone, telex and fax 24 hours a day, 365 days a year for both the insured traveller and the medical service provider

(b) required emergency referral to a physician, dentist or appropriate medical facility

(c) if the insured traveller is hospitalized, Allianz Global Assistance medical staff will contact the patient's attending physician to monitor the care and services being given and will, if necessary, contact the patient, the attending physician, and the patient's personal physician and family

(d) referrals to a local legal advisor and, when necessary, help in arranging a cash advance from credit cards or funds from family and friends to post bail and pay legal fees

(e) assistance in replacing necessary travel documents or tickets that have been lost or stolen (the cost of replacement is the responsibility of the insured traveller)

(f) emergency telephone interpretation services in most major languages

(g) exchange of emergency messages between the insured traveller and his/her family (messages are held up to 15 days)

(h) trying to ensure that the insured traveller is not obligated to pay hospital charges or medical fees by:

  (i) co-ordinating payment (where possible) directly by the appropriate Provincial Health Care Plan and the Company, or

  (ii) making payment to the medical provider with funds provided by the Company and then recovering the expenses payable by the Provincial Health Care Plan and forwarding such funds to the Company

(i) arranging all aspects of transporting the insured traveller if the Allianz Global Assistance medical staff and the attending physician decide it's medically necessary to transport the person to the nearest appropriate medical facility or to Canada for treatment (including ground transport to and from the hospital and airport at the points of departure and arrival and medical accompaniment deemed necessary by Allianz Global Assistance medical staff); these costs are a Covered Expense

(j) in the event of the death of an insured traveller, obtaining all necessary authorizations and making arrangements for the return of the remains to the place of its former residence; reasonable and necessary expenses of shipping the body back to the province of residence is covered by the Company, up to a maximum of $5,000 (excluding the cost of any coffin other than the minimum necessary to transport the body).

2. **Family Benefits**

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

(a) if an insured traveller is travelling alone and is hospitalized for more than 7 days outside his province of residence, Allianz Global Assistance will arrange, and the Company will reimburse, for the round- trip economy class transportation of one family member from the patient’s immediate family (spouse, parent, child, brother sister). This includes transportation from the family member’s place of residence in Canada to the place where the insured traveller is hospitalized, including reimbursement for expenses of up to $150 per day for the family member’s room and meals

(b) if the insured traveller requires hospitalization and any dependent child(ren) under age 16 travelling with him/her are left unattended by an adult, arrangement may be made for transportation of such child(ren) to their place of residence in Canada including, where necessary, escort for the child(ren)

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

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

3. **Limitations**

The following **Limitations** shall apply:

(a) circumstances (such as war, insurrection, epidemic, military operations, political conditions, local laws or orders of local legal and administrative agencies, strikes, flight conditions, severe weather, the geographical inaccessibility of health care providers) may delay, interfere or prevent Allianz Global Assistance from providing some or all of the services described

(b) Allianz Global Assistance and Equitable Life are not responsible in any way for the availability, quantity, quality or results of any medical treatment or other assistance received by the insured traveller or failure to receive medical services or other assistance for any reason

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

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

4. **How to contact Allianz Global Assistance**

Call their hotline at:

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

Give Allianz Global Assistance:

* your **name**
* your **Group Policy Number**
* your **certificate number**
* your **Government Health Insurance Plan number**

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

HEALTH BENEFITS - VISION CARE SERVICES

1. **EYE GLASSES OR CONTACT LENSES OR LASER EYE SURGERY**

Charges incurred for:

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

See the ***Employee and Dependent Health Benefits box on the Schedule of Benefits page for the Maximum Amount*** eligible **how often expenses are payable** for yourself and your eligible dependents.

Vision Care benefits are payable **in any period of 24 months**, not by calendar years. The date used to determine if a claim is eligible is **the date the service (the eye glasses/contact lenses/laser eye surgery) is paid for**.

Example: If Vision Care is payable in any period of 24 months and the patient paid for the services on December 10, 2012, the next time a claim will be eligible is December 11, 2014.

2. **WHAT IS NOT COVERED?**

* glasses used only for cosmetic reasons
* safety glasses where a corrective prescription is not required
* tinting

3. **"SPECIAL" CONTACT LENSES**

These are contact lenses prescribed by an ophthalmologist who certifies that they're medically necessary because of severe corneal astigmatism, corneal scarring, or as the result of surgery or treatment for keratoconus or aphakia. They are eligible only if vision can't be corrected to 20/40 or better with eye glasses. The maximum eligible for special contact lenses is $300 during the lifetime of the insured person. Complete **Form 466 - Supplementary Medical Benefits Claim Form** and attach any receipts and the prescription or letter from your ophthalmologist explaining the reason for the special contact lenses and send it to us.

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

Use **Form 466 - Supplementary Medical Benefits Claim Form***. Be sure all data listed above is completed on the form. Claims must be submitted within 365 days following the calendar year in which the claim was incurred. However, please note that **if your insurance terminates or if the Health Benefits under this Policy terminate or if this Group Policy terminates, all claims incurred prior to the date of termination must be submitted to the Company within 90 days of the date of termination.**

Form 466 can be picked up at your worksite office, or downloaded from Equitable Life's website www.equitable.ca (click on 'Group Benefit Forms' under 'Making a Claim?').

HEALTH BENEFITS - VISION CARE - EYE EXAMINATIONS

1. **EYE EXAMINATIONS**

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

See the ***Employee and Dependent Health Benefits box on the Schedule of Benefits page for the Maximum Amount*** and **how often expenses are eligible** for you and your eligible dependents.

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

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

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

Remember to **attach any receipts** from the supplier.

Claims must be submitted within 365 days following the calendar year in which the claim was incurred. However, please note that **if your insurance terminates or if the Health Benefits under this Policy terminate or if this Group Policy terminates, all claims incurred prior to the date of termination must be submitted to the Company within 90 days of the date of termination.**

Form 466 can be picked up at your worksite office, or downloaded from Equitable Life's website www.equitable.ca (click on 'Group Benefit Forms' under 'Making a Claim?').

SCHEDULE OF BENEFITS
EMPLOYEE AND DEPENDENT DENTAL BENEFITS

Deductible Amount per Calendar Year:
Nil

Type A - Basic Services.
This Dental Plan includes the following Basic Services Options:

Specialist Services	Endodontic Services
Space Maintainers	Periodontal Services *
Major Surgical Services	Denture Repair Services

* Maximum number of units eligible for periodontal scaling: 8 units per calendar year

Type B - Major Restorative Services:
This Dental Plan includes the following Major Restorative Options:
Dentures & Services other than Dentures

Type C – Orthodontic Services:
Only dependent children are eligible for Orthodontic Services.

Reimbursement Percentage:
Type A: 80%
Type B: 50%
Type C: 50%

Maximum Amount:
Annual calendar year maximum for Type A and Type B combined: $1,500
Lifetime maximum for Type C: $2,500

Specialist Fee Guide:
The current Specialist Fee Guide for the province of Manitoba.

Dental Fee Guide:
The current General Practitioner Dental Association Fee Guide for the province of Manitoba.

SURVIVOR BENEFIT

Maximum Period for Survivor Benefit: 2 years

DENTAL BENEFITS - GENERAL PROVISIONS

1. **DESCRIPTION OF THIS BENEFIT**

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

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

2. **WHAT ARE THE ELIGIBLE EXPENSES?**

These are the **reasonable and customary charges** made for required Dental treatment done by or prescribed by a Dentist, as long as the ***Schedule of Benefits page*** indicates they're included under this Group Plan and they are listed in the applicable Dental Fee Guide.

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

3. **WHAT IS THE "DEDUCTIBLE AMOUNT"?**

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

4. **WHAT IS THE "REIMBURSEMENT PERCENTAGE"?**

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

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

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

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

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

DENTAL BENEFITS - GENERAL PROVISIONS

6. **WHAT ARE THE MAXIMUM AMOUNTS?**

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

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

7. **PRE-DETERMINATION OF BENEFITS**

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

8. **ALTERNATE TREATMENT**

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

9. **WHAT IS NOT COVERED?**

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

- (a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)
- (b) active participation in a riot, rebellion or insurrection
- (c) war or hostilities of any kind (whether or not war is declared)
- (d) committing or attempting to commit a criminal offense
- (e) charges for unkept appointments, telephone time, or to complete forms or reports
- (f) examinations for a third party
- (g) procedures that aren't approved by the Canadian Dental Association or that are experimental in nature
- (h) any condition where you or your dependents are entitled to benefits under any Workers' Compensation Act or law or similar legislation or service, or where benefits are payable under any other insurance policy issued by the Company
- (i) services performed by a person who usually lives in the patient's home or services for which there would normally be no charge
- (j) cosmetic surgery or treatment (unless it's required as the result of accidental injuries and provided the surgery or treatment begins within 90 days of the accident)
- (k) any expenses for on-going treatment if it started before your coverage under this Plan became effective
- (l) treatment performed or supplies delivered after your coverage under this Group Plan terminates (except for covered prosthetic appliances ordered and fitted before the date of termination and delivered within 31 days after the date of termination)
- (m) treatment for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost because of abrasion or attrition (wearing away), or for disturbances of the temporomandibular joint (TMJ). Your Dentist should tell you if any of these conditions apply and explain them to you.
- (n) services provided outside Canada, except for emergency treatment for an unexpected and unforeseen event (such as the loss of a filling or crown while outside Canada)

DENTAL BENEFITS - GENERAL PROVISIONS

10. **HOW TO SEND IN CLAIMS**

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

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

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

If all of this information isn't filled in, we'll have to return the form to you for completion and this will cause a delay in getting your payment. Claims must be submitted within 365 days following the calendar year in which the claim was incurred. However, please note that **if your insurance terminates or if the Health Benefits under this Policy terminate or if this Group Policy terminates, all claims incurred prior to the date of termination must be submitted to the Company within 90 days of the date of termination.**

Form 520 can be picked up at your worksite office, or downloaded from Equitable Life's website www.equitable.ca (click on 'Group Benefit Forms' under 'Making a Claim?').

DENTAL BENEFITS
TYPE A - BASIC SERVICES

1. **DIAGNOSTIC SERVICES**

Services required to evaluate existing conditions, including:
* consultations and biopsies
* oral examinations (once every 5 months, twice in any 12 months)
* bitewing x-rays (once every 5 months, twice in any 12 months)
* complete mouth x-rays or panoramic films (once in any 24 months)

2. **PREVENTIVE SERVICES**

Services required to prevent dental disease, including:
* dental cleaning (once every 5 months, twice in any 12 months)
* oral hygiene instruction (once every 5 months, twice in any 12 months)
* application of fluoride (once every 5 months, twice in any 12 months)
* pit and fissure sealants for dependent children under age 18
* habit breaking appliances

3. **ROUTINE RESTORATIVE SERVICES**

Services required for the treatment of dental cavities, including:
* amalgam, acrylic or composite fillings
* prefabricated metal or plastic restorations

4. **ROUTINE SURGICAL SERVICES**

Routine extractions (including wisdom teeth) and the anaesthesia required to do them are eligible as long as they're not to prepare for orthodontic treatment.

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

* protective appliances (such as mouthguards) and space maintainers
* all extensive restorative services
* all major surgical services (other than the routine extractions in 4. above)

DENTAL BENEFITS
TYPE A - OPTIONAL SERVICES

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

A dentist who is licensed as a Specialist in the province or territory in which he/she practices and who performs a dental service within his/her specialty may charge a higher fee than the General Practitioners Tariff in the Dental Fee Guide. If the Schedule of Benefits indicates that the service is covered under this Group Plan, the extra charge is an eligible expense.

The maximum eligible is the difference between the amount payable in the Specialist Fee Guide and the amount payable in the General Practitioner Fee Guide (or, in the case of employees who reside in Alberta, the General Practitioner Fee Guide plus the inflationary adjustment as determined by the Company).

SPACE MAINTAINERS

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

MAJOR SURGICAL SERVICES

This Option covers major surgical services such as:

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

Surgical services to prepare for orthodontics or major restorative services (other than fillings) are **not covered**.

PERIODONTAL SERVICES

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

Periodontal services are **not eligible** if they're in any way connected to:

* endodontic treatment
* orthodontic treatment
* the installation of prosthetic appliances

ENDODONTIC SERVICES

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

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

DENTURE REPAIR SERVICES

This Option pays for services that are required to:

* rebase and reline removable full or partial dentures
* repair broken dentures
* add teeth to partial dentures

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

DENTAL BENEFITS
TYPE B - MAJOR RESTORATIVE SERVICES

1. **<u>SERVICES OTHER THAN DENTURES</u>**

This Option covers major restorative services that are required to:

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

Eligible expenses include:

* crowns (note that a crown following a root canal is <u>not</u> necessarily an eligible expense and we'll need a Pre-Determination in order to decide if it's payable)
* fixed bridges
* inlays and onlays (subject to 8. "Alternate Treatment" on the General Provisions for Dental page)
* cast restorations
* laboratory charges for prosthodontic materials

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

2. **<u>EXCLUSIONS AND LIMITATIONS</u>**

(a) replacement of lost or stolen fixed bridgework is not eligible

(b) replacement of an existing restoration is not eligible if the restoration is ordered within 5 years after the date of the initial placement or last replacement if it was eligible for reimbursement under this Group Policy. This time period doesn't apply if the replacement is required as a result of injuries caused solely through accidental, violent and external causes and the person is insured under this Group Plan at the time of the injury

(c) replacement of an existing restoration is eligible only if the existing restoration can't be made serviceable. The replacement will be of the value and quality of the original restoration (as determined by the Company)

(d) full or partial dentures are not covered

(e) for bridges and crowns that are eligible on molar (back) teeth, only metal bridges and metal crowns are an eligible expense, not porcelain fused to metal

DENTAL BENEFITS
TYPE B - MAJOR RESTORATIVE SERVICES (Dentures)

1. **DENTURES**

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

2. **EXCLUSIONS AND LIMITATIONS**

(a) replacement of lost or stolen dentures is not eligible
(b) charges for duplicate dentures are not eligible
(c) replacement of an existing denture is not eligible if the replacement is ordered within 5 years after the date of the initial placement or the last replacement if it was eligible for reimbursement under this Group Policy
(d) replacement of an existing denture is eligible only if the existing denture can't be made serviceable. The replacement will be of the value and quality of the original denture (as determined by the Company)
(e) replacement of an existing temporary denture is eligible only if the insured person was covered under this Group Plan when the temporary denture was installed. If the temporary denture is more than a year old, it may be considered "permanent" and would then not qualify for replacement

DENTAL BENEFITS
TYPE C - ORTHODONTIC SERVICES

1. **Orthodontic Services**

This covers the following services required to correct irregularities of the teeth, provided they're not included under any other part of this Group Plan:

* **space regainers** (space maintainers that are used to move teeth or are used in other ways in orthodontics)
* **orthodontic services to correct malocclusion** (when the teeth don't come together properly when biting)

Important: Payment will be made on a monthly basis as orthodontic treatment progresses. Please forward receipts with the claim submissions.

SURVIVOR BENEFIT - PREMIUM WAIVED

1. **DESCRIPTION OF THIS BENEFIT**

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

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

2. **WHAT BENEFITS ARE INCLUDED IN THE SURVIVOR BENEFIT?**

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

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

3. **WHEN DO THE SURVIVOR BENEFITS TERMINATE?**

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

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

PROTECTING YOUR PRIVACY

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

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

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

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

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

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

Chief Privacy Officer
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