# ADDENDUM TO THE COLLECTIVE AGREEMENT

BETWEEN

RYGIEL HOMES
- and -
CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3009

## ARTICLE 10 – SENIORITY

10:03 Amend second paragraph to read:

It is understood that there shall be one (1) seniority list for full-time and short-week employees, and one (1) seniority list for part-time employees.

10:05 b) An employee injured at work will continue to accumulate seniority while off on Workplace Safety & Insurance Board (WSIB) benefits for the following purposes, namely job postings, vacation scheduling preference, call-in, layoff and recall.

## ARTICLE 16 – WELFARE

16:01 Dental Plan 100%
O.D.A. – 2000 rates effective July 1, 2001

## ARTICLE 20 – LEAVE OF ABSENCE

20:02 a) i) An employee who is pregnant shall be entitled, upon her application therefore, to a maternity leave of absence of seventeen (17) weeks and a parental leave of up to thirty-five (35) weeks, all in accordance with the Employment Standards Act.

## ARTICLE 23 – UNION BULLETIN BOARDS

23:01 The Employer will send notices to all locations. All notices must be signed by the proper officers of the Union and approved by the Employer before being circulated.

## ARTICLE 27 – POSITIVE WORK ENVIRONMENT

27:01 The Employer and the Union agree to abide by the provisions of the Ontario Human Rights Code in order to provide a discrimination and harassment free work environment.

Wages, effective first full pay period in April 2001, 1%. Effective October 8, 2001, 1%.

Letter of Understanding – Re: Use of Contract Workers remains for the duration of the renewed Collective Agreement.

The term of the Collective Agreement shall be from April 1, 2001 to March 31, 2002.

IN WITNESS WHEREOF each of the parties hereto has caused this Agreement to be signed by its duly authorized representatives.

This 19th day of December, 2001.

RYGIEL HOMES

Donna Marcaccio
Donna Marcaccio, Executive Director

Susan McClure
Susan McClure, Coordinator of Personnel

Linda Coughlin January 17, 2002
Witness and Date

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3009

L. McDonnell per J. Cromwell
John Cromwell, CUPE Representative

Marjorie Banks
Marjorie Banks

Sylvia Rioux
Sylvia Rioux

Myrna Severino
Myrna Severino

Julie Sergi
Julie Sergi

10972(03)

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Appendix "B" |
| Effective First Full Pay October, 2001 | | | 1.0% Increase | | |
| | | | | Year 2 | Year 3 |
| Student | 9.8338 | 10.1806 | 10.4968 | 10.8335 | 11.1849 |
| Support Aide | 10.4995 | 10.9977 | 11.4752 | 11.9423 | 12.4303 |
| Support Worker | 10.7315 | 11.3231 | 11.9658 | 12.5880 | 13.1695 |
| Team Leader | 12.4758 | 12.8635 | 13.2511 | 13.6387 | 14.0060 |
| Hsk, Kit *Aide* | 10.1671 | 10.5823 | 10.9975 | 11.4023 | 11.8279 |
| Maint Aide | 9.2595 | 9.6747 | 10.0899 | 10.4947 | 10.9253 |
| Hsk, Kit Worker | 10.3642 | 10.9352 | 11.5268 | 12.0874 | 12.6715 |
| Maint Worker | 9.4670 | 10.0380 | 10.6296 | 11.1902 | 11.7693 |
| Receptionist | 10.1255 | 10.5304 | 10.9184 | 11.3193 | 11.1787 |
| Records Clerk | 9.4670 | 9.8615 | 10.2456 | 10.6400 | 11.0761 |
| Dept. Assistant | 12.7216 | 13.1887 | 13.6558 | 14.1229 | 14.5829 |
| Kinesiologist | 15.8253 | 16.1679 | 16.5416 | 16.8945 | 17.2371 |
| Worker II | 11.5224 | 11.8754 | 12.1972 | 12.5190 | 12.8560 |
| | | | | | |
| Sleepover Rate | | 65.3668 | | | |
| | | | | | |
| | | | | | |

Appendix "B"

| Effective First Pay of January, 2002 | | | Pay Equity Adjustment for 1999, 2000, 2001 | | |
|---|---|---|---|---|---|
| **Classification** | **Probation** | **Start** | **Year 1** | **Year 2** | **Year 3** |
| Student | 10.1562 | 10.5030 | 10.8192 | 11.1559 | 11.5073 |
| Support Aide | 10.8219 | 11.3201 | 11.7976 | 12.2647 | 12.7527 |
| Support Worker | 11.0539 | 11.6455 | 12.2882 | 12.9104 | 13.4919 |
| Team Leader | 12.7982 | 13.1859 | 13.5735 | 13.9611 | 14.3284 |
| Hsk, Kit Aide | 10.5143 | 10.9295 | 11.3447 | 11.7495 | 12.1751 |
| Maint Aide | 9.2595 | 9.6747 | 10.0899 | 10.4947 | 10.9253 |
| Hsk, Kit Worker | 10.7114 | 11.2824 | 11.8740 | 12.4346 | 13.0187 |
| Maint Worker | 9.4670 | 10.0380 | 10.6296 | 11.1902 | 11.7693 |
| Receptionist | 10.4975 | 10.9024 | 11.2904 | 11.6913 | 11.5507 |
| Dept. Assistant | 13.0440 | 13.5111 | 13.9782 | 14.4453 | 14.9053 |
| Kinesiologist | 16.0981 | 16.4407 | 16.8144 | 17.1673 | 17.5099 |
| Worker II | 11.5224 | 11.8754 | 12.1972 | 12.5190 | 12.8560 |
| | | | | | |
| Sleepover Rate | | 66.9670 | | | |
| | | | | | |
| | | | | | |

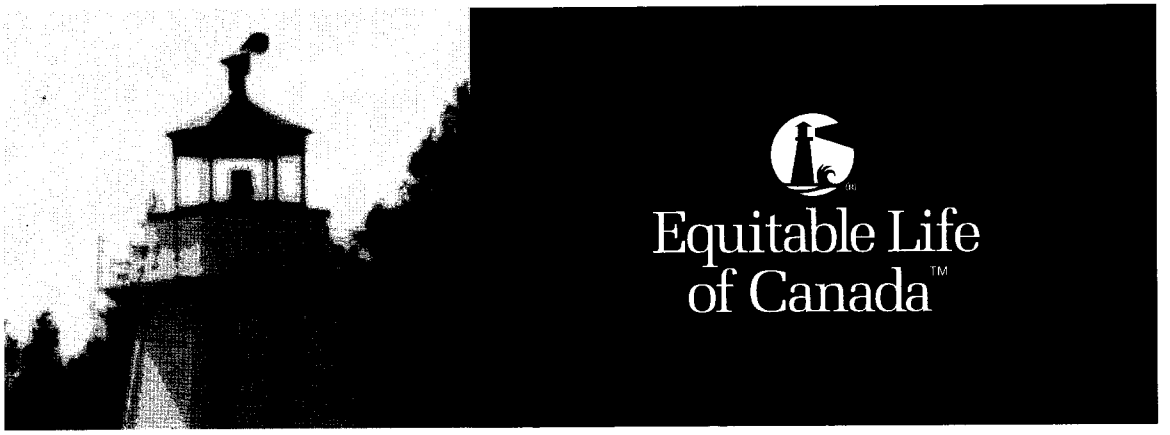
| | | | | | |
|---|---|---|---|---|---|
| | | | | | Appendix "B" |
| **Effective January 14, 2002** | | | Revitilization Adjustment | | |
| **Classification** | **Probation** | **Start** | **Year 1** | **Year 2** | **Year 3** |
| Student | 10.2831 | 10.6343 | 10.9544 | 11.2953 | 11.6511 |
| Support Aide | 10.9572 | 11.4616 | 11.9451 | 12.4180 | 12.9121 |
| Support Worker | 11.1921 | 11.7911 | 12.4418 | 13.0718 | 13.6605 |
| Team Leader | 13.1182 | 13.5155 | 13.9128 | 14.3101 | 14.6866 |
| Hsk, Kit Aide | 10.6457 | 11.0661 | 11.4865 | 11.8964 | 12.3273 |
| Maint Aide | 9.3752 | 9.7956 | 10.2160 | 10.6259 | 11.0619 |
| Hsk, Kit Worker | 10.8453 | 11.4234 | 12.0224 | 12.5900 | 13.1814 |
| Maint Worker | 9.5853 | 10.1635 | 10.7625 | 11.3301 | 11.9164 |
| Receptionist | 10.6288 | 11.0387 | 11.4315 | 11.8374 | 11.6951 |
| Dept. Assistant | 13.2071 | 13.6800 | 14.1529 | 14.6259 | 15.0916 |
| Kinesiologist | 16.2993 | 16.6462 | 17.0246 | 17.3819 | 17.7288 |
| Worker II | 11.6664 | 12.0238 | 12.3497 | 12.6755 | 13.0167 |
| | | | | | |
| Sleepover Rate | | 67.8041 | | | |
| | | | | | |
| | | | | | |

**RYGIEL**
*Supports for Community Living*

## POLICY # 93511

## CLASS A

# GROUP
# BENEFIT PLAN



**RYGIEL**
*Supportsfor CommunityLiving*

# POLICY # 93511

## CLASS A

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 the person in your company who administers your Group Benefits Plan.

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

*Group Department*

**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.**

# TABLE OF CONTENTS



## THIS GROUP INSURANCE PLAN HAS BEEN ARRANGED BY

Wentworth Financial Services Inc.
105 Main Street East, Suite 605
Hamilton, Ontario
L8N 1G6

**PLEASE SEND ALL CLAIMS DIRECTLY TO:**
**Equitable Life Insurance Company of Canada**
**One Westmount Road North**
**P.O. Box 1603 Stn Waterloo**
**Waterloo ON N2J 4C7**

**Phone:** 1-800-265-4556

# SCHEDULE OF BENEFITS

The Plan described in this booklet is effective as of July 1, 2001

In this booklet "the Company", "we" and **"us"** means The Equitable Life Insurance Company of Canada.

## CLASSIFICATION(S)

Class **A:** All Eligible 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 the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents):*
None

**Maximum Age for Coverage** *(also refer to 4. "When Does Your Insurance Terminate" in the General Provisions)*:
Long Term Disability terminates on your 65th birthday.
Optional Life terminates on the 65th birthday.
All other benefits terminate on your 70th birthday.

**Minimum Number of Hours per Week employees must work to be eligible for coverage:**
24 hours per week

**Accidental Death and Dismemberment coverage is provided by Seaboard Life Insurance Company.**

## DEFINITION OF "EARNINGS"

If any benefits are based on earnings, "earnings" are defined as follows:
**"Gross earnings"** means your actual income from employment with this Employer. **It does <u>not</u> include:**

| | |
|---|---|
| dividends | bonuses |
| expense allowance (including car allowance) | gratuities (tips) |
| profit-sharing plans | overtime pay |

or any other income that varies in amount or that you don't get on a regular basis.

If you receive commissions, your "earnings" **will include your commissions** from the previous <u>calendar</u> year (from January to December), **based on a I-year average.** If you didn't work for this Employer for a full calendar year, the amount of commissions you did earn will be converted to reflect a full calendar year amount.

The amount of earnings used to calculate the benefit amounts you're entitled to will be the lesser of:
(1) the earnings your Employer **has** reported *to* Equitable Life for insurance purposes, or
(2) your actual earnings calculated using the above definition.

**"Net Earnings"** means your gross earnings less tax, pension plan deductions, CPP/QPP and EI premiums.

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## EMPLOYEE LIFE INSURANCE

1 times annual earnings to the next higher $1,000 (if not already a multiple of $1,000) to a maximum benefit of $100,000

***No-Evidence Limit:***
Satisfactory evidence of insurability must be approved by the Company for amounts over $70,000.

***Reduction:***
On your 65th birthday, the amount of your insurance will be reduced by 50%.
This reduced amount will be subject to a maximum benefit of $35,000

## DEPENDENT LIFE INSURANCE

Eligible spouse: $2,000
Eligible dependent children from 14 days of age: $1,000

## EMPLOYEE OPTIONAL LIFE INSURANCE

Increments of $10,000 to a maximum benefit of $100,000

Amounts of Optional Life will be issued only after satisfactory evidence of insurability has been approved by the Company.

## EMPLOYEE WEEKLY INDEMNITY (W.I.) INSURANCE

66.67% of your weekly earnings to the next higher $1.00 (if not already a multiple of $1.00) to a maximum benefit of $489
per week, or the E.I.C. maximum, if greater.
***In no case will the benefit amount be higher than 85% of your net income if your plan is non-taxable. The actual amount payable is also subject to 2. Coordination of Benefits described in the W.I. section of this booklet.***

***Benefit Commencement:***
8th day of disability for accident
8th consecutive day of disability for sickness

***Maximum Benefit Period:***
17 weeks.

## EMPLOYEE LONG TERM DISABILITY (L.T.D.) INSURANCE

66.67% of monthly earnings to the next higher $1.00 (if not already a multiple of $1.00) to a maximum benefit of $1,500
per month.
**In no case will the benefit amount be higher than *85%* of your net income if your plan is non-taxable. The actual amount payable is also subject to *3.* Coordination of Benefits described in the *L.T.D.* section of this booklet.**

**Benefit Commencement:**
120th consecutive day of disability

**Maximum Benefit Period:**
to your 65th birthday

**C.P.P./Q.P.P. Offsets** *(see 3. Coordination of Benefits in* the *L.T.D. section of this* booklet *for an explanation of offsets)*:
Full

**Definition of "Total Disability":**
During the first 24 months of benefit payments, you must be completely unable to perform any duty of your regular occupation because of accident or sickness, and you must not be working at any job. After that, you must be completely unable to perform any duty of any occupation that you're qualified to do or that you might reasonably become qualified for through education, training **or** experience.

## EMPLOYEE AND DEPENDENT HEALTH BENEFITS

**Deductible Amount per prescription for the Drug Plan:**
$1.00

**Deductible Amount per calendar year:**
Single $10, Family $20 for Major Services only

**Reimbursement Percentage:**
100%

**Benefits:**
Pay-Direct Drug Plan #64
The maximum amount eligible is the cost of the drug plus a dispensing fee up to a maximum of $5.00.
Major Services, including Travel Assist
Semi-Private Hospital
Vision Care *(see the Vision Care Section in this* booklet *for more details):*
Eye Glasses or Contact Lenses or Laser Eye Surgery. Maximum $ 100
This maximum applies in any period of 24 months for both adults and dependent children.
Vision Care - Eye Examinations are not eligible.

**Lifetime Maximum Amount:**
Unlimited, except there is a $1,000,000 lifetime maximum for services received outside the employee's province of residence.
See Out-Of-Province Services in the Major Services section for the definition of "emergency treatment".

## EMPLOYEE AND DEPENDENT DENTAL BENEFITS

**Deductible Amount per calendar year:**
nil

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

| | | | |
|---|---|---|---|
| 1. | Specialist Services | 2. | Space Maintainers |
| 3. | Major Surgical Services | 4. | Periodontal Services * |
| 5. | Endodontic Services | 6. | Denture Repair Services |

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

**Reimbursement Percentage:**
Type A: 100%

**Maximum Amount:**
Annual calendar year maximum for Type A: $1,000

**Dental Fee Guide:**
The 2000 Dental Association Fee Guide for the province of Ontario.

# SUMMARY OF HEALTH BENEFIT MAXIMUMS

IMPORTANT

ANY DEDUCTIBLE AMOUNT OR REIMBURSEMENT PERCENTAGE SHOWN IN THE HEALTH BENEFITS SECTION ON THE SCHEDULE OF BENEFITS PAGE MAY BE APPLIED TO THE MAXIMUMS ON THIS PAGE AND THE FOLLOWING PAGE.

## THE FOLLOWING MAXIMUMS APPLY TO THE DRUG PLAN:

Maximum for Fertility Drugs:
$2,000 lifetime maximum per family

Maximum for Smoking Cessation Products (such products must have a DIN):
not eligible

Maximum for "lifestyle" drugs (such as Viagra and anorexiants/diet pills/injections):
not eligible

## 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.

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

**#4** Maximum Amount Payable for Nursing Care Services:
$10,000 less the amount paid in the preceding 2 calendar years

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

**#5(c)** Maximum for Breast Prosthesis and Surgical Brassiere(s):
one breast prosthesis per affected breast in any 36 month period
two surgical brassieres per calendar year

**#5(e)** Maximum for Hearing Aids:
$300 in any period of 60 consecutive months

**#5(f)** Maximum Amount for Orthotics:
$250 per calendar year

**#5(h)** Maximum for Wigs and Hairpieces (after chemotherapy or radiation therapy):
$200 lifetime maximum

# SUMMARY OF HEALTH BENEFIT MAXIMUMS

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

#7 **Maximums for Paramedical Services:**

| | |
|---|---|
| Chiropractor | $500 per insured person per calendar year |
| Masseur | $500 per insured person per calendar year |
| Naturopath | $500 per insured person per calendar year |
| Osteopath | $500 per insured person per calendar year |
| Physiotherapist | $1000 per insured person per calendar year |
| Podiatrist (Chiropodist) | $500 per insured person per calendar year |
| Psychologist | $500 per insured person per calendar year |
| Specialist in Acupuncture | $500 per insured person per calendar year |
| Speech Therapist | $500 per insured person per calendar year |
| Christian Science Healer | $500 per insured person per calendar year |

#8 **Out-Of-Province: Time Limit for Commencement of Emergency Treatment:**
90 days

**NOTE**

**The remaining pages of this booklet are standard pages. Some sections will tell you to look on the Schedule of Benefits page for the details that are specific to your Plan.**

# GENERAL PROVISIONS

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

You're eligible if you:

live and work in Canada as a permanent employee for this Employer, and
actively and regularly work "full-time" for this Employer ("full-time" means working the **Minimum Number of Hours Per Week** shown on the Schedule of Benefits page), and
belong in one of the Classifications shown on the Schedule of Benefits page.

2. **HOW DO YOU JOIN?**

Complete **Form #191 - Employee Group Insurance Application.**
Your Employer should send this card to us **before** (but **not later than 31 days** after) you become eligible **to** join the Group Plan.

**Important:** If we don't have your card within the 31 days, you'll be a "**late applicant**". You must then provide **satisfactory evidence of insurability,** Your benefits will become effective only if the evidence is approved by the Company. Some or all of your benefits could be declined or restricted.

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

You'll be given **a wallet card** showing the Effective Date of your entry into the Group Plan. There could be different waiting periods before some benefits become effective. Please check with your Group Plan Administrator.

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.

Coverage requiring evidence of insurability will **only** become effective on the first billing date following written approval by the Company. **You must be insured under this Group Plan to be eligible for any benefits.**

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

on the date you retire or 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** shown in the Schedule of Benefits.

5. **EVIDENCE OF INSURABILITY**

The Schedule of Benefits tells you if evidence of insurability is required for any amounts of insurance coverage. If the amount available without evidence (the **No-Evidence Limit)** changes under this Group Plan, the amount of coverage you're eligible for will be determined by the Company according to the terms of the Master Policy.

# 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. Look on the Schedule of Benefits page to see the **Maximum Age for Dependent Children.**

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. This child must have been insured under this Group Policy before reaching age 21. **If** approved, an **extra premium will be charged each month** for this child.

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

**If** you have any eligible dependents when you complete **Form #191 - Employee Group Insurance Application:**

Fill in the "Number of your Dependent Children" box.

Fill in the name of your spouse.

Check off the box marked "Family" in the Health and/or Dental sections if the Group Plan includes these benefits and you wish to cover your eligible dependents.

If you don't have any eligible dependents when you join the Group Plan, tell your Group Pian Administrator 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. We must be notified **within 31 days** of the date you acquire a dependent or the dependent will be a **"late applicant".** He/she must then provide **satisfactory evidence of insurability.** Benefits for your dependents will become effective ***only*** if the evidence is approved by the Company. Some or all of your dependent's benefits could be declined or restricted.

If you want to cover your partner, look under **CO-Habitation Requirement for Partners** on the Schedule of Benefits page to see if there's any minimum period that a you and your partner must live together before your partner and his/her children become eligible for coverage.

To continue coverage for a developmentally or physically disabled child, you must apply to the Company **in the 31-day period before the child's 21st birthday.**

If your spouse and/or dependent child(ren) are eligible for benefits elsewhere (such as with your spouse's Employer's group plan), it can still be to your advantage for you and your eligible dependents to be covered under both plans. Please discuss this with your Group Plan Administrator.

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. If you apply for dependent coverage after you joined, coverage for your dependent will be effective on the date you applied, provided your own coverage is inforce and you notify **us within 31 days** of acquiring the dependent.

# GENERAL PROVISIONS FOR DEPENDENTS

**Important: If** a dependent is **hospitalized** on the date coverage would have been effective, coverage will become effective after final discharge from the hospital. **If** a dependent is a "**late applicant",** satisfactory evidence of insurability is required and his/her coverage will **only** become effective on the next billing date following written approval by the Company.

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

# EMPLOYEE GROUP LIFE INSURANCE

1 **DESCRIPTION OF THIS BENEFIT**

If you die from any cause while insured under this Plan, the amount of Group Life Insurance you're eligible for will be paid to the beneficiary you named. Group Life Insurance cannot be assigned (it can't be used as collateral for a loan).

2. **HOW TO NAME YOUR BENEFICIARY**

When you joined the Group Plan, you named a beneficiary on Form #191 - Employee Group Insurance Application. You can change your beneficiary anytime. Complete **Section 5 on Form #438 - Employee Change Form** and have your Group Plan Administrator forward it to **us.**
**Important:** If any **beneficiary is a minor (is under age 18)**, be sure to **fill in the name of a Trustee.** If you don't, it could cause a delay in payment of the proceeds and affect who the proceeds are paid to.

3. **HOW WILL YOUR LIFE INSURANCE PROCEEDS BE PAID?**

Your Group Plan Administrator should notify Equitable Life when there is a claim. We'll supply the required forms to be completed and returned to us. Proceeds will be paid to your beneficiary in one lump sum (unless he/she chooses another payment option).

4. **EXTENDED LIFE INSURANCE (LIFE WAIVER)**

If you are unable to work at any job (not just your own job) because you've become **totally disabled before your 65th birthday,** you can apply for **Extended Life Insurance** (also known as **"Life Waiver").** You must have been disabled for 6 consecutive months and be under age 65. If accepted for Life Waiver, your Group Life Insurance will remain in effect and the Life premium doesn't have to be paid. Your Employer should notify us after you've been disabled for 6 months so the proper forms can be sent to you. From time to time you'll be asked to send in proof that you're still disabled. This Life Waiver benefit can continue until your 65th birthday (as long as you remain totally disabled).

If your employment with the Employer terminates while you're still totally disabled, you have up to 1 year to apply for the Life Waiver, provided you have remained totally disabled since the date your employment terminated.

5. **THE CONVERSION PRIVILEGE**

If **you terminate from the Group Plan,** you can convert (change) all or part of your Group Life Insurance to an individual Life Insurance policy without having to provide evidence of insurability. If your insurance terminates because **the Group Policy itself terminates,** you can convert your Group Life Insurance only if you were continuously insured under this Policy for at least 5 years. If you want to convert your Group Life Insurance, request an application form from us. Please note the following conditions that apply to the conversion:

You must **apply in writing and pay the first premium within 31 days** of terminating from the Group Plan. If you should die within that time, the Company will pay to your beneficiary the maximum amount of individual Life Insurance that you could have obtained under this Conversion Privilege (even if you hadn't applied for it).

The premiums for the individual policy will be based on your age, sex, and whether you've smoked a cigarette in the past 12 months.

Not all types of individual plans are available under Conversion and the individual policy wouldn't include Disability, Double Indemnity or other special features.

The individual policy may have to be for a minimum dollar amount.

The maximum amount of Group Life Insurance that can be converted is the lesser of:

$200,000, or

the full amount of your basic Group Life Insurance less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective.

# EMPLOYEE OPTIONAL LIFE INSURANCE

1. **DESCRIPTION OF THIS BENEFIT**

You can apply for Optional Life Insurance in addition to your basic Employee Group Life Insurance.

* **You** can choose the amount of Optional Life you want (see the Schedule of Benefits page for the amount available).

Satisfactory **evidence of insurability** is required before any amount of Optional Life is effective.

The Policy provisions that apply to the basic Employee Group Life Insurance also apply to Optional Life.

2. **HOW TO APPLY FOR OPTIONAL LIFE INSURANCE**

Complete the following forms and send them to us:

* **Form #750 - Application for Group Optional Life Benefit.**
* **Form #452 Part I - Statement of Health for Group Insurance.**

You'll be notified if any further information is required.

3. **WHEN DOES YOUR OPTIONAL LIFE BECOME EFFECTIVE?**

If your application is accepted, you'll be notified of the effective date of your Optional Life Insurance. If you're not actively at work on that date, your coverage will become effective when you return to active work.

4. **WHEN DOES YOUR OPTIONAL LIFE TERMINATE?**

Optional Life terminates **when** your basic Life Insurance does, but not later than your 65th birthday.

5. **SPECIAL PROVISIONS THAT APPLY TO OPTIONAL LIFE INSURANCE**

No amount of Optional Life is payable if you:

* die by suicide (whether you're sane or insane) within 2 years after your Optional Life became effective, was reinstated, or was increased, or
* become totally disabled from wilfully self-inflicted injury or any attempt to commit suicide (whether you're sane or insane).

In this case, only the amount of Optional Life premiums you paid will be refunded.

6. **THE CONVERSION PRIVILEGE**

Your Optional Life Insurance can be converted (see #5 on the Employee Group Life Insurance page in this Booklet for details).

The maximum amount of basic plus Optional Life Insurance that can be converted is the lesser of:

* $200,000, or
* the full combined amount of basic and Optional Life less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective.

7. **EXTENDED LIFE INSURANCE (LIFE WAIVER)**

The Extended Life Insurance (Life Waiver) described on the Employee Life Insurance page applies to Optional Life.

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

Your Group Plan Administrator should notify Equitable Life if there is a claim. We'll supply the required forms to be completed and returned to us.

# DEPENDENT LIFE INSURANCE

1. **DESCRIPTION OF THIS BENEFIT**

If an eligible dependent should die while you're insured under this Group Plan for the Dependent Life benefit, the amount of Dependent Life Insurance **shown on the Schedule of Benefits page** will be paid to you.

2. **WHO ARE YOUR ELIGIBLE DEPENDENTS?**

Eligible dependents are your spouse and dependent children as defined on the General Provisions for Dependents page in this booklet. Dependent children are eligible for coverage from 14 days of age.

3. **DOES THE CONVERSION PRIVILEGE APPLY TO DEPENDENT LIFE?**

Yes. If your own insurance terminates, your spouse can convert his/her Dependent Life Insurance to an individual insurance policy. The Conversion Privilege doesn't apply to dependent children. The conditions outlined in the Conversion Privilege on the Employee Group Life Insurance page in this booklet also apply to Dependent **Life.**

4. **HOW DOES MY SPOUSE APPLY FOR CONVERSION?**

If your spouse wants to convert the Dependent Life Insurance, request an application form from us. He/she must apply and pay the first premium **within 31 days** of the date your coverage terminated.

5. **DOES THE EXTENDED LIFE INSURANCE APPLY TO DEPENDENT LIFE?**

Yes. If you become totally disabled and are accepted for the Extended Life Insurance Benefit (Life Waiver) described on the Employee Group Life Insurance page in this booklet, the Dependent Life Insurance is also continued without cost.

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

Your Group Plan Administrator should notify Equitable Life if there is a claim. We'll supply the required forms to be completed and returned to us.

# EMPLOYEE WEEKLY INDEMNITY (W.I.) - Any Occ

## 1. DESCRIPTION OF THIS BENEFIT

This benefit replaces a portion of your employment earnings that you lose if you can't work because you become totally disabled from an injury (accident) or sickness while insured under this Group Plan.

The Schedule of Benefits page tells you:

* the **Weekly Indemnity Schedule** (how to calculate the amount of W.I. available; the amount actually payable is subject to #2 below)
  the **Commencement Date Accident** (on what day payments begin if you're injured in an accident)
  the **Commencement Date Sickness** (on what day payments begin if you're sick)
  the **Maximum Benefit Period** (the maximum length of time benefits are payable during any one period of disability, whether from one or more than one cause).

Weekly Indemnity benefits are **paid once a week.** Benefits are calculated on a **7-days-a-week** basis (1/7th of your Weekly Indemnity benefit is payable for each day that you're eligible for disability payments).

To be considered an "accident", disability must be the direct result of bodily injury that was caused solely through accidental, violent and external causes and the disability must occur within 7 days of the date you were injured. Please note that an injury as a result of bending, lifting, twisting, etc. is not considered "accidental" and will be paid as if it was a sickness.

Benefits are **taxable** if your Employer pays any portion of the W.I. premium. We don't automatically deduct the income tax from your benefit cheque (unless you live in the Province of Quebec).

If W.I. is taxable, you'll be given a **T4A Statement of Income** for benefits received in a tax year and you must include the disability earnings when filing your Income Tax Return.

## 2. COORDINATION OF BENEFITS

The Weekly Indemnity benefit payable under this Group Plan will be reduced so that the total amount of benefits from "all sources" (including this Policy) are not more than:

* **85%** of your **gross** earnings if the Weekly Indemnity benefit is **taxable,** or
* **85%** of your **net** earnings if the Weekly Indemnity benefit is **not taxable.**

"all sources" may include disability benefits you're eligible to receive from the following:

this Group Policy or any other insurance policy
any government or regulatory body (but not counting disability benefits payable through E.I.C. - Employment Insurance Act, Canada)
payment from any employer
retirement plans
completed or pending legal action or settlement.

If your Employer has registered this Weekly Indemnity plan with E.I., during the first 15 weeks of benefit payments, we will only count benefits or earnings that you get from this Employer as "other sources" and the amount of your benefit payments will be the lesser of:

the amount of Weekly Indemnity you're eligible for, or
the current E.I. maximum.

3. **WHAT HAPPENS IF YOU BECOME DISABLED AGAIN (RECURRENT DISABILITY)?**

If you recover and return to active work but then become disabled again from the same or related causes within 14 days of returning to work, the second disability will be treated as if it is a continuance of the first (original) disability and:

you don't have to go through another elimination period
the amount of benefit payable is based on the original period of disability
the Maximum Benefit Period available will be based on the original period of disability (benefits are payable for what's left of the original Maximum Benefit Period).

For example: You were receiving W.I. benefit payments. You returned to work before the Maximum Benefit Period was paid out. You become disabled again from the same or related causes within 14 days of returning to work. The maximum number of weeks that benefits are payable will be the number of weeks that are left in the Maximum Benefit Period.

If this Group Policy terminates and is replaced within 31 days by a policy issued by another insurance company, benefit payments are not payable under this Group Plan if you become disabled again and the new policy covers the same period of disability.

4. **WHEN ARE WEEKLY INDEMNITY BENEFITS NOT PAYABLE?**

Benefits are not payable for disabilities in the following situations:

(a) if you receive or are entitled to receive a benefit under any Workers' Compensation or similar law, or

(b) as a result of wilfully self-inflicted injury or any attempt at self-destruction (whether you're sane or insane), or

(c) if you're not under treatment by a licensed physician or surgeon (except that during the first 4 weeks of benefit payments, treatment by a legally licensed chiropractor or dentist will be eligible), or

(d) from any cause (if you're a pregnant female employee) during any of the following periods:
when your Employer allows you to or requires that you take pregnancy leave in accordance with provincial or federal laws, or
when you're entitled to or have asked for pregnancy leave under a condition of employment or the terms of a collective agreement, or
for a period during which you could request pregnancy leave or Employment Insurance Benefits (whether or not you're eligible to receive them), or
if you're claiming benefits that are payable under Section 30 of the Employment Insurance Act, Canada, or

(e) if you become disabled during a strike, lockout, layoff or leave of absence, no benefits are payable for the duration of the strike, lockout, layoff or leave of absence, however, if you're still totally disabled on your scheduled date of return to active, full-time work, you'll become eligible for disability benefit payments:
(i) on your scheduled date of return to work, provided the waiting period before payments begin (see * below) has expired and if your W.I. benefit has remained inforce, or
(ii) on the Benefit Commencement date shown on the Schedule of Benefits page, if later.
(* this "waiting period" is the number of consecutive days you must be totally disabled before the Benefit Commencement date)
(**Note**: If you're not able to return to work on your scheduled date of return because you're totally disabled, and if your Weekly Indemnity benefit has remained inforce, you should send in a claim and we will determine if any benefits are payable.), or

(f) as a result of alcohol or drug abuse (unless you're getting regular and personal medical supervision, treatment and counselling from a licensed medical doctor, rehabilitation centre or provincially designated institution that's approved by the Company), or

(g) any period of disability during a time when you're an inmate in a prison or correctional institution, or

(h) if you're not receiving regular and personal medical supervision and treatment (that is satisfactory to the Company) by a physician or surgeon who is duly licensed to practice medicine.

5. **WHEN DO W.I. BENEFITS TERMINATE?**

W.I. benefits terminate on the earlier of:

(a) the date you're no longer totally disabled, or
(b) the date the Maximum Benefit Period is reached, or
(c) the date you start any employment for pay or profit or volunteer work, or
(d) the date you stop receiving regular and/or appropriate medical treatment (that is satisfactory to the Company) by a physician or surgeon, or
(e) the date you fail to provide satisfactory evidence to the Company that you're still totally disabled, or
(f) the date you retire or would normally have retired under the Employer's employment practices, or
(g) the date of your death.

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

Use **Form #421 - Weekly Indemnity Claim Form.** There are 3 parts to be filled in:

* you complete Part I
* your Employer completes Part II
* the doctor completes the Attending Physician's Statement.

The claim must be submitted **within 90 days** of the date you become disabled. Please be sure **all** three **parts** are fully completed **so** the claim form won't have to be returned and delay your benefit payment.

Once we start paying benefits, **Form #422 - Supplementary Report on Claim for Disability Benefits** (to **be** completed by you, the doctor and your Group Plan Administrator) or **Form 563** (to be completed by the doctor only) may be included with your cheque from time to time.

**Benefit payments will stop and won't start again until the fully-completed Form 422 (or Form 563) *is* returned to us,** so please be sure it's sent back to us quickly.

# EMPLOYEE LONG TERM DISABILITY (L.T.D.) - Occ

1. **DESCRIPTION OF THIS BENEFIT**

This benefit replaces a portion of your employment earnings that you lose if you can't work because you become totally disabled from an injury (accident) or sickness **prior *to* your 65th birthday** and while you're insured under this Group Plan. While you're receiving L.T.D. benefit payments, the L.T.D. premium doesn't need to be paid.

The Schedule of Benefits page tells you:

the **Long Term Disability schedule** (how to calculate the amount of L.T.D. available; the amount actually payable is subject to #3 below)

the **Benefit Commencement** (on what day payments begin, if you're disabled because of either injury or sickness)

**Note:** If you're eligible for Weekly indemnity benefits from any Group Policy issued to your Employer, payments won't start under this L.T.D. Plan until the Maximum Benefit Period for W.I. has been reached.

the **Maximum Benefit Period** (the maximum length of time benefits are payable during any one period of disability, whether from one or more than one cause).

Long Term Disability benefits are **paid once a month.** Once your L.T.D. claim has been approved by the Company, payment is made at the end of each month for that particular month. Benefits are calculated on a **30-days-a-month** basis (1/30th of your Long Term Disability benefit will be payable for each day that you're eligible for disability payments).

Benefits are **taxable** if your Employer pays any portion of the L.T.D. premium. We don't automatically deduct the income tax from your benefit cheque (unless you live in Quebec). If L.T.D. is taxable, you'll be given a **T4A Statement of Income** for benefits received in a tax year and you must include the disability earnings when filing your Income Tax Return.

2. **WHAT IS THE DEFINITION OF "TOTAL DISABILITY"?**

The definition of "total disability" is shown on the Schedule of Benefits page

Please note that if you lose your license or fail to pass a periodic examination required by the Ministry of Transport or any other licensing body, this is not proof that you're totally disabled.

3. **COORDINATION OF BENEFITS**

The amount of L.T.D. you're eligible for (according to the L.T.D. schedule **and** the definition of "earnings" on the Schedule of Benefits page) will be reduced by all of the following:

(a) any benefits you receive or are entitled to receive from Workers' Compensation or similar law will be deducted dollar for dollar if they're payable for the same period of disability

(b) any benefits you're entitled to get under the Canada Pension Plan (C.P.P.) or Quebec Pension Plan (Q.P.P.) will be deducted dollar for dollar if they're payable for the same period of disability (except for any cost-of-living increases made by C.P.P./Q.P.P. after your Long Term Disability payments start)

The L.T.D. section on the Schedule of Benefits page tells you what C.P.P./Q.P.P. "offsets" (reductions) will apply for this Group Plan.

"**full offsets**" means we'll deduct both the disability benefits that you yourself are eligible for **("primary"** benefits) as well as benefits you're eligible for on behalf of your dependent children under age 18 **("secondary"** benefits)

"**Primary offsets"** means we'll deduct the disability benefits that you yourself are eligible for but not benefits you're eligible for on behalf of your dependent children

"**nil offsets"** means we won't deduct either your own or your dependent C.P.P./Q.P.P. disability benefits, but we will take them into consideration under the "all sources" clause in (c) below

(c) any disability benefits you may be eligible for from **"other sources",** including:
* any Group Insurance policy
* payment from any employer
* retirement plans
completed or pending legal action or settlement
any benefits available from any other government plan.

(d) any personal insurance (such as individual disability insurance, insured bank loans, automobile insurance, mortgages, etc.)

If you're eligible for any income from (c) above, the L.T.D. benefit payable under this Group Plan will be reduced so that the total amount of benefits that you're eligible for from "all sources" (including this Policy) are not more than:

85% of your **gross** earnings if the L.T.D. benefit is **taxable,** or
85% of your **net** earnings if the L.T.D. benefit is **non-taxable.**

If you're eligible for any income from (d) above, the L.T.D. benefit payable under this Group Plan will be reduced so that the total amount of benefits that you're eligible for from "all sources" (including this Policy) are not more than:

100% of your earnings if you're eligible for benefits from personal insurance.

If you were already getting a disability pension (such as a War Veterans Pension) before you became disabled, we'll only include an increase in that pension when calculating the "all sources" clause.

Be sure you apply for any other disability benefits you may be eligible for.

We may pay the full L.T.D. benefit (without taking off the deductions shown above) for a short period of time, **as long as you agree to refund any overpayment** we make.

4. **WHAT HAPPENS IF YOU BECOME DISABLED AGAIN (RECURRENT DISABILITY)?**

If you recover and return to active work and then become disabled again, the new disability will be treated as if it is a continuance of the first disability if:

you work continuously for **less than 1 month** and you become disabled again from completely **different** causes, or
you work for **less than 6 months** and become disabled again from the **same or related** causes.

If you recover and return to active work for this Employer and then become disabled again from the same cause(s) within 90 days after this Group Policy terminates, the new disability will be treated as if it is a continuance of the first disability, as long as you:

returned to work for less than 6 months from the date you last received L.T.D. benefits under this Policy, and
are not eligible for benefits under any policy issued by another insurance carrier within 31 days after the date this Policy terminated that replaces this Policy and covers the same period of disability.

When the new (recurrent) disability is treated as if it were a continuation of the first (original) disability:

you don't have to go through another elimination period
the amount of benefit payable is based on the original period of disability
the Maximum Benefit Period available will be based on the original period of disability (benefits are payable for what's left of the original Maximum Benefit Period)
no L.T.D. benefits are payable under this Policy if Weekly Indemnity benefits are payable for the Same period of disability under any other Group Insurance Policy issued to your Employer.

## 5. REHABILITATION

If you've been receiving L.T.D. disability benefits for some time, the Company and our Medical Advisors may determine that a rehabilitation programme will be the best way to help you return to work. Please note that the Company must approve any rehabilitation programme before you begin it.

While participating in the rehabilitation programme, L.T.D. benefits will continue to be paid to the earlier of:
- the length of time allowed (this will be determined by the Company and our Medical Advisors, but would not be more than 24 months from the date you start the rehabilitation programme), or
- until the date benefits would have stopped if you had remained totally disabled.

While you participate in a rehabilitation programme approved by the Company, the amount of your monthly L.T.D. benefit payments may be reduced so that the income you get from "all sources" isn't more than 100% of your pre-disability earnings (adjusted for inflation).

If you're unable to continue in the rehabilitation programme because of total disability, further benefit payments will be considered under the recurrent disability clause (see #4 - What Happens If You Become Disabled Again).

If you refuse to participate in the rehabilitation programme which the Company deems to be appropriate, your L.T.D. benefit payments will stop.

## 6. WHEN L.T.D. BENEFITS ARE NOT PAYABLE

Benefits are not payable for disabilities in the following situations:

(a) as a result of:
- wilfully self-inflicted injury or any suicide attempt (whether you're sane or insane)
- active participation in a riot, rebellion or insurrection
- war or hostilities of any kind (whether or not war is declared)
- committing or attempting to commit a criminal offence, or

(b) any period of disability during a time when you're an inmate in a prison or correctional institution, or

(c) if total disability begins within 12 months of the effective date of your L.T.D. insurance under this Policy, and the disability is a result of a condition for which you either received medical care or took prescribed drugs during the 90-day period before your L.T.D. coverage became effective (unless this Limitation is waived in the Master Policy), or

(d) from any cause (if you're a pregnant female employee) during any of the following periods:
- when your Employer allows you to or requires that you take pregnancy leave in accordance with provincial or federal laws, or
- when you're entitled to or have asked for pregnancy leave under a condition of employment or the terms of a collective agreement, or
- for a period during which you could request pregnancy leave or Employment Insurance Benefits (whether or not you're eligible to receive them), or
- if you're claiming benefits that are payable under Section 30 of the Employment Insurance Act, Canada.

(e) if you become disabled during a strike, lockout, layoff or leave of absence, no benefits are payable for the duration of the strike, lockout, layoff or leave of absence, however:
if you're still totally disabled on your scheduled date of return to active, full-time work, you'll become eligible for disability benefit payments:

(i) on your scheduled date of return to work, provided the waiting period before payments begin (see * below) has expired and if your L.T.D. benefit has remained inforce, or

(ii) on the Benefit Commencement date shown on the Schedule of Benefits page, if later.

(* this "waiting period" is the number of consecutive days you must be totally disabled before the Benefit Commencement date)

(f) as a result of alcohol or drug abuse (unless you're getting regular and personal medical supervision, treatment and counselling from a licensed medical doctor, rehabilitation centre or provincially designated institution that's approved by the Company), or

(g) if you're not receiving regular and personal medical supervision and treatment that's satisfactory to the Company, by a physician or surgeon who is duly licensed to practice medicine and who is qualified to treat such disability.

7. **WHEN DO L.T.D. BENEFITS TERMINATE?**

(a) on the date you're no longer "totally disabled" (according to #2 in this L.T.D. section and the definition of "total disability" shown on the Schedule of Benefits page), or

(b) on the date the Maximum Benefit Period is reached, or

(c) on your 65th birthday, or

(d) on the date you start any employment for pay or profit or any volunteer work (other than rehabilitative employment approved by the Company), or

(e) if you refuse to work at appropriate rehabilitative employment suggested by the Company's medical advisors, or

(f) on the date you fail to provide satisfactory evidence that you're still "totally disabled", or

(g) on the date you stop receiving regular and/or appropriate medical treatment (that is satisfactory to the Company) by a physician or surgeon, or

(h) on the date of your death.

If this Group Policy terminates, you'll still be entitled to (or can apply for) disability benefits if you're totally disabled on the date the Policy terminates and:

you're receiving L.T.D. benefit payments, or

you notify the Company of a pending L.T.D. claim within 30 days of the date of termination of this Policy.

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

If you're receiving Weekly Indemnity benefits from Equitable Life, we'll send the proper L.T.D. claim forms to you. If you're not receiving W.I. from us, you should complete **Form #709 - Preliminary Notice of Claim** within 30 days (but, if not possible, no later than 90 days) after you became disabled and send it to us. We'll send a letter to you and include the required claim forms that need to be completed.

Once we start paying benefits, **Form 422 - Supplementary Report on Claim for Disability Benefits** (to be completed by you, the doctor, and your Group **Plan** Administrator) or **Form #563** (to be completed by the doctor only) may be included with your cheque from time to time.

**Benefit payments will stop and won't start again until the fully-completed form 422 (or Form 563) is returned to us,** so please be sure it's sent back quickly.

# 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 **Co-ordination 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. The Deductible Amount for your Plan is **shown on the Schedule of Benefits page.**

**Note:** If the Family Deductible Amount is greater than the Single Deductible Amount, no more than the Single Deductible Amount can be taken from any one family member towards satisfying the Family Deductible Amount.

Claims incurred during October, November and December of a calendar year which satisfy the Deductible Amount for that year will also be used towards satisfying the Deductible Amount for the next calendar year.

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. The Reimbursement Percentage for this Group Plan is **shown on the Schedule of Benefits page.**

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?**

The Lifetime Maximum Amount is **shown on the Schedule of Benefits page.** 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.

**Important Note:** If any person insured under this Group Plan is

**over age 70** (either the employee is over age 70 or the spouse of an employee is over age 70), or
**a retired employee or the spouse of a retired employee** (look on the Schedule of Benefits to see if this Group Plan covers retired employees),

then the maximum amount payable for that person in any calendar year is the greater of:

$25,000, less any amount paid in the preceding 2 calendar years, or
$1,000.

6. **DEFINITION OF "PRACTITIONERS'**

In the following pages which describe the Health Benefits, various practitioner's "titles" may be used. If the practitioner is included under this Group Plan, here's what is meant by these terms:

"**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.

"**Dentist**" means a person who is legally licensed in dentistry.

"**Masseur**" means a person who is a member of the applicable Provincial Association of Masseurs and who is classified as a Registered Massage Therapist.

"**Chiropractor**", "**Naturopath**", "**Osteopath**" and "**Speech Therapist**" means a person who holds a degree from a recognized school.

"**Optometrist**" means a member of the Canadian Association of Optometrists or any other applicable associated provincial association.

"**Registered Graduate Nurse**", "**Registered Nursing Assistant**", "**Certified Nursing Assistant**' and "**Licensed Practical Nurse**" means a person listed on the appropriate provincial registry.

"**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.

"**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.

"**Ophthalmologist**" means a person who is a medical doctor who is legally licensed to practise ophthalmology.

" **Christian Science Healer**" means a person recognized as a specialist by the First United Church of Christ,
Scientist in Boston, Massachusetts and whose name is listed in the current Christian Science Journal.

7. **RECURRENT DISABILITY**

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.

This could 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 under Major Services, if this is included in the Group Plan).

# HEALTH BENEFITS - GENERAL PROVISIONS

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 offense
(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 nutritional, marital or other lifestyle counselling services, or for lifestyle drugs (such as Viagra and pills 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 (other than the Maximum Amount for Fertility Drugs, if any, shown on the Summary of Health Benefit Maximums)
(q) 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

# HEALTH BENEFITS - PAY-DIRECT PRESCRIPTION DRUGS #64

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

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) **fertility drugs** are eligible up to the **Maximum for Fertility Drugs** shown on the Summary of Health Benefit Maximums page.

2. **MAXIMUM SUPPLY**

The maximum eligible at any one time is a **I-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) all smoking cessation products, whether prescribed or not

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

(c) 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

(d) 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

(e) 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

(9 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 Assure Health Inc.

(g) all preventative immunization vaccines and toxoids

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

(i) items deemed cosmetic or hygienic by Assure Health 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. **OUT-OF-PROVINCE EXPENSES**

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 Assure Health 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.

# 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, drug addicts or alcoholics 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.

3. **OUT-PATIENT HOSPITAL SERVICES**

This includes services and supplies for an out-patient at a hospital (if prescribed by a physician), such as:

- anaesthesia for a surgical procedure
- use of an examination or operating room
- drugs administered at the hospital
- bandages, dressings and casts.

Dental services or dental supplies are not covered under Out-Patient Hospital Services

4. **NURSING CARE SERVICES**

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.

5. **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):

(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, and
- required for a period not exceeding 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
- orthopaedic braces that are custom made or modified for the patient (note that we may ask for additional information) are eligible expenses even when the date of disability which caused the need for such equipment occurs prior to the date of coverage for dependent children only
- 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 <u>not</u> 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
- support hose, surgical stockings and stump socks, unless specifically shown as an eligible expense on the Summary of Health Benefit Maximums

(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 or podiatrist, subject to the **Maximum for Orthotics** shown on the Summary of Health Benefit Maximums page. "Orthotics" includes the following:
- orthopaedic shoes (note that it does <u>not</u> 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) diagnostic services, such as laboratory services, x-ray services (but not Dental x-rays), deep x-ray and radium treatment or therapy

(h) reasonable and customary charges for oxygen (with a physician's prescription), anaesthesia, blood and blood plasma

(i) 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.

6. **<u>DENTAL ACCIDENT</u>**

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 **<u>within 365 days</u>** 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.

7. **PARAMEDICAL SERVICES**

**Important Note: IF YOUR PROVINCIAL HEALTH CARE PLAN PAYS ANY PORTION OF THE CHARGES MADE BY THE FOLLOWING PRACTITIONERS, NO PAYMENT IS ELIGIBLE UNDER THIS GROUP PLAN UNTIL THE OVERALL MAXIMUM ALLOWED FOR THAT TYPE OF PRACTITIONER HAS BEEN PAID OUT BY THE PROVINCIAL PLAN, UNLESS OTHERWISE SHOWN ON THE SUMMARY OF HEALTH BENEFIT MAXIMUMS.**

For example, if a practitioner charges $20 per visit and your Provincial Health Care Plan only pays $10 per visit, the difference is **not covered** under the Equitable Life plan. But, once your Provincial Health Care Plan has paid the overall maximum that they allow for a practitioner (or if your Provincial Health Care Plan doesn't cover *a* particular practitioner), charges may then be eligible for payment under your Group Plan.

The following practitioners are included, **provided we receive a written prescription from the physician which includes the reason for the treatment:**

Masseur
Physiotherapist
Psychologist
Specialist in Acupuncture
Speech Therapist

The following practitioners are also covered (including one x-ray from each in any calendar year):

Chiropractor
Naturopath (covers the office visit but excludes charges for such things as tests, supplements and remedies)
Osteopath
Podiatrist (Chiropodist)

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.

8. **OUT-OF-PROVINCE SERVICES**

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** for an injury or illness which occurs within the **Time Limit for Commencement of Emergency Treatment** shown on the Schedule of Health Benefit Maximums page 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 treatment**" means medical treatment which is necessary due to a sudden and unforeseen medical condition experienced while travelling. However, if the medical condition is directly or indirectly related to a medical condition that the insured person has received medical treatment for, or consulted a physician about, within the 3-month period prior to the start date of the emergency treatment, no benefits are payable under this Policy for the emergency medical treatment and services, unless the prior medical condition would have been determined to be stable by a reasonable person, taking into consideration the medical treatment received or the advice received from the consulting physician prior to the start date of travel.

Examples of conditions where travel is not recommended and where claims related to the condition may not be covered include: pregnancy within the 8 weeks prior to the expected due date, heart conditions where an acute attack has occurred within the past 3 months, changes in the dosage of medication to control an acute condition such as diabetes, and terminal illnesses where death is expected within 6 months.

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.

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.

Benefits are not payable under the Out-Of-Province Services for services performed outside Canada if the insured person lives outside Canada.

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 **S.I.N.** (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 original *receipts*, written prescriptions, referral letters,** etc.

Claims must be submitted **within 90 days** of the date of treatment

# HEALTH BENEFITS - TRAVEL ASSIST

"**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 #8.

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, World Access 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 in excess of $200 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 World Access 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 World Access 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, World Access 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, World Access 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 World Access from providing some or all of the services described.

(b) Services are not provided in Afghanistan, Burma, El Salvador, Iran, Iraq, Kampuchea, Laos, Lebanon, Libya, Nicaragua, North Korea, Vietnam or other countries designated by World Access from time to time.

(c) World Access 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 World Access Canada (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 World Access 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 World Access**

Call their hotline at:
1-800-321-9998 (in Canada or the U.S.A.)
519-742-3287 (elsewhere).

Give World Access:
your **name**
your **Group Policy number**
* your **certificate number**
* your **Government Health insurance Plan number.**

You must contact World Access to verify coverages. Once coverage has been verified, World Access will assist you in obtaining any of the above services which you need.

# HEALTH BENEFITS - SEMI-PRIVATE HOSPITAL

1. **WHAT IS COVERED?**

If you or one of your eligible dependents are confined **in a semi-private room** (a room with two beds) in a licensed hospital while insured under this Group Plan, you'll be reimbursed for **reasonable and "customary" charges made by the hospital** (taking into account any Deductible Amount and Reimbursement Percentage shown on the Schedule of Benefits page). Expenses are not eligible if the person is confined in a special ward or unit that would qualify as a "convalescent home".

The maximum amount eligible is the excess of:

reasonable and customary charges actually made by the hospital for semi-private care

and the greater of:

* the Provincial Health Care Plan allowance, or
* the amount the hospital charges for standard ward care.

The maximum amount eligible **if** confined *in* a hospital outside the province of residence is the amount that would be eligible if confined in the employee's own province of residence.

The maximum amount eligible if confined in a private room is the amount that would be eligible if the person was in a semi-private room **(but** not more than the hospital actually does charge).

2. **WHAT IS MEANT *BY* "CUSTOMARY" CHARGES?**

**These** are the standard hospital charges for semi-private or standard ward care, as the case may be. If there are no "standard" charges, it means the average daily room and board charges made by the hospital.

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

The hospital will usually send the claim directly to Equitable Life.

# 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 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 "x" months** (such as any period of 12 months or 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 12 months and the patient paid for the services on May 10, 2000, the next time a claim will be eligible is May 10, 2001.

Example: If Vision Care **is** payable in any period **of** 24 months and the patient paid for the services on May 10, 2000, the next time a claim will be eligible is May 10, 2002.

**Note: If** the Reimbursement Percentage for Vision Care is less than 100%, the Reimbursement Percentage is also applied to the Vision Care maximum. For example, it the Vision Care maximum is $100 and the Reimbursement Percentage is 80%, the maximum amount payable is $80. If the Vision Care maximum is $100 and the Reimbursement Percentage is 90%, the maximum payable is $90.

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. Your ophthalmologist must complete **Form #948** (see **#4**) and send it to us.

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

The Health section on the Schedule of Benefits page tells you if a change in prescription is required in order for benefits to be eligible under Vision Care

If a change in prescription **is required,** use **Form #948 - Vision Care.** Follow the instructions on the form. Be sure to fill in:

the **Group Policy Number**
your **S.I.N.** (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. The receipt should indicate the name of the patient and what was purchased (such as eyeglasses or contact lenses).

If a change in prescription **is not required**, use **Form #466 - SUPPLEMENTARY MEDICAL BENEFITS.** Be sure **all** data listed above is completed on the form. Claims must be submitted **within 90 days** of the date of treatment.

# 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 **Co-ordination *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 for your Plan is **shown on the Schedule of Benefits page.**

**Note: If** the Family Deductible Amount is greater than the Single Deductible Amount, no more than the Single Deductible Amount can be taken from any one family member towards satisfying the Family Deductible Amount.

Claims incurred during October, November and December of a calendar year which satisfy the Deductible Amount for that year will also be used towards satisfying the Deductible Amount for the next calendar year.

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.**

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.

# DENTAL BENEFITS - GENERAL PROVISIONS

## 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.

## 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:

**your Social Insurance Number (S.I.N.)** or **your certificate number** (if different)
the **Group Policy Number**
the **full birthdate (day/month/year) for your dependent,** if it's a Dental claim for your spouse or dependent child
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 90 days** of the date of treatment.

# 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.

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?**

- examinations by a Specialist
- 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

1. **SPECIALIST SERVICES** (if shown on the Schedule of Benefits page)

A dentist who is licensed as a Specialist in the province 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 service is covered under this Group Plan, the extra charge is eligible under this Specialist Option.

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.

2. **SPACE MAINTAINERS** (if shown on the Schedule of Benefits page)

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.**

3. **MAJOR SURGICAL SERVICES** (if shown on the Schedule of Benefits page)

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.**

4. **PERIODONTAL SERVICES** (if shown on the Schedule of Benefits page)

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.

5. **ENDODONTIC SERVICES** (if shown on the Schedule of Benefits page)

This Option covers services required *to* diagnose or treat the following:
- root canals
- diseases of the tooth pulp
- diseases of the periapical area.

6. **DENTURE REPAIR SERVICES** (if shown on the Schedule of Benefits page)

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 (provided the natural tooth is extracted while the insured person is covered under this Group Plan).

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

# BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

**NOTE: This** coverage **is** provided **by SEABOARD LIFE INSURANCE COMPANY.**

You are covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job for a Principal Sum of one times your annual salary rounded to the next higher $1,000.00 if not already an even multiple of $1,000.00 to a maximum of $100,000.00. Benefits are payable in addition to any other life insurance you may have.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

If injury shall, within 365 days of the date of the accident causing such injury, result in any of the following losses, the Company will pay for loss or permanent and total loss of use of:

| | |
|---|---|
| Life | The Principal Sum |
| Both Hands | The Principal Sum |
| Both Feet | The Principal Sum |
| Entire Sight of Both Eyes | The Principal Sum |
| One Hand and One Foot | The Principal Sum |
| One Hand and The Entire Sight of One Eye | The Principal Sum |
| One Foot and The Entire Sight of One Eye | The Principal Sum |
| Speech and Hearing | The Principal Sum |
| Speech or Hearing | One-Half of The Principal Sum |
| One Arm | Three-Quarters of The Principal Sum |
| One Leg | Three-Quarters of The Principal Sum |
| One Hand | Two-Thirds of The Principal Sum |
| One Foot | Two-Thirds of The Principal Sum |
| Entire Sight of One Eye | Two-Thirds of The Principal Sum |
| Thumb and Index Finger of Either Hand | One-Third of The Principal Sum |
| Hearing in One Ear | One-Sixth of The Principal Sum |

| | |
|---|---|
| Quadriplegia (Complete paralysis of both upper and lower limbs) | The Principal Sum |
| Paraplegia (Complete paralysis of both lower limbs) | The Principal Sum |
| Hemiplegia (Complete paralysis of upper and lower limbs of one side of body) | The Principal Sum |

"Loss" as used with reference to hand or foot means complete severance at or above the wrist or ankle joint, but below the elbow or knee joint, as used with reference to arm or leg means complete severance at or above the elbow or knee joint, as used with reference to thumb and index finger means complete severance at or above the first phalange, as used with reference to eye means the irrecoverable loss of the entire sight thereof, as used with reference to speech means the total and irrecoverable loss thereof, and as used with reference to hearing means the total and irrecoverable **loss** thereof.

Any indemnity payable for Loss of Use shall be paid only if such loss is permanent, total and irrecoverable and shall have been continuous for a period of 12 months from the date of the accident.

Benefits with respect to Quadriplegia, Paraplegia and Hemiplegia require total paralysis of the limbs which shall have been continuous for a period of 12 months from the date of the accident and is deemed to be permanent and irrecoverable.

Indemnity provided under this **Part** will not be paid under any circumstances for more than one of the losses, the greatest, sustained by any one Insured Person as the result of any one accident.

**AGGREGATE LIMIT**

$1,000,000.00 any one aircraft accident.

**REPATRIATION BENEFIT**

If injury shall result in the **loss** of life of an Insured Person outside Canada, within 365 days of the date of the accident, the Company will pay the actual expense incurred for preparing the deceased for burial or cremation and the shipment of the **body** of the Insured Person to the city of residence of the deceased, subject to a maximum amount of $2,500.00.

**WAIVER OF PREMIUM**

In the event an employee becomes totally disabled and such disability continues for a period of 6 consecutive months and prevents the employee from working, then premium due under this plan will be waived until the earlier of: attainment of age 65, death or recovery or date the policy **is** cancelled.

**EXCLUSIONS**

This policy shall not provide for payment for losses caused, resulting from or contributed by:

(1) suicide **or** any attempt thereat while sane or insane;

(2) intentionally self-inflicted injury;

(3) declared or undeclared war or any act thereof;

**(4)** full-time active service in the armed forces of any country;

(5) flying as a pilot or crew member in any aircraft or flying in an aircraft owned, operated or leased by or on behalf of the Policyholder.

**BENEFICIARY**

Benefits payable in the event of the **loss** of life of an Insured Person shall be that person or those persons designated by the Insured Person under the Group Life Insurance Plan. If no such designation exists, benefits payable in the event of the loss of life *of* an Insured Person are payable to the estate of the Insured Person. All other benefits payable are payable to the Insured Person.

This description is a summary of the principal features of the Plan which **is** governed by the terms of the insurance contract with Seaboard Life Insurance Company.

Group

Equitable Life of Canada®

# Pension Plan

1209(2000/06/01)

# Pension Plan
# for
# All Other Employees
# of
# RYGIEL *Supports for Community Living*
# (the "Plan")

# GP 955,960

Your employer has set up a pension plan with The Equitable Life Insurance Company of Canada (the "Company") to assist you in providing income for your retirement. This booklet is a summary of the important terms and provisions of your Plan. The Plan text and supporting documents held by the Company is the governing document and takes precedence if there is any discrepancy. Your employer has a copy of the documents which are available for you to examine. Please contact your plan administrator if you wish further information.

The Plan provisions herein are governed by Pension Benefits Legislation and are subject to change.

Founded in 1920, The Equitable Life Insurance Company of Canada is an independent, Canadian life insurance company. It is committed to providing quality financial products and responsive, helpful service to its customers.

The Equitable Life Insurance Company of Canada is a founding member of The Canadian Life and Health Insurance Compensation Corporation (CompCorp). CompCorp administers the Consumer Protection Plan which was instituted to provide protection to the policyholders of member companies.



Equitable Life of Canada®

## TABLE OF CONTENTS

## WHAT IS THE PURPOSE OF A PENSION PLAN?

The primary purpose of a pension plan is to provide periodic payments to you after your retirement and until death in respect of your service as an employee. As a member, contributions will be made on your behalf to the Plan and invested in the applicable investment account. At retirement, the accumulated contributions in all your accounts shall be used to purchase a monthly annuity. The greater the accumulated contributions, the greater the pension that will be purchased.

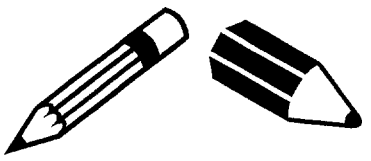
## WHO IS ELIGIBLE TO JOIN THE PLAN?

All full-time Employees who have completed at least 3 months of continuous service shall join the Plan. All part-time Employees with 2 years of continuous service and who, in each of the years had earnings of not less than 35% of the Year's Maximum Pensionable Earnings or completed 700 hours of employment with the employer shall be eligible to join the Plan.

## HOW DO I JOIN THE PLAN?

Your employer will give you an application form to complete. At this time, you will designate your beneficiary. For your contributions you made or made on your behalf after December 31, 1986, your beneficiary must be your spouse or same-sex partner, provided you have a spouse or same-sex partner.

**Personal information collected from the application form will be used for pension plan purposes only.**



## HOW MUCH DO I CONTRIBUTE TO THE PLAN?

You are required to contribute to the Plan 3% of your earnings.

Your contributions to the Plan are deductible from your income for tax purposes subject to the limit specified in the *Income Tax Act* (Canada) and will be shown on your annual T4 slip.

## MAY I MAKE ADDITIONAL CONTRIBUTIONS TO THE PLAN TO INCREASE MY PENSION?

Yes. You may make additional voluntary contributions in accordance with the provisions of the Plan over and above your required contributions. The *Income Tax Act* (Canada) limits the amount of total contributions that can be made in a calendar year. Details of the maximum amounts may be provided by your plan administrator.

Additional voluntary contributions made by you to the Plan are tax deductible and will be shown on your annual T4 slip.

## HOW MUCH DOES MY EMPLOYER CONTRIBUTE ON MY BEHALF?

As a member of the Plan, your employer will contribute on your behalf, 3% of your earnings. All members of a Class shall have the same contribution rate.

In addition, your employer pays any expenses related to the administration of the Plan.

Please call your Plan Administrator for assistance!

## HOW ARE THE CONTRIBUTIONS INVESTED UNDER THE PLAN?

Contributions received are deposited to the investment accounts according to the instructions received.

Under your Plan you have the choice of a daily interest account and a number of guaranteed deposit accounts.

The portion arising from investments in the Daily Interest Account and the Guaranteed Deposit Accounts is fully guaranteed.

The following are brief descriptions of the investment options currently offered under the Plan:

### *1. Daily Interest Account (DIA)*

The Daily Interest Account features a fluctuating interest rate which reflects the current yields on short-term investments. The effective annual rate is compounded daily, calculated on the full balance and credited to the DIA.

This account is for the investor who wants:

- a temporary place to earn interest while deciding which investment option to select
- to wait for market conditions to change

### *2. Guaranteed Deposit Accounts (GDA)*

The Guaranteed Deposit Accounts are guaranteed compound interest accounts offering a choice of investment terms of 1, 2, 3, 4, or 5 years, and are credited with a guaranteed rate of interest until the Deposit Account matures. Each deposit is treated as a separate investment with its own interest rate, investment term and maturity date.

The Deposit Account matures on the deposit anniversary immediately following the end of the term selected.

The maturity value of the Deposit Account will be reinvested on the maturity date for the same term as the maturing deposit at the then prevailing interest rate as determined by the Company, unless you elect a different term or investment fund by providing written notice to the Company prior to the maturity date.

This account is for the investor who wants:

- guaranteed interest earnings
- peace of mind investments

A market value adjustment will apply if you surrender a Guaranteed Deposit Account prior to the end of the investment term.

## WHAT HAPPENS IF I LEAVE MY EMPLOYMENT PRIOR TO RETIREMENT?

Once you have terminated employment with your employer, no further contributions may be made to the Plan.

Your options in respect of your pension benefits that are not locked-in are :

(a) transfer the accumulated value of member and vested employer contributions to another pension plan, if permitted by that plan, or

(b) transfer the accumulated value of member contributions and vested employer contributions to your RRSP, your RRIF, or other retirement savings arrangement acceptable under applicable legislation, or

(c) leave the funds on deposit with the Company and use to purchase an annuity at retirement, or

(d) accept a cash lump sum payment of the accumulated value of member and vested employer contributions.

Your options in respect of your pension benefits that are locked-in arc:

(a) transfer the accumulated value of member and employer contributions to another pension plan, if permitted by that plan, or

(b) transfer the accumulated value of member and employer contributions to your LIRA, your LIF, your LRIF or other retirement savings arrangement acceptable under applicable legislation, or

(c) purchase an annuity which would be payable for at least your lifetime to start no earlier than 10 years before your normal retirement date. or

(d) leave the funds on deposit with the Company and use to purchase an annuity at retirement.

**If** your pension benefits for Plan membership prior to January 1, 1987 are locked-in, you may **take** 25% of this amount in cash.

Funds that are transferred should remain locked-in until such time as they are used to purchase life annuities.

Please call your Plan Administrator for assistance!

**WHAT DO THE TERMS "VESTED" AND "LOCKED-IN" MEAN, AND HOW DO THEY AFFECT MY PENSION BENEFITS?**

The term "vested" means you are entitled to all or a portion of employer contributions made on your behalf. Zero percent vested means that you are not entitled to any employer contributions made on your behalf. Fully vested means that you are entitled to the full amount of the employer contributions made on your behalf.

Provincial legislation has minimum standards that must apply.

The vesting schedule for this Plan is:

A) For Plan Membership Prior to January 1, 1987 (includes membership in the prior plan)

Employer contributions for Plan membership prior to January 1, 1987 shall be vested according to the following schedule:

| Years of Continuous Service | Vesting Percentage |
|---|---|
| less than 5 years | 0% |
| 5 years but less than 6 | 25% |
| 6 years but less than 7 | 30% |
| 7 years but less than 8 | 35% |
| 8 years but less than 9 | 40% |
| 9 years but less than 10 | 45% |
| 10 years but less than 11 | 50% |
| 11 years but less than 12 | 55% |
| 12 years but less than 13 | 60% |
| 13 years but less than 14 | 65% |
| 14 years but less than 15 | 70% |
| 15 years but less than 16 | 75% |
| 16 years but less than 17 | 80% |
| 17 years but less than 18 | 85% |
| 18 years but less than 19 | 90% |
| 19 years but less than 20 | 95% |
| 20 or more years | 100% |

Employer contributions shall be fully vested provided you arc at least 45 years old and have completed 10 years of membership in the Plan or 10 years of continuous service with the employer.

B) For Plan Membership On and After January 1, 1987 (includes membership in the prior plan)

Employer contributions shall be fully vested after 2 years of Plan membership.

Please call your Plan Administrator for assistance!

The term "locked-in" means that all required contributions made by you and on your behalf into the **Plan** are not available in cash, and can only be used to provide an annuity at retirement.

The locking-in schedule for this Plan is:

A) For Plan Membership Prior to January 1, 1987 (includes membership in the prior plan)

All member and employer contributions shall be locked-in provided you are at least 45 years old and have completed 10 years of membership in the Plan or 10 years of continuous service with the employer.

B) For Plan Membership On and After January 1, 1987 (includes membership in the prior plan)

All member and employer contributions shall be locked-in after 2 years of membership in the Plan

## WHEN MAY I RETIRE FROM THE PENSION PLAN?

Your normal retirement date shall be the 1st day of the month coincident with or next following your 65th birthday. However, you may elect to commence your pension any time after age 55, or postpone your retirement to the end of the year in which you attain age 69 or such other time as is acceptable under the *Income Tax Act* (Canada) and its Regulations.

Please call your Plan Administrator for assistance!

## WHAT BENEFITS WILL I RECEIVE WHEN I RETIRE?

At the time you retire, the total proceeds in all of your accounts shall be applied towards the purchase of an annuity.

If you have a spouse or same-sex partner at retirement, the form of annuity shall be an annuity payable for as long as you and your spouse or same-sex partner both live reducing on either death by not more than 40% of that annuity, payable for as long as the survivor lives.

The normal form of annuity under the Plan is guaranteed for 120 months. Other forms of annuities are available.

If an annuity other than a Joint and Survivor annuity is chosen, or where the reduction is more than 40%, the spouse or same-sex partner must complete and sign the waiver form prescribed by applicable legislation.

Spouse means either of a man or woman who:

(i) are married to each other and are not living separate and apart at the time in question, or

(ii) are not married to each other and are living together in a conjugal relationship continuously for a period of not less than three years, or in a relationship of some permanence, if they are the natural or adoptive parents of a child, both as defined in the *Family Law Act*,

Same-sex partner means either of two persons of the same sex who are living together in a conjugal relationship:

(a) continuously for a period of not less than 3 years, or

(b) in a relationship of some permanence, if they are the natural or adoptive parents of a child, both as defined in the *Family Law Act.*

If you do not wish to start receiving your pension benefits immediately, you may choose other options that are available to members leaving their employment.

## WHAT BENEFITS ARE PAYABLE IF I DIE BEFORE RETIREMENT?

If you do not have a spouse or same-sex partner, the accumulated value of all member and employer contributions, as at the date of death, shall be payable in a cash lump sum to your designated beneficiary.

If you have a spouse or same-sex partner, the accumulated value to the date of death: of the contributions you made or made on your behalf after December 31. 1986, shall be payable to your spouse or same-sex partner.

However, your spouse or same-sex partner may waive the payment of the death benefit by completing and signing the waiver form prescribed by applicable legislation.

## WHAT BENEFITS ARE PAYABLE IF I DIE AFTER RETIREMENT?

If you die after annuity payments have commenced, the death benefit will depend upon the form of pension you chose at the time of your retirement.

For example, if you chose a Joint and Survivor annuity: your surviving spouse or same-sex partner will continue to receive annuity payments for his/her lifetime. The amount of the continued annuity payment may be reduced, depending on the form of annuity chosen at the time of retirement.

Please call your Plan Administrator for assistance!

## WHAT INFORMATION WILL I RECEIVE AS A MEMBER?

As a member, you will receive a semi-annual statement that provides a summary of information such as the accumulated value of all contributions made to date by you or on your behalf, interest rates, personal information, and the dates you will become vested and/or locked-in.

In addition, necessary information and/or statements will be provided in accordance with applicable provincial legislation, in the event of death, retirement, or upon termination of employment. Further information may be available upon request.

## WHAT IS A RRSP?

A Registered Retirement Savings Plan (RRSP) is a personal retirement savings account offered by financial institutions, to a specified amount.

RRSP contributions can be deducted from an individual's taxable income. RRSP's earned income is generally exempt from tax until payments are received from the plan. RRSPs are governed by the Income Tax Act (Canada).

## WHAT IS A RRIF?

A Registered Retirement Income Fund (RRIF) is a personal retirement income fund offered by financial institutions. An RRIF is used to provide an ongoing minimum flow of income. The payment schedule is flexible: you can elect to receive a steady stream of payments, or the minimum legislated payment with scheduled larger lump-sum payments, or a steadily increasing income. The minimum withdrawal amounts are determined by the Income Tax Act (Canada). RRIFs are governed by the Income Tax Act (Canada),

## WHAT IS A LIRA?

A Locked-In Retirement Account (LIRA) is a retirement savings account offered by financial institutions. It is similar to a RRSP, except that it is locked-in. A LIRA is used to hold money that is transferred out of a pension fund on termination of employment.

Locked-in funds can only be used to purchase **a** life annuity payable before the end of the calendar year you turn 69 years old or such other time as is acceptable under the Income Tax Act of Canada and its Regulations. LIRAs are governed by the applicable province's Pension Benefits Act and the Income Tax Act (Canada).

## WHAT IS A LIF?

A Life Income Fund (LIF) is a personal retirement income fund offered by financial institutions. It is similar to a RRIF. **A** LIF can be purchased with pension funds when a member leaves employment. A LIF is used to provide a regular retirement income, and is subject to minimum and maximum withdrawal limits. Payments are determined by a provincially legislated formula and you arc required to buy a life annuity with the assets remaining in the LIF by the end of the year in which you reach age 80. LIFs are governed by the applicable province's Pension Benefits Act and the Income Tax Act (Canada).

Please call your Plan Administrator for assistance!

## WHAT IS A LRIF?

A Locked-in Retirement Income Fund (LRIF) is also a personal retirement income fund offered **by** financial institutions. It is similar to a LIF except that you do not have to buy a life annuity at the age of 80. Hence, the maximum withdrawal limits of the LIF and LRIF are different. Also, if you do not withdraw the maximum amount of your LRIF in any given year, the balance may be added to the maximum amount in the following year. Payments are determined by a provincially legislated formula. LRIFs arc governed by the applicable province's Pension Benefits Act and the *Income Tax Act* (Canada).

## CUSTOMER SERVICE INQUIRIES

While the above is intended to provide you with a brief description of the features of your Plan, it may not answer all of your questions. Should you require additional information or have any questions, please feel free to speak to your plan administrator or call us toll-free at:

1-800-265-4556
or
(519) 886-5110
for those in the Kitchener-Waterloo area.