



# Employee benefits



Revised November 2006

## Participating Employee Groups

- Educational Assistants
- Educational Support Professionals
- Secondary School Teachers
- Elementary Teachers
- Plant Support Staff
- Principals & Vice-Principals
- Professional Student Services Personnel
- Union Exempt

*Prepared and distributed by  
Employee Support Services  
613-596-8250*





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## INTRODUCTION

The Ottawa-Carleton District School Board makes available to you and your family a comprehensive employee benefits package, ensuring that, in case of illness or injury, disability, or death, your financial security is safeguarded. The plans offer health and dental care, and a range of life and accidental death and dismemberment insurance.

We begin this booklet by outlining eligibility and other general conditions. This is meant to be read in connection with your *Benefits at a glance* (a copy is enclosed), which provides a brief summary of the coverage offered to your specific employee group. **However, your actual benefits coverage will be determined by the terms of the official insurance policies.** The details provided in this booklet have been reviewed and approved by the insurance carriers. The language presented in this booklet does not supersede the language in the official insurance contracts and in the event of a dispute, the official insurance policy language will prevail.

In this booklet, certain key words and terms appear in *italic* type. These words are defined in the **Definitions** section of the booklet.



## DEFINITIONS

<b>Actively employed</b>	<ul style="list-style-type: none"><li>▪ employed by the Board on a regular, full-time or part-time basis, for a number of hours specified in your <i>Benefits at a glance</i>,</li><li>▪ compensated by the Board for services rendered in the normal course of their business, and</li><li>▪ resident of Canada.</li></ul>
<b>Child/children</b>	<p>Unmarried children of you or your spouse, including adopted children, stepchildren, foster children, and children for whom you or your spouse is the legal guardian, who are:</p> <ul style="list-style-type: none"><li>▪ residents of Canada,</li><li>▪ under age 21 and working less than 30 hours a week (unless a full-time student),</li><li>▪ under age 25 if a full-time student, or</li><li>▪ of any age, and incapable of self-support due to a physical or mental disorder, provided they are and have been disabled for a continuous period beginning before age 21 or before age 25 if a full-time student.</li></ul> <p>A stepchild of a common-law relationship must be living with the employee to be eligible for coverage.</p> <p>Children are covered from birth under the health, dental, and accident insurance plans, but must be a minimum of 15 days of age to be covered under the Optional Term Life Insurance and the Optional Dependent Life Insurance.</p>



<p><b>Convalescent/rehabilitation hospital</b></p>	<p>An extended care facility (for example, a sanatorium or a special wing or ward of a hospital) that accepts the direct transfer of a covered person from an active treatment hospital where he or she has been an in-patient for at least three days—by virtue of a transfer agreement—primarily for rehabilitative or convalescent care for a condition that will significantly improve as a result of the care (treatment must begin within 14 days of the transfer), excluding federal hospitals, nursing homes, homes for the aged, private rest homes, chronic care facilities, health spas or hotels, establishments for custodial care or any institutions for the treatment of alcoholism, drug addictions or mental illnesses.</p>
<p><b>Covered accident</b></p>	<p>An accident causing bodily injury, directly and independently of all other causes, occurring while the person is covered under this policy. This excludes:</p> <ul style="list-style-type: none"> <li>▪ sickness or disease, except a pus-forming infection that occurs through an accidental wound, or</li> <li>▪ medical or surgical treatment of a sickness or disease</li> </ul>
<p><b>Earnings</b></p>	<p>Your regular annual rate of pay, excluding bonuses and overtime pay</p>
<p><b>Evidence of good health</b></p>	<p>Generally, a health questionnaire and, depending on the information you provide, possibly a medical or paramedical examination</p>
<p><b>Fee guide</b></p>	<p>The suggested dental fee guide in effect in Ontario in the year indicated in your <i>Benefits at a glance</i></p>
<p><b>Full-time student</b></p>	<p>A child is considered a full-time student until the September 1st following the date that child is no longer in regular full-time attendance at an accredited institute of learning for 15 hours a week or more some time in the last 6 months. Students on co-op terms in the middle of a school year will continue to be recognized as eligible dependent children.</p> <p>Full-time students, though, are no longer eligible for coverage under the Board’s Benefits Program if they are:</p> <ul style="list-style-type: none"> <li>▪ being paid to attend an educational institution, or</li> <li>▪ enrolled in an apprenticeship program.</li> </ul>
<p><b>Immediate family member</b></p>	<p>A person over the age of 18, who is your spouse, son, daughter, parent, sibling, grandparent or in-law (for the purposes of the Optional Accidental Death and Dismemberment Insurance plan).</p>



<b>Loss</b>	Resulting from an accidental injury, loss means: <ul style="list-style-type: none"><li>▪ with respect to:<ul style="list-style-type: none"><li>→ <b>hand or foot</b>—complete severance through or above the wrist or ankle joint, but below the elbow or knee joint,</li><li>→ <b>arm or leg</b>—complete severance through or above the elbow or knee joint,</li><li>→ <b>thumb</b>—complete severance of one entire phalanx of the thumb,</li><li>→ <b>finger</b>—the complete severance of two entire phalanges of the finger, and</li><li>→ <b>toe</b>—complete severance of one entire phalanx of the big toe and all phalanges of the other toes of the same foot,</li><li>→ <b>eye</b>—entire and irrecoverable loss of sight,</li><li>→ <b>speech</b>—complete and irrecoverable loss of the ability to utter intelligible sounds, and</li><li>→ <b>hearing</b>—complete and irrecoverable loss of hearing.</li></ul></li></ul>
<b>Loss of use</b>	Resulting from an accidental injury, loss <b>of use</b> means the total and irrecoverable loss of function of an arm, hand or leg, provided the loss is continuous for at least 12 consecutive months, and the loss is determined to be permanent after the initial 12-month period: <ul style="list-style-type: none"><li>▪ with reference to:<ul style="list-style-type: none"><li>→ <b>quadriplegia</b>—paralysis of both upper and lower limbs,</li><li>→ <b>paraplegia</b>—paralysis of both lower limbs, and</li><li>→ <b>hemiplegia</b>—paralysis of upper and lower limbs of one side of the body,</li></ul></li></ul> the complete and irreversible paralysis of such limbs.
<b>Medical emergency</b>	A sudden or unexpected injury that occurs, or an unforeseen illness that begins, while a covered person is travelling <b>outside their normal province of residence</b> and requires immediate medical attention. Such an emergency no longer exists when, according to the attending physician, the covered person is able to return to his or her province of residence.



<b>Medically necessary</b>	Broadly accepted and recognized by the standards of the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury.
<b>Spouse</b>	<p>The person:</p> <ul style="list-style-type: none"> <li>▪ to whom you are legally married, or</li> <li>▪ with whom you have been living in a common-law relationship, whether a person of the same or opposite sex, for at least 12 months.</li> </ul> <p>For purposes of health and dental coverage, your former spouse may be covered – that is, a divorced or ex-common-law spouse for whom insurance protection is mandated by court order (only one spouse may be covered at one time).</p>
<b>Total disability (totally disabled)</b>	The inability caused by sickness or injury to perform the regular duties of your own occupation during the qualifying period and the subsequent number of years indicated in your <i>Benefits at a glance</i> . After the qualifying period, it means the inability to work at any occupation for which you are qualified, or may reasonably become qualified by training, education, or experience. The insurer must be provided with satisfactory proof of your total disability.
<b>Qualifying period</b>	The number of calendar days indicated in your <i>Benefits at a glance</i> that you must wait before receiving Long-Term Disability plan benefits, which may be interrupted by a return to work of not more than 30 working days, provided the recurring disability is from the same or a related cause.



# GENERAL INFORMATION

## Eligibility

Your eligibility for coverage under the Board's plans depends on your employee group and on the type of coverage. You will find details of eligibility requirements for your employee group in the *Benefits at a glance* brochure.

You will participate in the plans described in your *Benefits at a glance*. Except for the Optional Term Life and Optional Accidental Death and Dismemberment Insurance plans, participation in all plans is mandatory for all new hires who meet the eligibility requirements.

## Enrolment

When you are eligible to join the Benefits Program, Employee Support Services will provide you with the required forms to complete.

## How do I change coverage?

If you want to make a change in coverage or beneficiary, simply call Employee Support Services. If your request complies with the plan rules, you will be required to complete any necessary document. For insurance purposes, any change must be made in your own handwriting, in ink.

You may reduce coverage under the Health Care and Dental Care plans at any time. If you want to increase your coverage, you may do so during the annual open enrolment period, provided that a period of one year has elapsed since your last change. You may also increase coverage in the Health Care and Dental Care plans if you have a change in status, provided you do so no more than 31 days after the date the change occurs.



Change in status would include marriage, establishment of an eligible common-law relationship (i.e. living in the relationship for at least one year), divorce, separation, addition of a dependent, loss of spousal coverage, retirement, or the death of a *spouse* or *child*.

You may apply for increased amounts of optional term life insurance and optional accidental death and dismemberment insurance for you or for your dependents at any time. However, every request for optional term life insurance must be accompanied by *evidence of good health*, and the insurance will take effect only when the insurer approves the application for coverage.

### **Are my parents eligible for coverage if they live with me?**

No. Only you and your eligible *spouse* and *children* are covered under the Benefits Program.

### **What happens to my coverage if I change positions at the Board?**

Your eligibility and coverage depend on your employee group, and different provisions apply to different groups. Please contact Employee Support Services to see how any change will affect your coverage.

## **When coverage begins**

### **Personal coverage**

Coverage under mandatory plans (as set out in your *Benefits at a glance*) begins on your first day of employment. For optional plans, coverage begins when your application is approved. If you are not actively at work on the date coverage should take effect, it will become effective when you return to work.



## Dependent coverage

Coverage for your *spouse* and *children* begins when your coverage begins or, if later, on the date your application for dependent coverage is approved. If you already have a dependent insured under the plan, i.e. you have family coverage, any newly acquired dependents are covered automatically, without making further application for coverage. However, if a dependent is hospitalized on the date coverage would otherwise begin, coverage will be delayed until the date following discharge from the hospital (except for a newborn).

## When coverage ends

Your coverage under the various benefit plans will end:

- on the last day of the month in which your employment terminates ,
- on the last day of the month following your entry into the armed forces of any country on a full-time basis,
- on the last day of the month in which you retire,
- for Optional Term Life Insurance for yourself and your covered *children*, the last day of the month in which you reach age 65, if you are still actively at work,
- for Optional Term Life Insurance for your *spouse*, on the last day of the month in which your *spouse* reaches age 65 or, if earlier, the last day of the month in which you reach age 65,
- for Basic and Optional Accidental Death and Dismemberment Insurance for yourself and your covered *children*, the last day of the month in which you reach age 70, if still actively at work,
- for Optional Accidental Death and Dismemberment Insurance for your *spouse*, on the last of the month in which your *spouse* reaches age 70 or, if earlier, the last day of the month in which you reach age 70,
- for Long-Term Disability insurance, the first of the month following the attainment of age 65 less the *qualifying period*, or retirement, whichever is earlier,
- for orthodontic expenses for a dependent *child*, incurred in relation to any remaining treatment after his or her coverage ends, when the *child* no longer meets eligibility criteria, except as indicated under ***Extension of coverage***,
- if any required premium is not paid, and
- when the plans terminate.

Except as indicated above, coverage for your *spouse* and *children* ends at the same time as your coverage ends or earlier, if they cease to qualify under the plans' definition of eligibility.



## Extension of coverage

### Health Care plan

If you are *totally disabled* or one of your covered dependents is hospitalized on the date health care coverage would otherwise end—and remains continuously disabled—benefits will be extended for disability-related expenses until the earliest of:

- 90 days after the date the coverage would have normally terminated,
- the date the disabled person becomes eligible for group coverage elsewhere,
- the date the group insurance policy terminates,
- the date the *total disability* ends, for an employee, or
- the date hospital confinement is no longer necessary, for a dependent.

However, if you or one of your covered dependents is pregnant on the date the coverage should cease (for any reason other than policy termination), benefits will be extended for pregnancy-related expenses, as long as the expenses are incurred while the group insurance policy is in force.

### Dental Care plan

If you or your *eligible dependents* had started a major restorative treatment and an impression had been taken before your dental coverage ended, coverage may be extended for 31 additional days.

### Orthodontic treatment

If coverage ends, benefits will continue for a course of orthodontic treatment that began before coverage ended and for which payment from the insurer had already begun before coverage ended, to a maximum of the amount that would have been paid in the three-month period immediately following the termination if the coverage had remained in force.



## Your benefits while on leave of absence

While you are on pregnancy or parental (adoption) leave, your coverage continues according to the provisions of applicable legislation. Contact Employee Support Services for details.

For all other types of leave of absence, continuation of coverage is governed by the terms of your collective agreement or terms and conditions of employment. Employee Support Services will inform you of the applicable conditions before your leave begins.

## What happens at retirement

Your coverage ceases at retirement unless otherwise indicated in your collective agreement or your employee handbook. You have the option of converting your life insurance coverage to individual policies, as explained on page 46.

# Benefits for your survivors

## Under the Health Care, Dental Care and Optional Term Life (OTL) plans

If you die while insured under the Board's plan, coverage under the Health Care, Dental Care and OTL plans for your *spouse* and *children* (including a *child* conceived before but born after your death) will continue—at the benefit level in effect on the date of your death—under the following conditions:

- If you have a *spouse* but no *children*—coverage for your *spouse* will continue without premium payment for up to three months after your death.
- If you have *children*—coverage for your *spouse* (if applicable) and *children* will continue for up to two years after your death. There is no premium payment required for the health and OTL plans, but your *spouse* or *children* must pay the required premium to continue coverage under the dental plan.

## Under the Optional Accidental Death and Dismemberment (AD&D) plan

If you die as a result of an accidental injury while *actively employed*, coverage under the optional AD&D insurance plan will continue for your *spouse* and *children*, without premium payment, for up to one year.



### Termination of survivor benefits

In all cases:

- *Child* coverage will terminate when your *child* no longer meets the plan's definition of *child*.
- Your *spouse's* coverage will terminate when:
  - coverage for all your *children* ends,
  - your *spouse* no longer meets the plan's definition of *spouse*, or
  - your *spouse* reaches age 65 (at the end of that month).

In addition, Optional Term Life coverage will terminate on all your dependents at the end of the month you would have reached age 65 if you were still living.



## HEALTH CARE

**Please refer to your *Benefits at a glance* for the coverage available to your employee group.**

Help with vital health and dental expenses comes from various sources, including your provincial health care plan, and the Board's health and dental coverage.

### Provincial health care plan

The government of each province provides residents with basic health care services, such as:

- hospital accommodation at ward level, along with associated services,
- physicians' fees, and
- auxiliary medical services.

In some provinces, government plans also provide coverage for drug and dental care costs for certain age groups, as well as the cost of assistive devices such as hearing aids and artificial limbs and eyes, and wheelchairs. These programs differ in Ontario and Quebec, but it is important that you inquire whether your expenses are covered, since the Board's plan will not pay expenses that are eligible for provincial reimbursement.

If you are a Quebec resident, and seek treatment on a non-emergency basis from an Ontario physician or hospital, Quebec's provincial health plan will cover the cost only to the level that would have been paid in Quebec. The excess charge is not reimbursed by the Board's plan for non-emergency services.



## Semi-private hospital and major medical coverage

The Board's coverage is designed to assist with some of the medical costs you may face that are not covered by provincial plans.

You pay the deductible indicated in your *Benefits at a glance*. Once you have paid the deductible, the plan reimburses the percentage of expenses indicated in your *Benefits at a glance*.

All expenses must be *medically necessary*, delivered at the level usually required for cases of the nature and severity of the case being treated, and considered reasonable compared with prices generally charged in the area where the expense is incurred. Unless indicated otherwise, all medical supplies and services must be prescribed, and reimbursement is limited to the amount not covered by the provincial plan. A list of expense limitations and exclusions is provided on page 17.

### Treatment plan

You will need to submit a treatment plan to the insurer if you are planning to go outside your province of residence to obtain medical treatment, on referral of your doctor because the treatment is not readily available in your province of residence. Your doctor should first contact your provincial plan, to ensure that the province will cover the procedure, and then submit a treatment plan to the insurer for prior approval.

Remember, too, that if the treatment is readily available elsewhere in Canada, the plan will not reimburse expenses for it to be performed outside Canada.

### Semi-private hospital room coverage

Semi-private hospital room charges are covered above the amount provided by the provincial plan for hospitalization that begins while the patient is insured under this plan in a general hospital in your province of residence, when such care is not primarily for chronic or custodial care (including hospital room charges during rehabilitative treatment).



After your hospital stay, Manulife Financial may send you a questionnaire related to the details of your hospitalization. Please take the time to complete this questionnaire. Manulife Financial will use your responses to ensure that the hospital's charges are correct.

For example, under government plans, hospitals should not charge if you are hospitalized and your doctor orders semi-private or private room accommodation as *medically necessary* for your condition. By providing Manulife Financial with all details of your hospitalization, you ensure that the Board's plan is not charged unnecessarily.

Manulife Financial will treat the information you provide in that questionnaire as completely confidential.

### Major medical coverage

**Note:** The following are eligible expenses provided they are reasonable, customary and *medically necessary*. **Unless indicated otherwise**, all medical supplies and services must be prescribed.

<b>Ambulance</b>	professional ambulance service to the nearest centre where adequate treatment is available over and above provincial coverage
<b>Convalescent/ rehabilitation hospital</b>	charges for coverage above the amount provided by the provincial plan for hospitalization that begins while the patient is insured under this plan in a convalescent or rehabilitative hospital in your province of residence
<b>Dental services</b>	charges for the treatment of accidental injuries to natural teeth, provided the treatment is rendered within 12 months of the accident (payment based on least-expensive procedure that will provide professionally adequate results)
<b>Diabetic supplies</b>	insulin, syringes, and home chemical testing supplies for diabetics, as well as supplies used with blood glucose monitoring machines
<b>Diagnostic services</b>	diagnostic laboratory procedures performed by a qualified technician (not covered under the provincial plan)
<b>Diapers</b>	for a dependent <i>child</i> who is three years of age or older, when required because of a congenital condition



<b>Hearing aids</b>	one hearing aid every 60 consecutive months per ear, on prescription of a physician or qualified audiologist recommended by a physician, including repairs and maintenance, but excluding batteries. See <i>How to claim benefits</i> , beginning on page 49, for details.
<b>Injectable drugs</b>	when administered by a physician, for which no reasonable non-injectable alternative is available, including serums and inoculation material
<b>Medical supplies</b>	<p>rental or, at the insurer's option, purchase of supplies, appliances and prosthetic devices, including:</p> <ul style="list-style-type: none"> <li>▪ standard, non-motorized wheelchairs (except for quadriplegics)</li> <li>▪ standard, non-electric hospital beds, bed rails, and trapeze bars</li> <li>▪ splints (excluding dental splints), canes, walkers, crutches, and casts</li> <li>▪ orthotic appliances—one pair, to a maximum of \$575 per person every two calendar years, specifically designed and constructed for the patient. An additional maximum of \$575 applies if the new appliances are required as a result of surgery. See <i>How to claim benefits</i>, beginning on page 49, for details.</li> <li>▪ Jobst burn garments, sleeves for lymphoedema following mastectomy, and Jobst support hose</li> <li>▪ braces with rigid supports (excluding lumbar supports)</li> <li>▪ stump socks, shoulder harnesses, head halters, traction apparatus, and cervical collars</li> <li>▪ enuretic devices</li> <li>▪ PUVA therapy for psoriasis, administered by a dermatologist</li> <li>▪ intermittent positive pressure breathing machine</li> <li>▪ aerosol equipment, mist tents, and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma</li> <li>▪ apnea monitors for respiratory disrhythmias</li> <li>▪ respiratory equipment</li> <li>▪ artificial eyes, excluding repairs</li> <li>▪ artificial limbs (other than myoelectrical limbs), including repair and maintenance</li> <li>▪ blood pressure monitor, if prescribed by a physician</li> <li>▪ colostomy or ileostomy apparatus and catheters,</li> <li>▪ incontinence supplies</li> <li>▪ post-mastectomy external breast prostheses</li> <li>▪ surgical brassieres, to a maximum of 4 per person per calendar year</li> <li>▪ transcutaneous nerve stimulator, for up to six months</li> </ul>



	<ul style="list-style-type: none"><li>▪ non-union bone stimulators</li><li>▪ intra-uterine devices and diaphragms</li><li>▪ support hose/stockings (6 pairs per calendar year with medical recommendation)</li><li>▪ back support corsets following back surgery</li><li>▪ arch supports (with prescription only)</li><li>▪ ovustick and first response kits</li><li>▪ orthopaedic shoes that are designed and constructed for the patient, including repairs and modifications, to a maximum of \$125 per calendar year</li><li>▪ wigs due to medical treatment or injury, to a lifetime maximum of \$250</li><li>▪ cryocuff (air cast) following knee surgery (prescription must specify diagnosis)</li><li>▪ pessary</li></ul>
<b>Oxygen</b>	<ul style="list-style-type: none"><li>▪ oxygen and its administration</li></ul>
<b>Paramedical/therapeutic services</b>	<ul style="list-style-type: none"><li>▪ out-of-hospital services, to the maximum specified in your <i>Benefits at a glance</i>, of the following duly qualified practitioners who must be licensed in the province where therapy is provided and are not related to the patient:<ul style="list-style-type: none"><li>→ chiropractor</li><li>→ osteopath, chiropodist or podiatrist, after OHIP annual maximum payment has been reached</li><li>→ naturopath</li><li>→ physiotherapist</li><li>→ clinical psychologist</li><li>→ speech therapist</li><li>→ massage therapist</li></ul></li></ul>
<b>Prescription drugs</b>	<p>charges for certain drugs legally requiring a prescription (unless otherwise specified in your <i>Benefits at a glance</i>), excluding over-the-counter drugs, but including:</p> <ul style="list-style-type: none"><li>▪ certain life-sustaining drugs</li><li>▪ fertility drugs, to a lifetime maximum of 12 cycles of treatment</li><li>▪ injections and medication for sclerotherapy</li><li>▪ recognized anti-obesity drugs</li><li>▪ smoking cessation drugs, to a lifetime maximum of a 90-day supply</li></ul>



<b>Private-duty nursing</b>	out-of-hospital services of a graduate registered nurse or nursing assistant or a licensed practical nurse, not related to the patient (you must <b>obtain written approval from the insurer before services begin</b> . See <i>How to claim benefits</i> , beginning on page 49, for details.
<b>Private hospital room</b>	the difference between semi-private and private hospital room charges, to the maximum indicated in your <i>Benefits at a glance</i>
<b>Radium</b>	radioactive material

### Out-of-country coverage

<b>Out-of-province hospitalization/physician fees</b>	<ul style="list-style-type: none"> <li>▪ services required as the result of an emergency or unexpected sudden illness</li> <li>▪ services required because they are not readily available in the patient's home province and must be obtained elsewhere</li> <li>▪ services of a physician or surgeon outside the patient's province of residence or outside Canada on an emergency basis</li> </ul>
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Such charges must be in excess of the amount paid by your provincial plan, up to a reasonable and customary level in the area in which treatment is rendered.

### Limitations and exclusions for semi-private hospital and major medical coverage

The Health Care plan does not provide reimbursement for supplies or services for:

- treatments or operations that do not conform to the usual current practice of the health professional, or are considered experimental in nature,
- expenses covered by any workers' compensation, hospital insurance or automobile insurance legislation, or any similar law, whether such law is in force in your province of residence, any other province of Canada, or any other country,
- expenses incurred for examination for purposes other than curative,
- expenses incurred for aesthetic surgery or treatment (when determined as such by the insurer), unless such surgery or treatment is for accidental injuries and treatment commenced within 90 days of the accident,
- expenses for eye examinations or for verifying ocular refraction,
- expenses for adjustment to glasses or contact lenses,



- expenses for purchase of dentures (except initial denture required as a result of accidental dental injury to natural teeth),
- expenses for x-rays by a chiropractor, or podiatrist/chiropracist, osteopath,
- expenses for transportation or travel other than in an ambulance,
- expenses for services and supplies which are required for recreation or sport but which are not *medically necessary* for regular activities,
- expenses for massage and other similar therapies performed by an unlicensed therapist,
- expenses for vitamins, vitamin supplements, dietary supplements and diet foods, and food and food products, including infant formula, infant foods, and salt and sugar substitutes,
- accidental injury to natural teeth incurred more than 12 months after the accident,
- elective surgery, such as vasectomy, tubal ligation reversal and circumcision,
- elective lifts for non-ambulatory patients,
- posturepedic mattresses,
- remedies or supplements dispensed by a naturopath,
- expenses for elective medical care outside of Canada,
- injury resulting from war, insurrection, services in the armed forces of any country, or
- expenses from intentionally self-inflicted injuries.

## Vision care coverage

The following vision care expenses are covered, if they are prescribed by an ophthalmologist or optometrist. These expenses are also subject to the maximum for each covered person indicated in your *Benefits at a glance*.

- **Eyeglasses/lenses:** prescription eyeglasses or contact lenses (including tinting, photograying, and hardening of such lenses), to the limits specified in your *Benefits at a glance*.
- **Repairs:** to broken or damaged eye glasses or replacement if they cannot be repaired.
- **Contact lenses prescribed for severe corneal conditions:** provided that vision can be improved to at least 20/40 in the better eye with the contacts and that such improvement cannot be achieved with glasses, and *medically necessary* supplies and services for the treatment of special conditions, to an overall lifetime maximum of \$200 per person,



- **Eyeglasses/lenses required after cataract operation:** purchase of glasses or contact lenses following a cataract operation, to a lifetime maximum of one pair per person.
- **Laser vision correction:** laser eye surgery performed by a licensed ophthalmologist.

### Limitations and exclusions for vision care

The vision care coverage under the Health Care plan does not provide reimbursement for:

- expenses for adjustment to glasses or contact lenses,
- eyeglasses which have been lost or stolen,
- the cost of replacing damaged, lost or torn contact lenses,
- treatment furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits,
- eye tests or examinations required by an employer, school or government for screening purposes, or
- repairs to artificial eyes, safety glasses or non-prescription sunglasses.

## ManuAssist – Worldwide Medical Assistance

ManuAssist is a travel assistance program available for you and your covered dependents. It is administered through World Access Inc., an international medical assistance organization.

**Before** you leave for your trip, you should call World Access professionals at the number recorded on your ManuAssist card (1 800 265-9977) to find out whether or not ManuAssist is available in the country you are visiting. ManuAssist may not be available in countries of political unrest.

Also, if a *medical emergency* occurs while travelling, it is very important that you contact World Access either **before** incurring any required emergency expense, or **as soon as possible**, after being admitted to hospital, to verify your eligibility for hospital coverage and the various services.



An out-of-Canada *medical emergency* includes an accidental injury or illness for which you had not been diagnosed or treated in Canada before leaving the country. However, unforeseen complications of a pre-diagnosed condition that require immediate medical attention may be covered, if this condition was completely stable when you left the country.

Such an emergency no longer exists when, according to the attending physician, you are physically fit to return to your province of residence.

In any case, you should always contact World Access, who will immediately help by providing the following services.

### **Medical assistance**

- **Around-the-clock access**

Assistance in almost any language, through a toll-free/call-collect telephone hotline and fax line, is available 24 hours a day, seven days a week.

- **Information on local medical care**

ManuAssist will refer you to a local physician, dentist, pharmacist, or appropriate medical facility.

- **Monitoring of your medical care**

Medical care and services will be monitored by medical staff who will maintain contact as often as necessary with you, your attending physician, your personal physician, and your family.

- **Claims payment service**

If medical expenses are over \$200, ManuAssist arranges for the payment of medical expenses, **provided ManuAssist is contacted before the expense is incurred.** You will be asked to sign an authorization form that allows ManuAssist to coordinate payment of the claim on your behalf through your provincial government's health insurance plan and your Employee Benefits Program.



If needed, ManuAssist will forward an advance deposit to the hospital before medical services are rendered. If payments made on your behalf are later determined to be for ineligible services or amounts, ManuAssist will have the right to recover the overpayment from you.

If you did not contact ManuAssist first, you are responsible for paying the expense and submitting the claim for reimbursement to your provincial government's health insurance plan and employee Benefits Program.

If medical expenses are \$200 or less, you are responsible for paying the expense and submitting for reimbursement to your provincial government's health insurance plan and employee Benefits Program.

- **Medical transportation**

Medical transportation arrangements will be made to transfer you to and from the nearest medical facility or to a medical facility in your province of residence. Expenses incurred for the medical transportation will be paid by the insurer of your Health Care plan, Manulife Financial.

If *medically necessary*, round-trip transportation for a medical attendant to accompany and care for you will also be arranged and paid by Manulife Financial.

- **Return of dependent *children***

If dependent *children* are left unattended due to the hospitalization of an insured person, transportation will be arranged to return them to their normal place of residence. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary, round-trip transportation for a qualified escort to accompany the *children* will be arranged and paid.

- **Visit by a family member**

ManuAssist can help if, while travelling alone, you or one of your covered dependents becomes hospitalized and are expected to stay in the hospital for more than seven days. Expenses incurred for round-trip economy transportation will be paid for one member of the immediate family to visit. The visit must be approved in advance by ManuAssist.



- **Trip interruption or delay**

If a trip is interrupted or delayed due to an illness or injury of an insured person, one-way economy transportation will be arranged so that each covered person (and a travelling companion, if applicable) may rejoin the trip or return home. The extra cost over and above any allowance available under pre-paid travel arrangements will be paid.

If the choice is made to rejoin the trip, further expenses incurred related directly or indirectly to the same illness or injury **will not be paid**.

A travelling companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the insured person's fare.

- **Convalescence after hospital discharge**

If you are unable to travel for medical reasons following hospital discharge, expenses incurred for meals and accommodations after the scheduled date of departure will be paid (subject to the maximum shown under "Accommodation and meals" below).

## **Non-medical assistance**

Around-the-clock access in most languages is also available for the following services.

- **Pre-trip assistance**

Up-to-date information is provided for passport, visa, vaccination and inoculation requirements for your travel destination.

- **Vehicle return**

If you are unable to operate your own or rented vehicle due to illness, injury or death, arrangement and payment, to a maximum of \$1,000 (Canadian), will be made for a commercial agency to return the vehicle to your home or nearest appropriate rental agency.



- **Accommodation and meals**

Reimbursement will be made for the cost of accommodation and meals, subject to a maximum payment of \$2,000 (Canadian) for each *medical emergency*, in the following situations:

- return home of dependent *children*,
- visit by a family member,
- trip interruption or delay,
- convalescence after hospital discharge, and
- identification of the deceased.

- **Identification of deceased**

If a covered person dies while travelling alone, round-trip economy transportation will be arranged and paid for one member of the immediate family, if necessary, to identify the deceased before release of the body.

- **Return of deceased**

If a covered person dies while travelling, all necessary authorizations will be obtained and arrangements made to transport the deceased back to city or town of their province of residence. The costs of preparation and transportation of the body are eligible, up to a maximum of \$5,000 (Canadian). Expenses related to the burial are not eligible.

- **Lost or stolen document and ticket replacement**

In the event of theft or loss, ManuAssist will help you in contacting local authorities to assist you in replacing travel documents or tickets.

- **Legal referral**

When required, ManuAssist will provide referral to a local legal advisor, as well as assistance in arranging to obtain a cash advance from funds available through personal credit cards, family, or friends.

- **Interpretation service**

ManuAssist will provide telephone interpretation services in most major languages.

- **Emergency message service**

A telephone and message service for you and your covered dependents will be provided for emergency messages to or from family, friends, or business associates, while travelling. Messages will be held for 15 days.



## Limitations

Neither World Access nor Manulife Financial will be liable in any manner whatsoever, if conditions, events or factors beyond their control delay, interfere with, or prevent the provision of any services.

Neither World Access nor Manulife Financial is responsible for the availability, quality, or results of any medical treatment received by you or your covered dependents, or the failure to obtain medical treatment or emergency assistance services for any reason.

## Claim procedures

Your ManuAssist card lists the toll-free or call-collect numbers to call in case of an emergency while travelling outside your province. You will then be put in touch with World Access.

Your ManuAssist card also lists your Member ID number and Group Number, which World Access needs to confirm that you are covered by Manulife Financial.

If you are enrolled but do not have a ManuAssist card, contact Employee Support Services.

## Maximum reimbursement

Maximums for specific supplies and services under the Health Care plan are indicated in your *Benefits at a glance*. There is no lifetime maximum reimbursement provided under the Health Care plan.

## Deadline for claim submission

All Health Care claims for you and your family that are incurred while you are an employee must be submitted no more than 15 months after the date the claim was incurred.

If your coverage ends, all claims incurred before termination of coverage must be submitted within 90 days of the date of termination.



## Questions and answers about health coverage

### How are benefits coordinated if I am covered under more than one Health Care program?

If you, your *spouse*, or your *children* are eligible to receive benefits from more than one group Health Care plan, the benefits will be coordinated so that total reimbursement does not exceed the actual expenses incurred.

If both you and your *spouse* are covered by group plans, individual expenses should be submitted to the plan that covers the person as an employee first. For your *children*, expenses should first be submitted to the plan of the *spouse* whose birthday falls earliest in the year. Any amounts not reimbursed in both cases may then be submitted to the other *spouse's* plan.

### How does reimbursement of paramedical services work in conjunction with the provincial plan's reimbursement?

Ontario's provincial health care plan covers visits to certain paramedical practitioners. This currently applies to osteopaths and chiropodists or podiatrists, but this is subject to change as the provincial plan is modified. For each of these practitioners, the provincial plan generally reimburses expenses, to a maximum for any one visit and to an annual maximum.

The Board's plan will reimburse expenses that are incurred after the date the provincial annual maximum has been reached.

Once the provincial plan has reached its annual maximum, the Board's plan will reimburse future expenses related to these services, to the maximum listed in the *Benefits at a glance* for each practitioner.

In Quebec, where no reimbursement is provided under the provincial plan, these expenses are eligible immediately, to the maximum specified for each service.



**Will I have emergency out-of-country coverage no matter where in the world I travel?**

Political instability, epidemics, and geographic inaccessibility may interfere with the provision of services in certain parts of the world. Please contact the phone number provided on the front of your ManuAssist card before you leave Canada, to confirm coverage.

**What additional information do I need to send to the carrier when claiming for orthotics, orthodontics or private-duty nursing?**

Claim submission guidelines have been established for these services. Please refer to the Benefits folder on BEAM for up-to-date information on orthotics and orthodontics. Contact Employee Support Services regarding claim submission guidelines for private-duty nursing.



## DENTAL CARE

**Please refer to your *Benefits at a glance* for the coverage available to your employee group.**

The Board's Dental Care plan assists you in meeting the expenses related to basic dental care and, if the need arises, to major restorative and orthodontic services. The reimbursement percentage, applicable maximums, and dental *fee guide* on which reimbursement is based, are indicated in your *Benefits at a glance*. A list of expense limitations and exclusions is included on page 30.

Although you may choose to go to any dentist you wish and receive the recommended treatment, plan reimbursement is based on the least-expensive procedure available that is consistent with good dental care.

### Treatment plan

If the total cost of proposed dental work is expected to be more than \$500—or any amount if the proposed work is orthodontic—your dentist should prepare a treatment plan, which you will submit to the insurer before treatment begins.

The treatment plan is not intended to limit your choice of dentist, or to tell you or your dentist what treatment should be performed, or to tell the dentist what fee to charge. It is a plan of dental care (including X-rays if required), showing the patient's dental needs, a written description of the proposed treatment required in the professional judgment of the dentist, and related costs. The insurer will provide a statement that will let you know before you undertake dental treatment exactly what percentage of the total cost that will be covered by the plan. The treatment plan shall be valid only if the course of treatment starts within 90 days of the date the treatment plan is submitted.



## Covered expenses

The following routine, major restorative and orthodontic treatments are covered by the Dental Care plan.

### Routine services

- recall exam: oral examination, prophylaxis (the cleaning and scaling of teeth) bitewing x-rays, topical application of fluoride, oral hygiene instructions, polishing of teeth, and supervised fluoride brush-in, limited to the number of treatments indicated in your *Benefits at a glance*,
- full-mouth series of X-rays, provided that at least 24 consecutive months have elapsed since the last such series was performed,
- surgical removal of teeth and residual roots, including wisdom teeth,
- amalgam, silicate, acrylic, or composite fillings, including pin reinforcement,
- dental surgery, including general anaesthesia,
- diagnostic X-rays and laboratory procedures required in relation to dental surgery,
- endodontic treatment,
- periodontal services,
  - treatment of diseases of the gums and other supporting tissue of the teeth,
  - scaling (other than that covered under prophylaxis, above) and root planing, to a combined maximum of 16 units per person per calendar year,
  - provisional splinting, and
  - occlusal equilibration, to a maximum of eight units per person per calendar year,
- necessary treatment for relief of dental pain,
- the cost of medication and its administration when injected in the dentist's office,
- space maintainers not involving movement of teeth,
- consultations required by the attending dentist,
- repairs, relines, rebases, and adjustments to existing dentures,
- stainless steel crowns (temporary), and
- interproximal discing of teeth.



## Major restorative treatments

- crowns, including gold and porcelain, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative materials (your *Benefits at a glance* indicates the reimbursement level for crowns). When crowns are rendered on molar teeth, only the cost of metal material will be considered,
  - onlays, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative services,
  - inlays, when three or more surfaces are involved and the tooth cannot be restored using basic restorative materials. If only one or two tooth surfaces are involved, the inlay will be considered for reimbursement as a restorative service under *Routine services* and payment will be determined based on the cost of a comparable amalgam or composite restoration,
  - initial provision of a prosthodontic appliance (e.g. fixed bridge restoration, removable partial or complete dentures) if required because at least one additional natural tooth was necessarily extracted after the person became covered under this plan,
  - replacement of existing appliances\*, provided:
    - a natural tooth must be extracted and the existing appliance cannot be made serviceable,
    - the existing appliance is at least five years old and cannot be made serviceable,
    - the replacement appliance replaces, within 12 months, an existing appliance that was temporarily installed after the person became covered under this plan,
    - the replacement appliance is required as the result of the installation of an initial opposing denture after the person became covered under this plan, or
    - the replacement is required as the result of accidental dental injury that occurs after the person became covered under this plan,
- \* If the existing appliance could have been made serviceable, only the expense for that portion of the replacement that replaces the extracted teeth will be covered.
- repairs to existing bridgework,
  - adjustments to initial or replacement bridgework after the three-month post-insertion care period, and
  - procedures involving the use of gold, if such treatment cannot be rendered at lower cost by using a reasonable substitute consistent with generally accepted dental practice (if the treatment could have been rendered with the lower-cost substitute, only the expense for that alternative treatment will be covered).



## **Orthodontic treatments**

Treatment and appliances for the correction of Class I, II, or III malocclusions related to primary, mixed, or permanent teeth.

## **Maximum reimbursement**

Maximums for specific types of service under the Dental Care plan, are indicated in your *Benefits at a glance*. There is no lifetime maximum reimbursement provided under the Dental Care plan.

## **Deadline for claim submission**

All dental claims for you and your family that are incurred while you are an employee must be submitted no more than 15 months after the date the claim was incurred.

If your coverage ends, all claims incurred before termination of coverage must be submitted within 90 days of the date of termination.

## **Limitations and exclusions for dental coverage**

The Dental Care plan does not provide reimbursement for supplies, services, or expenses for:

- cosmetic treatment, experimental treatment, dietary planning, plaque control, congenital or developmental malformation which is not a Class I, II or III malocclusion,
- charges made by a dentist for broken appointments or for completion of claim forms required by the insurance company,
- charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used,
- services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint (TMJ) dysfunction,
- dentures which have been lost, mislaid or stolen,
- treatment not yet approved by the Canadian Dental Association,
- treatment not necessarily rendered above the treatment usually required for cases of the nature and severity of case being treated,



- replacement of an existing bridge or denture will not be considered if the replacement is not a result of extraction of additional natural teeth while covered under the policy,
- injury resulting from war, insurrection, services in the armed forces of any country,
- expenses from intentionally self-inflicted injuries,
- implants or any services rendered in conjunction with implants, or
- replacement of mercury (amalgam) fillings with composite fillings, unless a medical certificate is supplied to confirm that the patient is allergic to mercury.

## Questions and answers about dental coverage

### How are benefits coordinated if I am covered under more than one Dental Care program?

If you, your *spouse*, or your *children* are eligible to receive benefits from more than one group Dental Care plan, the benefits will be coordinated so that total reimbursement does not exceed the *fee guide* for dental expenses indicated in your ***Benefits at a glance***.

If both you and your *spouse* are covered by group plans, individual expenses should be submitted to the plan that covers the person as an employee first. For your *children*, expenses should first be submitted to the plan of the *spouse* whose birthday falls earliest in the year. Any amounts not reimbursed in both cases may then be submitted to the other *spouse's* plan.

### How do I know when and how to submit a treatment plan?

The Dental Plan has a provision called "predetermination of benefits". As explained in the *Treatment Plan* section, this plan is designed to enable you and your dependents to determine how much the Board's plan will pay before you start a course of dental treatment with estimated expenses higher than \$500.

This is how you obtain a predetermination of benefits.

- After your dentist examines you or your dependent and determines the required treatment, and that the total expense expected for the course of that treatment will exceed \$500, he or she completes the claim form and submits it to Manulife Financial.



- Manulife Financial reviews the proposed course of treatment, verifies that the treatment is a covered expense under the plan, applies the policy provisions, determines the estimated benefit payment payable by the plan, and communicates the results to you.
- After treatment is rendered, the completed claim form is submitted to Manulife Financial for actual payment. The claim is compared to the original claim form previously reviewed. A claim settlement cheque is then forwarded.

The predetermination provision is voluntary and is not intended to interfere in your dentist-patient relationship. It is merely a means by which the dentist and the patient are informed, in advance, of the benefits payable for these services. This allows you to decide on a more expensive or elaborate treatment program, with a clear understanding of the benefits available from the plan, and of the fact that you will have to pay any additional cost quoted by your dentist.



## SICK LEAVE PLAN

The sick leave plan provides disability income protection for short-term illness or injury.

You accumulate sick leave days during each month you are actively at work. The number of days you are entitled to accumulate are indicated in your collective agreement or employee handbook.



## LONG-TERM DISABILITY PLAN

Please refer to your *Benefits at a glance* for the coverage available to your employee group.

The Board's Long-Term Disability plan provides disability income protection for longer term illness or injury for Educational Support Professionals, Plant Support Staff Unit, Professional Student Services Personnel, and Union Exempt employees.

If you are a Secondary Teacher—OSSTF, Elementary Teacher—OCETF, Educational Assistant—OSSTF, or Principal/Vice-Principal—OPC, contact your Federation Office or designated contact person for Long-Term Disability plan details.

If you are still *totally disabled* after the *qualifying period*, and if the insurer approves your application, you will receive the percentage of your *earnings* to the specified maximum as indicated in your *Benefits at a glance*. These benefits will continue for as long as you remain *totally disabled* or until you reach age 65.

*Totally disabled* means the inability caused by sickness or injury to perform the regular duties of your own occupation during the *qualifying period* and the subsequent number of years indicated in your *Benefits at a glance*; thereafter, the inability to work at any occupation for which you are qualified, or may reasonably become qualified by training, education, or experience. The insurer must be provided with satisfactory proof of your *total disability*.

The *qualifying period* is the number of calendar days indicated in your *Benefits at a glance* that you must wait before receiving Long-Term Disability plan benefits, which may be interrupted by a return to work of not more than 30 working days, provided the recurring disability is from the same or a related cause.



During the *qualifying period* you can use your accumulated sick leave. If you have not accumulated enough sick leave credits to carry you through the *qualifying period* for Long-Term Disability benefits, you will be placed on leave without pay pending Long-Term Disability. You may be eligible to receive Employment Insurance Illness benefits during this period and you will be provided with a record of employment upon commencement of the leave.

Depending on your employee group, your Long Term Disability benefits may be adjusted to compensate for increases in the cost of living. If this provision applies to your group, your ***Benefits at a glance*** will indicate the percentage increase. Increases are applied once you have been receiving Long-Term Disability benefits for two years, and on each anniversary of the beginning of your benefits after that.

If you die while receiving benefits from the plan, your surviving *spouse—or children*, if you have no *spouse*—will receive a lump-sum payment equal to three times your last monthly benefit. If you have no surviving dependents, this benefit will be paid to your estate.

## Disability benefits from other sources

You may be entitled to disability benefits from other sources, such as Employment Insurance, the Canada/Quebec Pension Plan, your pension plan, a provincial automobile insurance plan, or a provincial workers' compensation plan—if your disability is work-related.

Your Long-Term Disability benefits are reduced by the amount of any benefits you are entitled to receive from:

- a provincial workers' compensation plan,
- the Canada/Québec Pension Plan, including benefits paid to or on behalf of your dependents, and
- a provincial automobile insurance plan.

Benefits will be further adjusted, if necessary, so that your total income from all sources does not exceed 100% of your pre-disability *earnings*. Other sources include income from:

- an approved rehabilitative program,
- a group, association, or franchise plan,
- any retirement or pension disability plan, and
- any employer.



## Recurrence of disability

If, during the *qualifying period* for Long-Term Disability benefits, you return to work and become disabled again less than 30 working days later from the same or a related cause, the second disability will be applied toward the *qualifying period*.

Once you are receiving Long-Term Disability benefits, if you return to work and become disabled again from the same or a related cause in less than six months, the second disability will be considered a continuation of the first, and Long-Term Disability benefits will resume immediately.

If the second disability is from a cause totally unrelated to the first, or recurs more than six months later, you will have to complete a new *qualifying period* and use sick leave credits until you once again become eligible for Long-Term Disability benefits.

## Rehabilitation program

Disability benefits generally stop when you go back to work. However, to help you return to productive, full-time employment as soon as possible, the Long-Term Disability plan continues to pay you benefits while you are working at rehabilitative employment approved by your doctor, the insurer, and the Board.

Your disability benefit, however, will be reduced by the earnings you receive from any rehabilitative employment if the total income you receive exceeds 100% of your pre-disability earnings.

## Limitations and exclusions

No benefits will be paid from the Long-Term Disability plan unless you are under the regular, ongoing care of a physician, are undergoing an appropriate course of treatment or participating in a rehabilitation program that the insurer considers appropriate. In addition, no benefits are payable while you are:

- receiving Employment Insurance pregnancy or parental (adoption) benefits,
- on lay-off during which you become disabled,
- on leave of absence during which you become disabled, unless the Employer is required by law to continue benefits,



- receiving benefits from an employer-sponsored salary continuance or short-term wage loss replacement plan, and
- working at any occupation other than rehabilitative employment, or imprisoned.

In addition, no benefits are payable for a disability directly or indirectly related to:

- self-inflicted illness or injury, whether you are sane or insane,
- war, insurrection, the hostile action of any armed forces, or participation in a riot or civil commotion,
- cosmetic medical or surgical care,
- commission or attempted commission of an assault or criminal offence,
- substance abuse, unless you are actively participating in a treatment program approved by the insurer, and
- an illness or injury for which you were treated or attended by a physician, or for which prescribed drugs were taken, in the 90 days before the date you were insured under the plan (this exclusion applies only to conditions that cause a disability within the first three months of your coverage under the plan).

## Benefit coverage in case of disability

Your coverage under all the plans of the Benefits Program will continue during the *qualifying period* for Long-Term Disability benefits, and while you continue to pay your share of the required contributions.

While you are receiving Long-Term Disability benefits:

- the monthly premiums for this coverage will be waived, and
- the status of your coverage under all other benefit plans are dictated by the terms of your collective agreement or terms and conditions of employment, as detailed in your *Benefits at a glance*.



# LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Please refer to your *Benefits at a glance* for the coverage available to your employee group.

The Board offers a full complement of life and accident insurance protection for both you and your family.

## Group life insurance

### Basic coverage

Your amount of coverage is indicated in your *Benefits at a glance*. Your beneficiary will receive the insured amount in the event of your death.

### Voluntary coverage

This coverage is only available to those employees who were members of the following employee groups, and who had Basic coverage of three times annual salary and chose to retain the difference between \$45,000 and three times annual salary (in effect as of the date(s) indicated below) as voluntary coverage.

- Secondary Teachers prior to February 1, 1999
- Elementary Teachers prior to April 1, 1999
- Principals and Vice Principals prior to May 1, 1999
- Educational Assistants prior to September 1, 1999
- Professional Student Services Personnel prior to November 1, 1999
- Plant Support Staff prior to December 1, 1999, and
- Educational Support Professionals prior to September 1, 2000

Employees who chose to retain this coverage must pay the full cost of the additional voluntary coverage.



## Optional Term Life Insurance

### Employee coverage

If you wish, you may also choose to purchase additional coverage: one, two, three, or four times your *earnings*, to a maximum of \$300,000.

### Dependent coverage

Provided that your *spouse* does not work for the Board, you may also purchase protection for your *spouse* under this plan, again, in amounts equal to one, two, three, or four times your *earnings*, to a maximum of \$300,000.

Provided you have chosen coverage for yourself, you may also choose to insure your *children* under this plan, in amounts of \$5,000, \$10,000, \$15,000, \$20,000, or \$25,000. Each **eligible** *child* must be insured for the same amount, and you may not have a larger amount of insurance on your *children* than you have on your *spouse*.

### Late application

*Evidence of good health* is required for both employee and spousal coverage if you apply more than 31 days after your date of hire or your documentation date, if later. For *children's* coverage, you must provide *evidence of good health* for amounts above \$15,000 if you apply more than 31 days after your date of hire or your documentation date, if later. *Evidence of good health* is always required if you apply to increase coverage, or to reinstate coverage that you have earlier cancelled.

The insurance will take effect only when the insurer approves the application for coverage.



## Basic Accidental Death and Dismemberment Insurance

This plan provides protection for you against any accidental injury resulting in death, dismemberment, paralysis, *loss of use*, sight, speech or hearing that occurs within 365 days of a *covered accident*. Your coverage extends 24 hours a day, in case of accidental death or injury occurring anywhere in the world, on or off the job.

The coverage level is indicated in your *Benefits at a glance*.

### Specific *loss* schedule

If an accidental injury results in any of the following specific *losses* or *loss of use* within 365 days of the date of the *covered accident*, the insurance company will pay the percentage of the benefit amount specified in the table that follows, based on the amount of basic benefit stated in your *Benefits at a glance*.

If you suffer several *losses* as a result of the same accident, you will receive only one such benefit—the largest.

<b><i>Loss of:</i></b>	<b>Benefits (% of coverage)</b>
Life	100%
Both hands or both feet or entire sight of both eyes	
One hand and one foot	
Speech and hearing in both ears	
One hand or one foot and entire sight in one eye	
One arm or one leg	
One hand or one foot or entire sight of one eye	66 2/3%
Speech or hearing in both ears	
Thumb and index finger of either hand or at least four fingers on one hand	33 1/3%
Hearing in one ear	33 1/3%
All toes of one foot	33 1/3%



<b><i>Loss of use of:</i></b>	<b>Benefits (% of coverage)</b>
Quadriplegia (movement of both upper and lower limbs) Paraplegia (movement of both lower limbs) Hemiplegia (movement of upper and lower limbs of one side of the body)	200%*
Both hands Both arms or both legs	100%
One arm or one leg	75%
One hand	66 2/3%

\* If you die within 90 days after the date of the accident, only 100% of the coverage will be paid.

### **Repatriation benefit**

If you die as the result of a *covered accident* while more than 200 kilometers from home, the plan will pay the reasonable and customary cost of preparing the body for burial or cremation, and of shipment of the remains to the place of burial by the most direct route, to a maximum of \$10,000.

If you suffer a covered *loss* while more than 200 kilometers from your permanent place of residence in your country of residence, the plan will pay the cost of one-way economy transportation by a licensed common carrier by the most direct route, to a maximum of \$10,000.

### **Rehabilitation benefit**

If you suffer a covered *loss* and must take formal training to qualify for active employment again, the plan will pay the reasonable expenses related to such training (limited to the cost of such training and the materials needed for it), to a maximum of \$10,000. Such training must be undertaken not more than two years after the date of the accident.

Board, lodging or other ordinary living, travelling or clothing expenses are not covered.



## Education benefit

If you die as a result of a *covered accident*, each of your *children* may be eligible to receive an education benefit, equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your coverage or \$5,000.

To be eligible for this benefit, your *child* must have been enrolled as a *full-time student* in an accredited university, college, CEGEP or trade school at the time of your death, or have been in secondary school and subsequently enrol as a *full-time student* in a university, college, CEGEP or trade school within 365 days of the date of your death.

This benefit will be paid in annual instalments each year for up to four consecutive years, as long as your *child* remains eligible. The first payment will be made as soon as your *child* furnishes proof of full-time enrolment to the insurer; subsequent payments will be made annually when the insurer receives confirmation of continued enrolment.

Room, board or other ordinary living, travelling or clothing expense are excluded.

If you do not have a *child* eligible for this benefit, the plan will pay an additional \$1,000 to your designated beneficiary.

## Daycare benefit

If you die as a result of a *covered accident*, each of your *children* under age 13 (including any *child* born within nine months of your death, provided he or she was conceived before your death) already enrolled in a legally licensed daycare that they will attend one year after your death, may be eligible to receive a daycare benefit, equal to 5% of your coverage or \$5,000.

Payment will be made to the person who has legal physical custody of the *child* and who has primary responsibility for that *child's* expenses, once that person provides proof of enrolment in the program, as long as the *child* lives with that person.

This benefit will be paid in annual instalments for up to four consecutive years, as long as the *child* remains eligible, and will cover only expenses incurred after you die.

Room, board or other ordinary living, travelling or clothing expense are excluded.

If you do not have a *child* eligible for this benefit, the plan will pay an additional \$1,000 to your designated beneficiary.



### ***Spouse's occupational training benefit***

If, because of your death that results from a *covered accident*, your *spouse* requires formal occupational training to enter the workforce, the plan will pay the reasonable expenses related to such training (not including day-to-day living expenses), to a maximum of \$10,000. Such training must be undertaken not more than three years after the date of your death.

Board, lodging or other ordinary living, travelling or clothing expenses are not covered.

### **Home alteration and vehicle modification benefit**

If you receive a benefit under this plan for accidental *loss* or *loss of use* of both feet or legs, or become quadriplegic, or paraplegic or hemiplegic, you may require, as a result, the permanent use of a wheelchair to be ambulatory. In this instance, the plan will pay the reasonable expenses actually incurred to alter your current home to make it wheelchair accessible and habitable and to modify your current motor vehicle to make it accessible or driveable (when such modifications are required by vehicle licensing authorities), to a maximum of \$10,000. Such alterations and modifications must be carried out by people experienced in such matters, and must be done within three years of the date of the accident.

### **Seat belt benefit**

If you suffer a specific *loss* as the result of a *covered* motor vehicle *accident* while wearing your seat belt, the plan will pay an additional benefit of 10% of the amount payable for such *loss*. The driver of the vehicle must hold a current and valid driver's license at the time of the accident.

This benefit does not cover:

- driving or riding as a passenger in any vehicle being used in a race, speed or endurance test, or for acrobatic or stunt driving, or
- driving while being intoxicated or under the influence of drugs, except for drugs prescribed by a physician.



### **Accident hospital indemnity benefit**

If you are hospitalized and under the care of a physician, the plan will pay you a daily benefit of 1/30th of 1% of your insurance amount, to a maximum monthly benefit of \$2,500:

- from the first day if you are hospitalized because of a *loss* suffered in a *covered accident* (for a maximum of 365 days), or
- from the fifth day, if you are hospitalized due to any other injury.

If any injury requires more than one period of hospitalization, then the maximum benefit period of 365 days will be reinstated, provided that at least 183 days have elapsed between the periods of hospitalization. All periods of hospitalization must occur within two years of the date of the accident.

Hospitalization must:

- be uninterrupted,
- result from an injury, and
- begin while insurance is in force.

### **Family transportation benefit**

If you suffer a covered *loss* and are hospitalized more than 150 kilometres from your normal place of residence, the plan will pay the reasonable costs for an *immediate family member* at least 18 years old to travel by the most direct route to the hospital, including return fare, to a maximum of \$10,000. The attending physician must certify that this attendance is required.

Board, lodging or other ordinary living, travelling or clothing expenses are excluded.

### **Pilot and crew member coverage**

If you complete an application for pilot coverage, which is accepted by the insurer, the plan will pay 50% of the applicable benefit if you hold a current and valid private pilot's license and suffer a covered *loss* while riding as a pilot or crew member on a civil or public aircraft, or a military transport aircraft, provided such aircraft is operated in accordance with the regulations of the authority having jurisdiction over the operation of such aircraft.



## Exposure to the elements

If you are exposed to the elements as the result of a *covered accident*, and such exposure results in a covered *loss*, the plan will pay the applicable percentage.

## Optional Accidental Death and Dismemberment Insurance

You may purchase additional accident coverage for you, you and your *spouse*, or your whole family.

<b>Employee only</b>	<ul style="list-style-type: none"> <li>▪ Units of \$5,000 from \$10,000 to \$250,000</li> </ul>
<b>Employee &amp; spouse</b>	<ul style="list-style-type: none"> <li>▪ <b>Employee:</b> units of \$5,000 from \$10,000 to \$250,000</li> <li>▪ <b>Spouse:</b> units of \$5,000 from \$10,000 to \$125,000 (<i>spouse's</i> coverage cannot exceed employee's coverage)</li> </ul>
<b>Family</b>	<ul style="list-style-type: none"> <li>▪ <b>Employee:</b> units of \$5,000 from \$10,000 to \$250,000</li> <li>▪ <b>Spouse, no dependent children:</b> 60% of employee's coverage</li> <li>▪ <b>Spouse and dependent children:</b> <i>spouse</i> – 50% of employee's coverage and each <i>child</i> – 15% of employee's coverage</li> <li>▪ <b>No spouse, but dependent children:</b> each <i>child</i>: 20% of employee's coverage</li> </ul>

The same table of benefit percentages, and the list of additional benefits provided under the Basic Accidental Death and Dismemberment Insurance plan are also provided under this Optional Accidental Death and Dismemberment Insurance plan. However, there are some limitations in the maximum amounts payable. Contact Employee Support Services for details.



### **Enhanced *loss* schedule for *children***

If you have family coverage and your *child* suffers a covered *loss* other than loss of life, you will receive double the applicable percentage payable for that *loss*, to a maximum of \$100,000. Loss of life will be payable as per the covered *loss* schedule.

Only the benefit for the loss of life will be paid if the *child*'s death occurs within 90 days of the date of the accident.

## **Conversion privilege**

### **Basic and Optional Term Life**

When any of your life insurance, or that of your *spouse*, ends—provided certain conditions are met—you may purchase individual policies from the insurer (with some restrictions), without having to provide *evidence of good health*. This option must be exercised no more than 31 days after coverage ends. The maximum amount that may be converted under the Basic and Optional Term Life plans **combined** is \$200,000.

If the covered person dies during the 31-day conversion period, the insurer will pay the full benefit you were insured for prior to termination of coverage.

Conversion is **not** available on life insurance for your *children*.

### **Basic and Optional Accidental Death and Dismemberment Insurance**

When any of your accident insurance, or that of your *spouse* or *children*, ends—provided you are less than age 70, and certain conditions are met—you may purchase individual policies from the insurer (with some restrictions), without having to provide *evidence of good health*. This option must be exercised no more than 31 days after the coverage ends. The maximum that may be converted under Basic and Optional Accidental Death and Dismemberment Insurance plans combined is \$250,000.



## Limitations and exclusions

There are no limitations or exclusions for Group Life Insurance.

For Optional Term and Optional Dependent Life Insurance, if the death of a covered person is a result of suicide, while sane or insane, payment will be limited to the coverage amount that has been in effect for one or more years.

No benefits are paid from the Basic or Optional Accidental Death and Dismemberment Insurance plans for death or injury related to:

- intentionally self-inflicted injury, suicide or attempted suicide, whether the person was sane or insane,
- a war or act of war, declared or undeclared,
- full-time active duty in the armed forces (land, water, or air) of any country or international authority, unless your *spouse* is on permanent assignment as a member of the Canadian Armed Forces within the boundaries of Canada in a non-combat unit,
- an injury that occurs while you are working for another employer or for yourself for gain or profit.
- travel on any aircraft while acting as a crew member, student pilot, flight instructor or examiner, and
- travel on any aircraft which is owned, operated, chartered or leased by the School Board.

## Designating a beneficiary

In general, you may name anyone as beneficiary, including an organization or foundation. A minor may also be named beneficiary. In this case, however, you should consider appointing a guardian or trustee to handle the *child's* affairs until he or she reaches the age of majority, as per the applicable provincial legislation.

You may also name more than one person or group as beneficiary. If you do so, remember to indicate the percentage of coverage to be paid to each. If one of your beneficiaries predeceases you, the remaining beneficiary or beneficiaries will share the benefit proportionately. If all beneficiaries predecease you, or you do not name a beneficiary, benefits will be paid to your estate. You should inform Employee Support Services of any divorce decree in effect that could have an impact on your beneficiary designation.



You are the beneficiary of any benefits under the dependent coverage of the Optional Term Life Insurance plan, the Dependent Life Insurance Plan, and for personal injury or the injury or death of your dependents under the accident insurance plans.

You may change your beneficiary when you wish, subject to applicable legislation, by completing the appropriate form at Employee Support Services.

If you live in Quebec, the designation of your *spouse* as your beneficiary is irrevocable, unless otherwise specified. If a beneficiary designation is irrevocable, the signature of the irrevocable beneficiary is required for any changes, including the change in beneficiary. If you live in Quebec and wish to change your beneficiary designation, you may wish to seek legal advice on this matter.

**Note:** A change in beneficiary designation will only be effective on the date the document is received by Employee Support Services and if the document is dated and includes your original signature.

## Questions and answers about Life and Accidental Death and Dismemberment Insurance

### How much life insurance is appropriate?

Each person will need to determine individually how much insurance coverage is enough. Here are a few questions to consider in making your decision.

- Do people depend on you for financial support, and would your death cause them financial hardship now or in the future?
- Do you have other term or paid-up life insurance?
- Will there be financial obligations to meet when you die?
- Have you provided for your *children's* education?
- Considering your present financial situation, can you afford to purchase additional protection?

## HOW TO CLAIM BENEFITS

### Health Care

For all eligible expenses, obtain an *Extended Health Care Claim* form from your work location, or from the Benefits folder on BEAM. You must sign the form, include your employee (certificate) number, even if the claims are for a member of your family, date it and submit it with original bills or receipts to:

Manulife Financial  
Group Health Claims  
P.O. Box 1653  
Waterloo, Ontario  
N2J 4W1

#### Claim procedures for eligible expenses under the Health Care plan

##### Prescription drugs

To claim reimbursement for eligible prescription drugs, you will have to pay the full cost of the prescription at the time of purchase, and submit a paper claim later to Manulife Financial.

Fertility drug claims require specific information and follow specific guidelines.

To submit a fertility drug claim, you must:

- obtain and follow the *Fertility Claim Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.



### **Psychological services**

For psychological services, the receipt should specify the patient's name, date of each session, and the length of time of each session, in half-hour segments (for example, a one-hour session is two half hours, a one-and-a-half hour session is three half hours) and the cost of each session.

### **Private-duty nursing services**

If your doctor recommends out-of-hospital private-duty nursing care, you must obtain written approval (pre-determination) from the insurer before the services begin.

To do so:

- obtain and follow the *Private-Duty Nursing Claim Submission Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.

Certain charges for private-duty nursing, such as for custodial care or care that could be given by someone other than a private-duty nurse, may not be covered by the health care plan.

### **Wheelchair claims**

Submission of claims for expenses incurred in relation to the purchase of a wheelchair requires specific information and follows specific guidelines. To submit wheelchair claims, you must:

- obtain and follow the *Wheelchair Claim Submission Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.

### **Semi-private hospital room charges**

The procedure for reimbursement of payments for services received in a hospital not covered by your provincial health plan is different than for other eligible expenses. The health care facility will ask you to sign a form authorizing direct payment to the facility by Manulife Financial.



As explained on page 14, after your hospital stay, Manulife Financial will send you a questionnaire related to the details of your hospitalization. Please take the time to correctly and completely fill out this questionnaire. Manulife Financial will use your responses to ensure that the hospital's charges are correct.

If your doctor orders private room accommodation as *medically necessary* for your condition, you won't have to pay for the difference between semi-private and private accommodation. It will be covered by the provincial health plan.

### **Hearing aids**

When you claim expenses for hearing aids, you must submit your claim form together with the original Explanation of Benefits from the provincial Assistive Devices program.

### **Orthotic appliances**

Submission of claims for expenses incurred in relation to the purchase of orthotic appliances requires specific information and follows specific guidelines. To submit claims for orthotics, you must:

- obtain and follow the *Orthotic Claim Submission Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.

No orthotics claim will be paid if any of this information is missing. Once Manulife Financial receives the complete information, they will review it and will let you know the result of your claim.

### **Medical equipment claims**

To claim expenses for medical equipment:

- obtain and follow the *Medical Equipment Submission Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.



## Oxygen requirement claims

When you submit an oxygen requirement claim:

- obtain and follow the *Oxygen Requirement Guidelines*, available from the Benefits folder on BEAM, and
- use a regular *Extended Health Care Claim* form, attaching all required documents.

## Deadline for claim submission

All health care claims for you and your family that are incurred while you are an employee must be submitted no more than 15 months after the date the claim was incurred.

If your coverage ends, all claims incurred prior to termination of coverage must be submitted within 90 days of the date of termination.

## Dental care

Before you or a member of your family goes to the dentist, obtain a claim form from your work location, and have the dentist complete it. Make sure you complete your section of the claim form. You will be responsible for paying the dentist and submitting the form to the insurer for reimbursement. If your dentist has electronic access to the insurer, the amount eligible under the plan will be calculated and you will be responsible for paying your dentist for any difference.

## Claiming orthodontic expenses

Because orthodontic treatment is normally rendered over a long period, in calculating the benefits, such expenses are considered to be spread over the treatment period, regardless of the way in which the orthodontist's bill is actually paid.

Submit the dated and signed form, with original bills or receipt to:

Manulife Financial  
Group Dental Claims  
P.O. Box 1654  
Waterloo, Ontario  
N2J 4W2



### Deadline for claim submission

All dental claims for you and your family that are incurred while you are an employee must be submitted no more than 15 months after the date the claim was incurred.

If your coverage terminates, all claims incurred prior to termination of coverage must be submitted within 90 days of the date of termination.

### Important items to remember

- Claims are paid based on the date the cost is incurred, **not** the day you submit a claim.
- If you are unsure when you last purchased eyeglasses or contact lenses, and intend to make a subsequent claim, verify eligibility with the insurer.
- If you are traveling outside Canada and become ill or are injured, immediately contact Worldwide Medical Assistance (ManuAssist) at the number provided on the back of your ManuAssist card.
- Be sure to tell your dentist which dental *fee guide* is applicable to the dental plan, as indicated in your ***Benefits at a glance***, as it may impact on the amount you are out of pocket.

## Life and Accidental Death and Dismemberment Insurance

In the event of a claim, you or your beneficiary should, as soon as possible, notify Employee Support Services, who will provide the necessary forms and assistance to complete them. They will also let you know what documentation will be required by each insurer, and the specific time limits for claims.

