

Benefits Plan Eastern School District

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Employee/Retiree Responsibility [top](#)

Employees/Retirees should note that they also have responsibilities to fulfill.

- You are responsible for ensuring that you have applied for the coverage you wish to have for yourself and your dependents within the appropriate time frames.
- You are responsible to change your coverage from single to family within the appropriate time frame. If the coverage is not changed within 31 days of acquiring your first eligible dependent a Statement of Health on Dependents is required for approval.
- You are responsible to add a spouse to this plan in the event that he or she loses coverage under another plan within a 31 day period following the loss of coverage to avoid having to provide medical evidence.
- You are responsible for examining payroll deductions for all group insurance benefits. This will ensure accuracy and allow for corrections on a timely basis.
- You are responsible for amending your coverage to delete any coverage you no longer require. Contributions which you have paid are not refundable if they were consistent with the application on file.
- You are responsible for effecting conversion of the coverage eligible to be converted upon the earlier of termination of employment or at age 65.
- You are responsible for completing the necessary forms required for continuing benefits while on maternity leave, sick leave, special leave without pay, retirement, etc. It is extremely important these arrangements be made prior to commencing eligible leave.
- You are responsible for providing appropriate claim information necessary to process LTD and/or Waiver of Premium claims as well as to ensure notice of claim/proof of claim where necessary and provided within appropriate time frames as required under the contract.
- You are responsible for completing appropriate forms necessary for such things as change of address, addition of new dependent etc
- You are responsible to register overage student dependents at age 21 and at the beginning of each school year

Summary of Your Benefit Program [top](#)

The following summarizes the various benefits which are available for the security and well being of you and your family, while you are an employee, upon your retirement and in the event of your death before or after retirement. Please note as this is a "summary" of your benefits, if any discrepancies arise, the wording in the Insurance Contract will prevail.

The benefits are explained in greater detail in this booklet.

Eligibility for Group Insurance

- All full-time, active employees, including part-time employees who work 50% of the regular work week, are required to participate in the group insurance program from their first day of employment. All retired employees who are receiving a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan may elect to continue coverage.
- All temporary employees, if hired for a period of more than three months, are covered under the program from the first day of employment. Employees who are hired for a period of less than three months, who receive notice of extension to at least six months, are required to participate from the date of notification.
- Seasonal, recurring employees are covered under the plan during their term of active employment. During periods of lay-off, provided they do not work for another employer during such lay-off, employees have the option to continue coverage. **However, coverage will not continue unless a "Continuation of Coverage" form is completed, signed and given to your Administrator prior to your leaving.**
- All elected members of the Legislature are covered under the program on a voluntary basis.

Basic Group Life Insurance

In the event of your death, an amount of life insurance equal to that described in this booklet on basic group life insurance is payable to the beneficiary you have appointed on your Group Enrollment Card.

Dependent Life Insurance

In the event of the death of your insured spouse or dependent child, an amount of life insurance is payable to you as outlined in this booklet on dependent life insurance.

Accidental Death and Dismemberment Insurance

In the event of an accidental death, accidental dismemberment, loss of use, paralysis or loss of speech or hearing, within 365 days of an accident, a benefit is payable in accordance with the details outlined in this booklet.

Supplementary Health Insurance

This plan provides benefits not covered under the Provincial medical services and hospital insurance programs, for you and your insured dependents including:

Semi Private Hospital Benefit
Extended Health Benefit
Prescription Drug Benefit
Emergency Ambulance Benefit
Out-of-Province Benefit
Non-Emergency Transportation Benefit
Vision Care Benefit

Group Travel Insurance

This plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred outside the province while traveling on business or vacation.

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Optional Long Term Disability Insurance

This plan is available to you on an optional and employee-pay-all basis. Long term disability insurance may provide disability benefits for periods of total disability which exceed 119 days. To be eligible for this program, you must be a member of either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan.

Optional Dental Care Insurance

This plan is available to you and your insured dependents on an optional and employee-pay-all basis.

Optional Group Life Insurance

This plan is available on an optional, employee-pay-all basis and you may apply to purchase additional group life insurance coverage for you and /or your spouse. Coverage is available from a minimum of \$10,000 to a maximum of \$300,000 in increments of \$10,000.

Optional Accidental Death and Dismemberment Insurance

This plan is available on an optional, employee-pay-all basis and enables you to purchase additional amounts of accidental death and dismemberment insurance on an employee and/or family plan basis. Coverage is available from a minimum of \$10,000 to a maximum of \$300,000 in increments of \$10,000.

Optional Life-Link Insurance

This plan is available on an optional, employee-pay all basis and enables you to purchase coverage for yourself and your family which will provide a lump sum payment in the event of a "Critical Condition" and you meet the necessary Criteria. Maximum Benefit \$25,000. Employee \$10,000. Spouse and \$5,000 Dependent Child.

Change of Beneficiary

You may change your designated beneficiary(ies) at any time subject to any legal requirements affecting such right. For further information, please contact your Administrator.

Continuation of Benefits

Please note that for any employee who retires or is granted a leave of absence, such as maternity leave, education leave, continued absence following exhaustion of sick leave credits, or is suspended for any reason, group insurance coverage **will not continue unless a "continuation of coverage" form is completed, signed and given to the Administrator or department head, prior to your leaving**, in order that they may arrange for your premium payments during your absence.

Please Note: If you are granted an unpaid leave of absence and are engaged in any occupation or employment (self employed included) you are not eligible to continue group insurance coverage.

Note

The information contained in this booklet is important to you and we suggest it be kept in a safe place.

When your insurance terminates you must return your identification card(s) to your Administrator.

Definition of Dependent

For the purpose of the group insurance program, the following definition of dependent is applicable:

Spouse

- a. An individual to whom you are legally married; or
An individual of the opposite sex who has been publicly represented as your spouse for at least one year; or
An individual of the same sex who has been publicly represented as your spouse for at least one year.

Dependent Children

You or your spouse's unmarried, natural, adopted, foster or step-children, including a child of an unmarried minor dependent, who are:

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- a. under 21 years of age and dependent upon you for support and maintenance; or
- b. under 25 years of age and in full-time attendance at a recognized post-secondary educational institution and dependent upon you for support and maintenance; or
- c. age 21 or over, who, by reason of mental or physical infirmity, are incapable of self-sustaining employment, and are dependent upon you for support and maintenance, provided they were disabled and insured under the plan on the day before they reached age 21.

Children of your spouse are considered dependents only if:

- they are also your children; or
- your spouse is living with you and has custody of the children.
- This plan does not cover a spouse or dependent child who is not a resident in Canada nor does it cover any child who is working more than 30 hours per week, unless the child is a full-time student.

Supplementary Health Insurance [top](#)

In addition to the benefits available under the provincial government programs, supplementary health insurance is provided to you and your insured dependents as outlined below.

Hospital Benefit

If you or any of your insured dependents are confined in a hospital on the recommendation of a physician, coverage is provided for **semi-private hospital room**, 100%, to a daily maximum of \$85.00

Prescription Drug Benefit

The program will pay the ingredient cost of eligible drugs (including oral contraceptives and insulin), and the employee/retiree will pay the co-pay, which will be the equivalent of the pharmacist's professional fee plus any applicable surcharge.

The drug plan provides coverage for most drugs which require a prescription by law, however, some drugs may require special authorization, but does not provide coverage for over-the-counter drugs, cough or cold preparations, nicotine products, etc. Details of the special authorization process are outlined in this booklet.

Extended Health Benefit

This portion of the program includes coverage for the following. It is important to note that reimbursement under the extended health care benefit is made at **80% of covered eligible expenses** up to \$5,000; expenses over \$5,000 and less than \$10,000 are reimbursed at 90%, and expenses over \$10,000 are reimbursed at 100% in any calendar year. Eligible expenses are as stated below. Where no maximum eligible expense is noted, reasonable and customary rates will apply.

- Services of a Registered Nurse, Licensed Practical Nurse and Registered Nursing Assistant, including Home Health Care Services (excluding a relative), in your home to a maximum covered eligible expense of \$10,000 per disability. Service must be for active medical care and reimbursement will not be made when the services are custodial in nature. **Pre-approval is required;**
- Services of a qualified physiotherapist (requires a physician confirmation) massage therapist (requires physician referral stating medical reason) osteopath, chiropractor, naturopath and podiatrist to an annual covered eligible expense of \$500 per practitioner (excluding a relative);
- Acupuncture service is covered to an annual eligible expense of \$500.
- Purchase of wheelchair cushions to an annual covered eligible expense of \$300;
- Casts, trusses, braces, crutches, canes, walkers and splints (excluding dental splints);
- Hearing aids are eligible, one for each ear every three consecutive calendar years. The maximum eligible expense for each hearing aid is \$750.

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- Artificial limbs (excluding myoelectrical limbs) and eyes and other prosthetic appliances including repair and replacement where the loss of the natural member was incurred while insured;
- Rental or purchase of a wheelchair (every five years), hospital bed, iron lung or other durable equipment. Pre-approval is required;
- Rental or purchase of transcutaneous electrical nerve stimulator (TENS);
- Jobst burn garments, Jobst sleeves for lymphoedema following mastectomy and Jobst support hose and surgical stockings;
- Stump socks;
- Colostomy and ileostomy apparatus;
- External breast prosthesis, once per calendar year, post mastectomy;
- Surgical Brassieres, post mastectomy are added as an eligible benefit providing 80% of a maximum eligible expense of \$100 per brassiere. The contract will allow up to two brassieres per calendar year.
- Treatment by x-ray, radium and radioactive isotopes;
- Oxygen, plasma or blood transfusions;
- Up to a covered eligible expense of \$20 per day for room and board for active treatment or convalescent care in a licensed nursing home supervised by a Registered Nurse on a 24-hour basis. Confinement in the nursing home must be for rehabilitation or convalescent care and not for custodial care;
- Services of a dental surgeon including dental prosthesis required for treatment of a fractured jaw or for treatment of accidental injuries to natural teeth if reported within six months of the accident where the injury was caused by external, violent and accidental means;
- Injectable drugs when administered by a physician, (Excludes Vaccines);
- Insulin syringes and home chemical testing supplies for diabetics including glucometer and supplies. (Note: Insulin is covered under the prescription drugs benefits portion of the plan). Maximum allowable expense per year is \$1,580.
- Insulin pumps are an eligible benefit with effect April 1, 2004, for insured 16 years of age or less. The program will allow 80% reimbursement to a maximum payable of \$4,800 in a five year period.
- Insulin pumps are an eligible benefit with effect April 1, 2010, for adults (17yrs and over) on restricted circumstances with a maximum reimbursement of \$2,500 every sixty (60) months.
- Up to a covered eligible expense of \$500 per year for the services of a psychologist on the written prescription of a psychiatrist or pediatrician;
- The requirement for a Psychiatrist referral will be replaced with a General Medical Practitioner referral. Effective April 1, 2010, the access to a Psychologist with the referral by a General Practitioner will be introduced with a maximum eligible amount per visit of \$65 and an annual eligible maximum of \$325.
- Up to a covered eligible expense of \$500 per year for the services of a speech therapist on the written prescription of a Medical Specialist; and
- Orthopedic shoes and orthopedic aids to a maximum covered eligible expense of \$200 every calendar year.
- Services of a qualified Occupational Therapist to an annual eligible covered expense of \$500.

Emergency Ambulance Benefit

Emergency Ambulance Benefit is amended for professional ambulance service, including licensed air ambulance services when certified as immediately necessary by the attending physician. Reimbursement covers transportation to and from the nearest hospital of licensed medical facility able to provide treatment for bodily injury or sickness subject to 80% of a covered eligible expense of \$1,000 outside the province and \$500 within the province. For employees who are residents of Labrador, the benefit is 80% of a covered eligible expense of \$500 outside the province and \$1,000 within the province. Further, all eligible amounts are now subject to 80% of the maximum eligible expense applicable per person per calendar year.

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Non-Emergency Transportation Benefit

- Transportation expenses incurred for non-emergency service to and from the nearest hospital or medical facility which can provide necessary services, including x-rays or examinations, not readily available in the local area to 80% of a covered eligible expense of \$300 in respect of all such claims in a calendar year;
- Expenses for an escort, including the parent if the person requiring treatment is under 15 years of age, up to 80% of a covered eligible expense of \$300 for each calendar year;
- Services must be prescribed by a physician or surgeon. No benefit is payable for aesthetic surgery (cosmetic surgery for beautification purposes); and
- Any expenses incurred for meals or accommodations will not be considered as eligible expenses.

Note

Benefits for transportation expenses shall be paid only if:

- a. written documentation and confirmation is received from the physician who prescribed the treatment and the hospital or medical facility that rendered the treatment, that such treatment was actually rendered.
- b. the nearest hospital or medical facility able to provide the necessary treatment was at least 80 kilometres or 160 kilometres round trip by the most direct route, from your city, town or community of residence; and
- c. the most economical means of transportation available was used or the physician provides written documentation that an alternate, more expensive means was necessary due to the patient's medical condition. Where a private vehicle is used, a maximum of
- d. \$0.125 per kilometre would be paid, but in no event shall this exceed the cost of the most economical means available.

Vision Care Benefit

You and your insured dependents are covered for the following vision care expenses:

- a. **Up to 80% of** charges for eye examinations performed by an Ophthalmologist or Optometrist where the Medicare plan does not cover such services, limited to one such expense in a calendar year for dependent children under age 18 and once in two calendar years for all other insured persons;
- b. Up to **100%** of covered eligible expense of \$150 for single lenses and frames and **100%** of a covered eligible expense of \$200 for bifocal lenses and frames limited to one expense in every three calendar years. And \$225 for trifocal lenses and frames limited to one expense in every three calendar years. Once in a calendar year for dependent children **under age 18 if a change in the strength of the prescription is required**. Please note that expenses for contact lenses will be reimbursed at the same level as for eyeglasses. Coverage is not provided for sunglasses, safety glasses, or repairs and maintenance.
- c. Coverage for "laser eye surgery" to a one time maximum amount of \$450. If a claim is made for this benefit, no further vision care will be payable for six (6) years.
- d. Up to 100% of the covered eligible expense of \$250 in two calendar years for the purchase of contact lenses prescribed for severe corneal scarring, keratoconus or aphakia, provided vision can be improved to at least a 20/40 level by contact lenses, but cannot be improved to the level by spectacle lenses. If contact lenses are selected for cosmetic reasons, you will be eligible for up to the eyeglasses maximum once in any two calendar years. Dependent children will be eligible for this benefit once in any calendar year, provided that a change in the strength of the prescription is required;
- e. One pair of eyeglasses when prescribed by an Ophthalmologist following surgery, to 100% of a lifetime covered eligible expense of \$200; and
- f. 50% of the cost of visual training or remedial therapy.

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Out-of Province Benefit

Coverage is provided for 80% of expenses incurred outside your home province when the required medical treatment is not readily available in your home province.

If the medical treatment is readily available elsewhere in Canada but you seek treatment outside Canada, benefits will be limited to the reasonable and customary charges of the nearest Canadian medical centre equipped to provide the necessary treatment. It is suggested that you submit a treatment plan so the insurer can advise you of the amount payable before you incur the expense.

Coverage is provided for the following:

- semi-private hospital accommodation;
- hospital out-patient services;
- physicians' fees;
- laboratory tests and x-rays; and
- other eligible expenses that would have been covered in your home province.

Co-ordination of Benefits

Should similar benefits be provided by more than one section of the policy, any claim for these benefits will be assessed by the Insurance Company in a manner which provides the greatest benefit to the participant.

Where compensation for benefits covered under this plan is available to a participant under any other prepaid health service contract or insurance policy, the amount payable under this plan shall be coordinated with such other coverages in accordance with the Canadian Life and Health Insurance Association (CLHIA) Guidelines so that the total benefits from all plans will not exceed the expenses actually incurred.

Effective April 1, 2010, Co-ordination of Benefits will be allowed between spouses insured under the Plan.

If the other plan does not contain a coordination of benefits provision, then that plan shall be considered first payer.

Conversion Privilege

If you should terminate employment prior to age 65, you may convert to an individual health plan currently offered by the insurer, provided that application is made within 31 days following your date of termination. After 31 days following your date of termination, medical evidence of insurability will be required.

Services not Covered Under the Supplementary Health Insurance Program

You and/or your dependents are not covered for medical expenses incurred as a result of any of the following:

- injury or illness due to war or engaging in a riot or insurrection;
- aesthetic surgery (cosmetic surgery for beautification purposes)
- services required due to an intentional self-inflicted injury;
- delivery charges;
- hearing tests;
- pregnancy tests;
- injury or illness for which you or your dependents are covered under Worker's Compensation or a similar program;
- services or supplies received from a dental or medical department maintained by your employers, a mutual benefit association, labour union, trustee or similar type group;

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- services or supplies which are covered under a government hospital plan, a government health plan or any other government plan;
 - expenses for contraceptives other than oral contraceptives;
 - expenses for vitamins (except injectables), minerals, and protein supplements (other than expenses that would qualify for reimbursement under Eligible Expenses under the Drug Benefit);
 - expenses for diets and dietary supplements, infant foods and sugar or salt substitutes;
 - expenses for drugs which are used for a condition or conditions not recommended by the manufacturer of the drugs; and
 - experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's a treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the satisfaction of the administrator.
 - expenses for lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleaners, protectives, or emollients.
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Special Authorization Drug Claims [top](#)

The Special Authorization process has been developed to ensure you have access to a wide range of prescription drug benefits, when you need them. This section has been designed to familiarize you with the Special Authorization process.

How does Special Authorization apply to my prescription drug program?

Your prescription drug program provides you with immediate access to more than 3,000 prescription drugs. Certain other medications require Special Authorization before your prescription is eligible for coverage.

How does Special Authorization affect me?

This new process applies to you if a medication you require falls under the Special Authorization category. It is important to familiarize yourself with these medications and discuss the process with your doctor. Special Authorization is designed to provide you with your required medications as quickly as possible.

Will I need to pay for my prescription myself?

You will only need to pay for your prescription yourself if you purchase the medication prior to receiving Special Authorization approval, or if your request for Special Authorization is denied

How do I apply for Special Authorization?

1. If you are currently taking a medication that requires Special Authorization, you should begin the Special Authorization process before your prescription runs out.
2. Request a Special Authorization form from your Group Administrator or nearest from your pharmacist. This form requires the prescribing physician's signature.
3. If your current medication, or new prescription, requires Special Authorization, have your doctor complete the form. Any costs associated with completing the form are the responsibility of the patient/subscriber.
4. Send your completed form to:

Desjardins Financial Security, Special Authorization Unit
P. O. Box 4359, STN "A"
Toronto, ON
M5W 3M8

or **FAX** your form to Desjardins Financial at 1-416-324-7980, our secured facsimiled location which ensures confidentiality. Desjardins offices may be contacted during regular business hours: Monday to Friday, 8:00 a.m. to 5:00 p.m. Tel: 1-877-838-7763.

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What happens to my Special Authorization request once I have sent it to the Insurance Company?

Your request will be confidentially reviewed by a medical consultant, after which you will receive written notification of the decision. Normal turnaround for assessment is seven to ten working days.

In cases where a doctor requires an urgent response due to a medical condition, every effort will be made to respond the same day. The patient/subscriber may also wish to purchase the prescription before applying for Special Authorization, recognizing that there is no guarantee that Special Authorization will be granted. If information is incomplete and more details are required, turnaround may be delayed.

If your request is approved, the approval will indicate the specified period of time. You will not be required to apply for Special Authorization each time your prescription is filled within that specified time period. Please check your form carefully for the effective and termination date.

How are Special Authorization claims reimbursed?

Once your request has been approved, have your prescription filled. In the unlikely event your pharmacist will not submit your claim to the insurance company, you will need to forward the Special Authorization approval form and your paid-in-full receipts directly to the insurance company. Reimbursement will be mailed to you directly.

Claims for prescription drugs requiring Special Authorization can be paid either through Pharmacies that are on Point of Sale or through Desjardins Financial Security Claims office in the Customer Service Centre at 430 Topsail Road (Village Mall), P. O. Box 92, St. John's, A1E 4N1, or you may forward your claims to the Toronto head office (See #4 above).

If you have further questions about Special Authorization, please call the Desjardins Financial Security customer service centre at **1-877-838-7763**.

Group Travel Insurance [top](#)

The group travel insurance plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred outside the province or country while traveling on business or vacation. The plan provides coverage for a period of 90 days per trip for travel within Canada and 30 days per trip for travel outside Canada. There will be no coverage for travel outside Canada following the first 30 days of a trip outside the participants province of residence. Proof of departure and return date from province of residence is required.

The insurer will pay 100% of the reasonable and customary charges (subject to any benefit maximums) for the following eligible expenses:

- a. Charges of a public general hospital, less the amount allowed under the provincial government health plan for (a) room accommodation (not a suite of rooms), and (b) medically necessary in-patient and out-patient services.
- b. Customary charges by physicians and surgeons for services rendered, less the amount allowed under the provincial government health plan.
- c. Rental of wheelchairs, crutches and canes when required as a result of sickness or accident. This benefit will be payable only when the sickness or accident occurs outside the insured person's province of residence. Rental expenses must be incurred outside the province of residence and ordered by a physician.
- d. Private duty nursing when ordered by a physician at the usual and customary fee. registered nurses providing the service must not be a relative of the patient or an employee of the hospital.
- e. Charges for normal ambulance service to and from the nearest hospital able to provide the type of care essential to the patient.
- f. Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative).

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Written authorization is required from the attending physician. If returning on a commercial aircraft, this coverage includes:

- o two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant;
 - o the number of economy seats required to accommodate the covered patient if on a stretcher and one round trip fare for a medical attendant.
- g. The cost of diagnostic laboratory and x-ray services, less the amount allowed under the provincial government health plan, when ordered by the attending physician.
- h. The cost of services provided by Chiropractors, Osteopaths, Chiropodist/Podiatrist and Physiotherapist (not a relative) in excess of payment by a provincial government health plan, excluding charges for x-rays.
- i. Charges for prescription drugs in a quantity sufficient for the period of travel. Payment of eligible drug expenses will be made only when proof of purchase is supplied in the form of an account from a pharmacist, physician or hospital located outside the insured person's province of residence, showing the name of the preparation, date of purchase, quantity, strength and total cost.
- j. Charges for dental treatment to a maximum of \$1,000 in all, when, as the result of accidental injury (direct accidental blow to the mouth), natural teeth have been damaged or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by the insurer within 180 days of the accident and be supported by proper certification. When such dental treatment must be deferred because of the age of the patient, or other factors which are justified in the opinion of the insurer within 180 days of the accident, complete details of the required services from the dentist and reason for deferment.
- k. An allowance of up to \$500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.
- l. Up to \$3,000 Canadian towards the cost of preparation and homeward transportation of the deceased (excluding the cost of a coffin) to the point of departure in Canada by the most direct route in the event of the insured person's death.
- m. Up to \$700 Canadian (\$100 per day for seven days) per trip for extra costs of commercial accommodation and meals incurred by the insured person, or by an insured dependent remaining with you or a traveling companion. This must be verified by the attending physician and supported with receipts from commercial organizations.
- n. Return economy fare by the most direct route for transportation costs (air, bus, train) when the insured person has been confined to hospital for seven days or more, or has died and the attending physician has advised the necessary attendance of a family member or close friend.
- o. The services of a 24-hour emergency hotline are available to insured persons who need assistance while traveling. By telephoning the appropriate number shown on your Identification Card "Voyage Assistance" when a medical emergency occurs, coverage will be confirmed to the hospital or physician. **Payment of medical expenses will be arranged or co-ordinated on behalf of the insured person.**
- p. The patient may call for a list of hospitals or medical facilities and arrangements will be made for:
- o advice from a qualified physician;
 - o medical follow-up of the patient's condition and communication with the insured person's family;
 - o return home or transfer of patient if medically permissible; and
 - o transportation of a family member to the patient's bedside or to identify the deceased.
- q. The patient may call to obtain:
- o An emergency response in any major language;
 - o emergency assistance in contacting the family or business; and
 - o referral to legal counsel.

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Co-ordination of Benefits

Should similar benefits be provided by more than one section of the policy, any claim for these benefits will be assessed by insurance company in a manner which provides the greatest benefit to the participant.

Where compensation for benefits covered under this plan is available to a participant under any other prepaid health service contract or insurance policy, the amount payable under this plan shall be coordinated with such other coverages in accordance with the Canadian Life and Health Insurance Association (CLHIA) Guidelines so that the total benefits from all plans will not exceed the expenses actually incurred.

Effective April 1, 2010, Co-ordination of Benefits will be allowed between spouses insured under the Plan.

If the other plan does not contain a coordination of benefits provision, then that plan shall be considered first payer.

Limitations and Exclusions

No benefits are payable under the plan for expenses in connection with:

- Traveling outside the province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
- Elective (non-emergency) treatment or surgery;
- Benefits received from a third party;
- The abuse of medications, drugs or alcohol;
- Suicide or attempted suicide; and
- Criminal acts, wars or other hostilities.

The insurer, in consultation with the attending physician, reserves the right to return the patient to Canada. If any patient is (on medical evidence) able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the insured person elects to have such treatment or services rendered or surgery performed outside of Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan.

Coverage is available to all insured employees/retirees as long as they are insured under provincial Medicare programs.

Termination of Coverage

Your Group Health Insurance Coverage terminates on the earlier of termination of employment or on the attainment of age 75. Coverage may be continued during retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan.

Basic Group Life Insurance [top](#)

Life Insurance for Employee

You are insured for a life insurance benefit equal to two times your current annual salary for active employee's, and two times your current annual pension for retiree's up to age 65, rounded to the next higher \$1,000, if not already a multiple thereof, subject to a minimum of \$10,000 and a maximum of \$1,000,000.

Reduction Clause

In the event you have been insured under this program for a period of five consecutive years immediately prior to your 65th birthday, you may be eligible for a reduced paid-up life insurance policy on the first of the month following attainment of age 65 which will remain in force throughout your lifetime.

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Waiver of Premium

While insured under the plan, should you become disabled from engaging in your own occupation, your group life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death. At age 65, coverage reduces in accordance with the reduction clause.

Beneficiary Designation

In the event of your death, the group life insurance benefit is payable to the beneficiary(ies) you have appointed on your Group Enrollment Card.

Termination of Coverage

Your group life insurance terminates on the earlier of termination of employment or on the attainment of age 75.

Conversion Privilege

If your insurance reduces and/or terminates on or prior to age 65, you may be entitled to convert up to the cancelled amount of basic group life insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date, and no medical evidence of insurability would be required. The premium rate would be based on your age and class of risk at that time. For further information, please contact your Administrator.

Dependent Life Insurance [top](#)

Life Insurance for Dependents (Only applicable with Dependent Medical Coverage)

In the event of the death of your spouse or dependent child from any cause whatsoever while you are insured under the plan, the insurance company will pay you \$10,000 in respect of your spouse and \$5,000 in respect of each insured dependent child. (See page showing **Summary of Your Benefit Program** for definition of eligible dependents.)

Waiver of Premium

While insured under the plan, should you become disabled from engaging in your own occupation, your dependent life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death.

Termination of Coverage

Dependent life insurance coverage terminates upon termination of employment. In respect of dependent children, coverage terminates on the earlier of the date they are no longer eligible, as outlined in the Summary of Benefits, or on your attainment of age 75.

In the event of your death while insured under the plan, if your spouse qualifies for a pension from either the Public Service Pension plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan, insurance in respect of your spouse may be continued, at the spouse's option, until the spouse's 65th birthday.

Conversion Privilege

If your dependent life insurance terminates on or prior to your spouse having attained age 65, your spouse (does not apply to dependent children) may be entitled to convert up to the amount of dependent life insurance to an individual policy of the type then being offered by the insurer to conversion applicants within 31 days of termination, without submission of evidence of health. The premium rate will be determined from your spouse's age and class of risk at the time of conversion. For further information, please contact your Administrator.

Basic Accidental Death and Dismemberment Insurance [top](#)

The plan provides accidental death and dismemberment insurance coverage in an amount equal to your basic group life insurance (two times your current annual salary to a maximum of \$1,000,000). Coverage is provided 24 hours per day, anywhere in the world, for any accident resulting in death, dismemberment, paralysis, loss of use of, or loss of speech or hearing.

In order to be covered by this benefit, all losses must result directly and independently of all other causes from bodily injuries suffered by accidental, external and violent means. Death caused by accidental drowning shall also be covered. Death or loss must occur within 365 days from the date of the accident causing such loss. In the case of accidental death, the benefit will be paid to the beneficiary you have named to receive your group life insurance benefits.

The amount payable shall be the following percentage of the amount of Accidental Death and Dismemberment Insurance for which you are insured on the date of the injury. The maximum amount payable for all losses sustained as a result of the same accident shall not exceed 100% of the amount of insurance. Only one amount, the largest applicable, will be payable for injuries to the same limb resulting from any one accident.

- Loss of life - 100%
- Loss of both hands or both feet - 100%
- Loss of one hand and one foot - 100%
- Loss of the entire sight of both eyes - 100%
- Loss of one hand and the entire sight of one eye - 100%
- Loss of one foot and the entire sight of one eye - 100%
- Loss of use of both arms or both legs or both hands - 100%
- Loss of speech and loss of hearing in both ears - 100%
- Quadriplegia - 200%
- Paraplegia - 200%
- Hemiplegia - 200%
- Loss of or loss of use of one arm or one leg - 100%
- Loss of or loss of use of one hand or one foot - 100%
- Loss of the entire sight of one eye - 100%
- Loss of speech or loss of hearing in both ears - 100%
- Loss of thumb and index finger on one hand - 66 2/3%
- Loss of four fingers on one hand 66 2/3%
- Loss of hearing in one ear - 66 2/3%
- Loss of all the toes on one foot - 33 1/3%

Loss of a hand or foot means severance at or above the wrist or ankle joint but below the elbow or knee joint. Loss of an arm or leg means severance at or above the elbow or knee joint. Loss of a finger or thumb means severance at or above the metatarsophalangeal joint. Loss of a toe means severance at or above the phalangeal joint. Severance is defined as the permanent and complete detachment of the affected area.

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Loss of use means, with regard to arms, hands and legs, the total loss of ability to perform each and every action and service the arm, hand, or leg was able to perform before the accidental occurred. Loss of use must be total and irrecoverable and beyond remedy by surgical or other means.

Loss of entire sight means that it is total and irrecoverable. Loss of entire sight is also deemed to have occurred if sight cannot be restored to better than 20/20 vision by surgical or other means (i.e. spectacles).

Loss of speech means irrecoverable loss which does not allow audible communication through surgical or other means.

Loss of hearing means irrecoverable loss which cannot be corrected through surgical treatment, hearing aid or device.

Quadriplegia means total paralysis or both the upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on one side of the body. Paraplegia means total paralysis of both lower limbs.

Additional Benefits [top](#)

Exposure and Disappearance

Benefits are payable if, due to an accident, you are exposed to the elements and suffer an insured loss under the policy within 365 days of the accident.

The plan also will pay for a loss of life benefit if due to accidental wrecking, sinking or disappearance of a conveyance in which the insured is riding and the body is not found within 365 days of the accident and will be presumed dead after one year.

Air Travel Accidents

If you are traveling as a passenger or as a crew member in an aircraft properly licensed and flown by a pilot properly certified to fly such aircraft, you are entitled to the benefits described herein.

Repatriation Benefit

When injury results in your loss of life more than 50 kilometers from your normal place of residence and the death benefit becomes payable under the policy, the actual expenses incurred for the preparation and transportation of the body to the place of burial, in proximity to the normal place of residence, will be paid to a maximum of \$20,000 (excluding the cost of a coffin).

Rehabilitation Benefit

In the event you sustain an injury which results in a loss payable under the policy and such injury requires that you undergo special training in order to engage in an occupation in which you would not have engaged except for such injury, the reasonable and necessary expenses actually incurred by you for such training will be paid to a maximum of \$20,000 as a result of any one accident. No payment will be made for any expense incurred more than three years after the date of the accident, nor for room, board or other living, traveling or clothing expenses.

Education Benefit

In the event of your accidental death, the insurer will pay an education benefit for each dependent child enrolled in a school for a higher learning, or who enrolls in a school for higher learning within 365 days after your death. The benefit is equal to the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of your principal sum or \$5,000 for each year the dependent child continues their education on a full-time basis, not to exceed five consecutive years per child. Payment will not be made for room, board or other living, traveling or clothing expenses.

If you have no dependents eligible for the education benefit, the insurer shall pay an additional amount of \$1,000 to the designated beneficiary.

Benefits Plan Eastern School District

Spousal Retraining Benefit

In the event of your accidental death, the insurer will pay the reasonable and necessary expenses to a maximum of \$20,000 actually incurred by your spouse who engages in a formal occupational training program in order to become qualified for employment in an occupation for which they would not otherwise have sufficient qualifications. Payments will not be made for room, board or other living, traveling or clothing expenses.

Seat Belt Benefit

Benefits will be increased by 25% to a maximum of \$25,000 if your injury or death results while you were a passenger or driver of an automobile and your seat belt was properly fastened. Seat belt use must be certified by the investigating officer or verified on the official accident report.

In-Hospital Indemnity

The plan 1% of the benefit payable, up to \$2,500 per month, if you are hospitalized for at least four days as a result of injury occurring in a covered accident. The benefit is payable for a maximum of 12 months for confinement due to any one accident. This benefit is reduced by the amount by which this benefit, plus benefits payable under the Government of Newfoundland and Labrador optional long term disability insurance plan, exceed 100% of pre-disability net monthly earnings.

Benefit in the Event of Coma

In the event that you suffer an accidental injury which directly results in a state of coma, the benefit payable will be equal to 1% each month of the principal amount. The monthly benefit will be payable, while the state of coma exist, until the principal amount has been paid in full or until death, whichever occurs first. The benefit will be payable in your name with any remaining balance upon your death paid to the beneficiary named to receive your group life benefits.

Should any claim for a loss as provided in the Schedule of Benefits be paid for the same accidental injury, benefits payable in the event of subsequent coma will be based on the balance of the principal sum.

Coma or comatose means a state of completed and total unconsciousness which begins within 31 days of the injury and exists uninterrupted for 31 days before benefits become payable.

Family Travel

If an insured Employee suffers a loss covered under the accidental death and dismemberment provision and is hospital confined, or suffers from an illness or injury other than as specified in the schedule of losses which requires hospital confinement of at least four days, and such confinement occurs more than 100 kilometers from his normal place of residence, the plan will pay for the reasonable and necessary traveling expenses or one or more family members to the insured Employee's place of confinement. The total amount will be \$10,000 for hotel accommodation and transportation cost combined. If personal transportation is used in lieu of public conveyance, a rate of \$0.20 per kilometer will apply.

Day-Care Benefit

In the event accidental Loss of Life is sustained by an insured person and indemnity for such Loss becomes payable, the plan will pay the Day-Care Benefit below for each of the insured person's dependent children who:

1. are enrolled in a day-care centre on the date of such Loss; or
2. enroll in a legally licensed day-care centre within 365 days after the date of death of the insured Employee; and

The Day-Care Benefit is equal to the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of the insured person's Principal Sum or \$5,000, which maximum is in combination with the Day-Care Benefit maximum provided under any other policy issued to the Policy holder by the insurer, for each year the dependent child described above is enrolled in a legally licensed day-care, but not to exceed four years, which must run consecutively, with respect to any one dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally license day-care centre, but payment will not be made for expenses incurred prior to the death of the insured person, nor for room, board or other ordinary living, traveling or clothing expenses.

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In the event the insured person's dependent child does satisfy the requirement indicated above, the Day-Care Benefit will be payable to the surviving spouse if the spouse has custody of the child. If there is no surviving spouse or the child does not reside with the spouse, benefits payable under this provision will then be paid to the child's legally appointed guardian. If none of the insured person's dependent children satisfy the above requirements, the insurer will pay an amount of \$2,500 under one of the policies issued to the Policyholder by the insurer to the insured person's beneficiary.

"Day-Care Center" means a facility which is run according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a hospital, the child's home or care provided during normal school hours while a child is attending grades one through 12.

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

"Spouse" means

- a. the individual to whom the insured person is legally married, or
- b. the individual of the opposite/same sex with whom the insured person has continuously co-habitated for a minimum of one year immediately before a loss is incurred under the policy.

Only one individual will qualify as a spouse.

If the insured person is legally married but is also cohabiting with an individual of the opposite sex, the spouse will be the individual to whom the insured person is legally married.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity is payable in accordance with the terms of the policy, and he/she subsequently requires the use of a wheelchair to be ambulatory, the plan will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such loss for:

- a. the cost of alterations to the insured person's principal residence and/or
- b. the cost of modifications to one motor vehicle utilized by the insured person, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

The total of all expenses incurred by or for any insured person will not exceed \$20,000 in three (3) years as the result of any one accident, nor will this benefit be payable under more than one of the policies issued to the policyholder.

Waiver of Premium

While insured under the plan, should you become disabled from engaging in your own occupation, your accidental death and dismemberment insurance may be continued in force following four (4) months of continuous disability.

For the duration of such disability without further premium payment up to your attainment of age 65, recovery or death.

Termination of Coverage

Your accidental death and dismemberment insurance coverage terminates on the earlier of termination of employment or on the attainment of age 75. Coverage may be continued during early retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan, but not beyond your 65th Birthday.

Conversion Privilege

If your insurance reduces and /or terminates on or prior to age 65, you may be entitled to convert up to \$100,000 of basic accidental death and dismemberment insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date, and no medical evidence of insurability will be required. The premium rate will be based on your age and class of risk at that time. For further information, please contact your Administrator.

Exclusions

Benefits are not payable if loss results from or was associated with:

- suicide or self-destruction or any attempt thereat while sane or insane;
- declared or undeclared war, insurrection or participation in a riot;
- active full-time service in the armed forces of any country; and
- air travel in any aircraft not properly licensed or flown by a pilot not properly certified.

Benefits for Retired Employees [top](#)

If you are a retiree and are receiving benefits from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan and have elected to continue your group insurance benefit, you are eligible for benefits as outlined below.

Retirees under age 65

If you retire early and are in receipt of a pension from one of the pension plans outlined above, you will be given a one time option at your retirement date to continue your group insurance coverage, without evidence of good health.

If you elect to continue benefits, **all** basic group insurance benefits must be continued, i.e. group life, accidental death and dismemberment, dependent life, supplementary health and group travel insurance.

The level of benefits will be identical to those offered to active employees, with the exception of the basic group life and basic accidental death and dismemberment insurance benefits, which will each be two times your annual pension rounded to the next higher \$1,000, if not already a multiple thereof, subject to a minimum of \$10,000 and a maximum of \$1,000,000.

Premiums for the basic group insurance benefits will continue to be cost-shared 50/50 with the Government. You may also elect to continue optional dental care, optional group life and optional accidental death and dismemberment insurance during early retirement provided you pay 100% of the premiums. Optional long term disability insurance may not be continued.

Note: If you elect to continue your group insurance coverage during early retirement, a **Continuation of Coverage Form** must be completed and given to your Administrator **prior to your retirement or last day worked**.

If you elect a deferred pension, no benefits are available other than those continued through the conversion during the period of deferment. A continuation form must be completed prior to leaving your place of employment for benefits to commence when you are eligible to receive pension.

Retirees over Age 65

In the event you have been insured under this program for a period of five consecutive years immediately prior to your 65th birthday, you can be eligible for a reduced insurance policy with no further premium payment on the first of the month following attainment of age 65, which will remain in force throughout your lifetime.

Benefits Plan Eastern School District

You are also eligible to continue your supplementary health and group travel insurance plans on a 50/50 cost-shared basis. The supplementary health and group travel insurance plans are identical to those offered to active employees. Dental insurance may also be continued during retirement.

In the event of your death, your surviving spouse, who on the date of your death was insured under the plan, will be given the option of continuing in the group health insurance program if in receipt of a survivor pension.

Pensioners should note that certain provisions may vary; however, any questions should be forwarded to:

Insurance Division
Department of Finance
P. O. Box 8700
Confederation Building, East Block
St. John's, NF A1B 4J6
Telephone: (709) 729-0511
Fax: (709) 729-2156

Note: In all correspondence, please indicate your name, address and Identification Number.

Optional Dental Care Insurance [top](#)

Dental care insurance is available to all active and retired employees and their eligible dependents (see **Summary of Your Benefit Program**) on an optional and employee-pay-all basis. In order to be insured for this benefit, you must also be insured under the basic group insurance program.

Coverage will be based on the 2008 Newfoundland and Labrador Dental Association Fee Guide for general practitioners and specialists in accordance with the following:

Basic Benefits

Eligible expenses will be reimbursed at 80%; there is no annual or overall maximum applicable.

Diagnostic Services

- Clinical oral examinations (one recall examination every *calendar year* for adults; every five months for a dependent child age 17 or less)
- X-ray examinations - full mouth or panoramic films (one set of each in a *calendar year*) single films (up to ten), occlusal, posterior bitewing or extraoral films (four of each type in five months); and
- Tests, laboratory examinations and treatment planning.

Preventative Services

Cleaning and polishing, fluoride treatments (once a *calendar year* for adults; every five months for a dependent child age 17 or less) nutritional counseling, oral hygiene instruction, pit and fissure sealants, space maintainers and protective athletic appliances (one in 12 months).

Restorative Services

Fillings, recementing inlays and crowns, removal of inlays and crowns and cement restorations.

Endodontic Services

Diagnosis and treatment of the pulp (nerve) and tissue which supports the end of the root, root canal therapy and emergency procedures.

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Periodontic Services

Diagnosis and treatment of disease which affects the supporting tissue of the teeth, such as the gums and bones surrounding the teeth.

Prosthodontic Services - Removable

Denture repairs, denture rebasing and relining (once in 24 months) and tissue conditioning.

Surgical Services

Extraction of teeth

Adjunctive General Services

Emergency treatment of pain, local anaesthetic or conscious sedation and consultation with another dentist.

Major Restorative Benefits

Eligible expenses will be reimbursed at 70% to a maximum of \$1,250.00 per insured person per calendar year.

Extensive Restoratives

Major repairs and restorations, including inlays, onlays and crowns

Prosthodontic Services

Complete dentures, partial dentures, denture adjustments and repairs, pontics, retainers, abutments, crowns and fixed bridges.

This program excludes:

- replacement of the denture, unless it is at least five years old and cannot be made serviceable; and
- the replacement of dentures that have been lost, mislaid or stolen.

Major Surgical Procedures

Surgical exposure of the tooth, surgical repositioning or transplantation, cutting of bone to aid in removal of teeth or to permit insertion of a denture, surgical shaping of gum or tissue in order to support teeth and treatment of tumors and cysts.

Note

If you do not apply for optional dental coverage within 31 days of being eligible, you will be considered a late applicant.

Late applicants, provided they are not eligible for coverage under their spouse's dental program, will be limited to an eligible expense of \$100.00 per individual during the first 12 months of coverage.

Termination of Coverage

Your dental insurance coverage terminates on the termination of employment. Coverage may be continued during early retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly.

Optional Long Term Disability Insurance [top](#)

In order to be insured under this benefit, you must also be insured under the basic group insurance program and be a member of either the Public Service Pension Plan, Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan.

This plan is intended to provide a level of income while you are unable to work due to total disability resulting from

Benefits Plan Eastern School District

accident or illness which continues beyond the elimination period of 119 consecutive days. At your option, the elimination period may be extended to the expiration of accumulated sick leave (maximum accumulation 480 days). Benefits are payable through to your recovery, attainment of age 65 or death, whichever occurs first. Regular medical examinations and reports are required throughout your entire period of disability.

Benefits Payable

The monthly income benefit payable will be 66 2/3% of your regular monthly salary at the date of disability, to a maximum monthly benefit of \$2,500 on a non-taxable basis.

Definition of Disability

Benefits are payable for the first 12 months **following initial receipt of benefits** if sickness or accident prevents you from doing your own job. You will be considered disabled if there is no combination of duties you can perform that regularly took at least 60% of your time at work to complete.

After 12 months, benefits continue to be payable if disease or injury prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications and which provides you with an income of at least 50% of your pre-disability monthly earnings, adjusted for inflation. The availability of work will not be considered in assessing disability.

Recurrence of Disability

Effective April 1, 2004 the recurrent disability provision will read as follows:

Successive periods of Total Disability occurring while this benefit is in force will be considered to be one period of Total Disability if :

- They result from the same or related causes, and are separated by an interval of less than six months during which the employee was actively at work on a full time basis, or
- They result from entirely unrelated causes, unless they are separated by an interval during which the employee was actively at work on a full time basis.

If a period of total disability is considered under this provision to be a continuation of a previous Total Disability, then benefits will be resumed based on the original benefit period and for the same amount of monthly benefit, but without the application of another elimination period.

Rehabilitation

Provision has been made in the plan to assist you in undertaking rehabilitative employment, however, it is necessary to have the approval of the insurance company prior to commencing rehabilitative employment. The plan allows you to receive increased income in connection with work performed in an approved rehabilitative program, in that your long term disability benefit will be reduced by only the amount of your rehabilitative earnings and other income as outlined below exceed 100% of your pre-disability net earnings.

Benefit Reduction

Your monthly long term disability benefit will be directly reduced by any amount payable under:

- Workers' Compensation
- Canada Pension Plan (excluding any payments for your dependents); or
- Pension benefits from the Public Service Pension Plan, Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan payable due to the disability. **Benefits are automatically assumed to commence after 12 months of disability unless written notice of proof is received confirming benefits were denied.**

Long term disability benefits will only be further reduced if your total disability income from all sources, as outlined below, exceeds 85% of your net income at the date of disability.

- Canada Pension Plan dependent benefits;
- Disability benefits through employment or from a group insurance or association plan; and

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- Payments from Government plans except those being received prior to effective date of insurance.

Cost of living increases in Canada Pension Plan benefits that take effect after you qualify for benefits are not included as "other income" when your long term disability benefit is calculated.

Termination of Coverage

Long term disability insurance coverage terminates on your attainment of age 65, termination of employment, or the date you cease to be in an eligible classification, whichever is earlier. **If you are granted a leave of absence or are on seasonal lay-off, you may continue long term disability insurance for one (1) month from your last day worked.**

General Limitations and Exclusions

- No benefits will be payable for disability periods that begin before your insurance starts or after it ends.
- Benefits will not be paid for any period in which you do not participate and co-operate in a reasonable and customary treatment program. If your disability involves a psychiatric disorder, the treatment program must be supervised by a Psychiatrist. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program. Substance abuse includes alcoholism or drug addiction.
- No benefits will be paid if you fail to participate or co-operate in a recommended or approved rehabilitation program.
- No benefits will be paid during any period for which Employment Insurance maternity benefits are paid.
- No benefits will be paid if disability arises from attempted suicide or intentionally self-inflicted injury while sane or insane.
- No benefits will be paid if the disability arises from active service in the armed forces of any country or in any civilian non-combatant unit that serves with the forces in combat.
- Disabilities arising from war, insurrection, or voluntary participation in a riot are not covered. Benefits will not be paid for any period of confinement in a prison, nor will they be paid for any 12 month period in which the disabled employee does not reside in Canada for at least six of the twelve months.
- **If you have received medical care or have taken drugs prior to the effective date of insurance, you will not be covered for that medical condition until you have completed 90 days from the effective date of coverage without any recurrence of medical treatment or taken prescribed drugs for that medical condition. Medical care is considered to be obtained when you consult a doctor, use medication on the advice of a doctor, or receive other medical services or supplies. This limitation expires on the date two years after your effective date of coverage.**

Conversion Privilege

Should your insurance terminate on or before the attainment of age 65, you may be eligible to convert the terminated amount to an individual disability income policy without medical evidence subject to the following conditions:

- your insurance terminates at the end of a rehabilitation program that requires you to change employers;
- you start employment with another employer during the rehabilitation program or within six months after its end;
- you apply for conversion in writing within 31 days after your insurance terminates, if you are then employed. If you are not employed, your application must be made within 31 days after employment

starts; and

- your application must be acceptable in accordance with the insurer's underwriting rules for individual disability insurance other than medical evidence and length of employment rules.

The individual policy of the type then being offered by the insurer to conversion applicants. Coverage will be effective on the date the insurer approves the application provided the first premium has been paid.

Optional Group Life Insurance [top](#)

In order to be insured under this benefit, you must also be insured under the basic group life insurance program.

Amount of Insurance

Your basic group life insurance covers you for two times your current salary. However, additional group life insurance is available over and above what you are covered for under the basic plan. You may apply to purchase, on behalf of your self and/or your spouse, additional group life insurance from \$10,000 up to \$300,000 in units of \$10,000. You pay the full cost of this additional coverage. For new employees, up to \$100,000 is available without medical evidence of insurability if applied for within 31 days of your employment date.

Payment of Benefits

You and/or your spouse are covered 24 hours a day and benefits are paid as the result of death from any cause whatsoever.

Beneficiary Designation

You may appoint any beneficiary(ies) to receive the benefits you have selected. You are automatically the beneficiary of any coverage selected for your spouse.

Waiver of Premium

While insured under the plan, should you become disabled from engaging in your own occupation, your optional group life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death.

Termination of Coverage

You and/or your spouse's coverage terminates on the earlier of your termination of employment or you/your spouse's attainment of age 75. Coverage may be continued during early retirement but not beyond your 65th birthday.

Conversion Privilege

If insurance terminates on or prior to age 65, you and/or your spouse may be entitled to convert the amount of optional group life insurance within 31 days of this date, without submission of evidence of health. The premium rate will be determined from your and/or your spouse's age and class of risk at the time of conversion. For further information please contact your Administrator.

Applying for Coverage

Employee

For new employees, the first \$100,000 of optional group life insurance coverage is available without medical evidence if applied for within 31 days of becoming eligible. If the employee selects an amount of insurance over \$100,000 an evidence of insurability form must be completed.

Spouse

Employees may select coverage for their spouse up to \$100,000 upon the spouse signing a declaration of good health form. For amounts in excess of \$100,000 an evidence of insurability form must be completed. If the spouse

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is not in good health evidence of insurability must be completed for all amounts of insurance. The completed forms must be forwarded to your Administrator for forwarding to the insurance company.

Effective Date of Insurance

For new employees only, the first \$100,000 of optional life insurance becomes effective on the date the application is received by your employer but, in no event prior to the commencement of active, regular employment. Optional Group Life Insurance coverage in excess of \$100,000 and all amounts for the spouse of an employee will not become effective until the application has been approved by the insurance company. If additional medical information is required, you will be notified accordingly.

Optional Accidental Death and Dismemberment Insurance [top](#)

Amount of Insurance

In order to be insured under this benefit, you must also be insured under the basic group life insurance program.

This plan provides additional accidental death and dismemberment insurance for you, your spouse and dependent children, if desired, on an employee-pay-all basis. You are covered 24 hours a day, 365 days a year, on or off the job, while traveling or at home.

You may select coverage for yourself or yourself and your family by choosing one of the following plans:

- **Employee Only Plan**

You may purchase, in units of \$10,000, any amount of coverage between \$10,000 and \$300,000.

- **Family Plan**

You may elect to insure your family under the following plan:

Your spouse is insured for 40% of the benefit which you have selected and each dependent child is insured for 5% of the selected amount.

Where there are no dependent children, the spouse is automatically insured for 50% of the benefit selected. Where there is no spouse, each dependent child will be covered for 10% of your benefit. (Refer to the Benefit Summary for definition of eligible dependents.)

Payment of Benefits

Benefits are payable for injuries or death sustained in an accident occurring while the policy is in force, which results in a loss within 365 days of the accident. Benefits are payable as a percentage of the principal sum in accordance with the schedule applicable to the basic accidental death and dismemberment insurance plan.

Beneficiary Designation

Your loss of life benefit will be paid to the beneficiary(ies) you have named on your Group Enrollment Card. All other benefits for you, your spouse and dependent children will be paid to you.

Waiver of Premium

While insured under the plan, should you become disabled from engaging in any occupation for which you are, or may become qualified, by education, training or experience, your optional accidental death and dismemberment insurance may be continued in force following six months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death.

Termination of Coverage

Your optional accidental death and dismemberment insurance coverage terminates on the earlier of termination of employment or on your attainment of age 75. Coverage may be continued during early retirement but not beyond your 65th birthday.

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Conversion Privilege

If your insurance reduces and/or terminates on or prior to age 65, you may be entitled to convert up to \$100,000 of optional accidental death and dismemberment insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date and no medical evidence of insurability would be required. The premium rate would be based on your age and class of risk at that time. For further information, please contact your Administrator.

Additional Benefits

The following benefits are covered in addition to the benefits provided under the basic accidental death and dismemberment policy.

Common Disaster Benefit

In the event that you and your insured spouse both suffer loss of life due to injury sustained in the same accident, the principal sum applicable to your insured spouse will be increased to equal the principal sum applicable to you. Both deaths must occur within 90 days of the date of the accident.

Extended Family Benefit

If an insured employee suffers loss of life for which benefits are payable under the schedule of benefits in this policy, the insurance which is in force for the insured spouse and dependents will be continued for a period of six months without payment of premium.

Escalation Benefit

An increase in the Employee's Principal sum of 3% per year with maximum of 15% will be applied on each and every anniversary date of the policy, up to a maximum of five years, provided the policy remains in effect. The amount of such increase shall not form part of the employee's principal sum for the purpose of calculating subsequent increases under this provision.

Exclusions

The exclusions applicable to the basic accidental death and dismemberment insurance plan also apply to the optional plan.

Applying for Coverage

You may elect coverage for yourself, or yourself and your family by indicating on your Group Enrollment Card the plan selected and the amount of coverage you want. Your coverage becomes effective on the date the application is received by your employer but in no event prior to the commencement of active, regular employment.

Open Enrollment Period

If an Employee chooses not to take advantage of this benefit provision within 31 days of the date of eligibility, an opportunity to enroll or increase present coverage in this plan is provided once every two years during an open enrollment period. The date of the open enrollment period is selected by the policyholder and agreed upon by the company.

Optional Critical Illness Insurance [top](#)

Critical Illness is available to all active employees (under age 65) and their eligible dependents on an optional and employee-pay-all basis. In order to be insured under this benefit, you must also be insured under the basic group insurance program.

Amount of Insurance

You may apply to purchase optional Critical Illness insurance, a benefit which pays a lump sum cash payment to cover you and/or your family in the event a Critical Condition strikes and you are saddled with a long recovery period and unexpected expenses. The benefit payable is:

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Insured Person Cash	Payment
Employee	\$25,000
Spouse	\$10,000
Dependent	\$ 5,000

Payment of Benefits

Critical Illness is a living benefit, which means the covered person must survive the onset of the critical condition for a period of 30 days before the benefit will be paid. At the end of this 30-day period, the covered person must still meet the definition of the critical condition.

Definition of Critical Condition

An illness or disease whereby you are unable to perform 3 of the 5 Activities of Daily Living.

Activities of Daily Living

The five Activities of Daily Living that a person would normally perform without assistance are:

Eating: manipulating prepared food or liquid into the mouth.

Dressing: putting on and removing necessary articles of clothing that are normally worn, including leg braces.

Bathing: the ability to cleanse the entire body using soap and water; including turning on faucets and shower mechanisms, getting into and out of the bath itself and drying oneself off.

Ambulation: the ability to move independently from place to place with or without the use of equipment.

Toileting: the ability to use a toilet, bedside commode or urinal.

Covered Critical Conditions

The following critical conditions are covered under Critical Illness. All conditions with the exception of burns, must be the result of illness or disease. Conditions resulting from an accident (except in the case of burns) will not be eligible for coverage.

Alzheimer's disease: Unequivocal diagnosis by a specialist. Loss of cognitive function must be to a degree that warrants supervision on a daily basis.

Blindness: Permanent and uncorrectable loss of sight from both eyes as determined through vision acuity testing and according to set degrees of severity.

Burns: Third-degree burns covering at least 20 per cent of the body.

Coma: State of unconsciousness with no reaction to external stimuli and the requirement of life support systems.

Deafness: Permanent and uncorrectable functional deafness as determined by a specialist.

Heart transplant: Medically-necessary heart transplant from a donor to the insured person.

Kidney failure or transplant: End-Stage renal disease requiring permanent, regular dialysis or kidney transplantation.

Life-threatening cancer: A malignant tumor characterized by uncontrollable growth and spread of malignant cells (including Leukemia) which is likely to result in death within 24 months.

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Liver failure or transplant: End-stage liver failure with permanent jaundice, encephalopathy and ascites, or liver transplantation.

Loss of speech: Complete, permanent and uncorrectable loss of speech.

Lung Failure or transplant: End-stage lung disease requiring permanent oxygen therapy. The condition must meet set degrees of severity according to a respiratory specialist, or require lung transplantation.

Motor neuron disease: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Multiple Sclerosis: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Paralysis: Total and permanent loss of use of two or more limbs.

Parkinson's disease: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Senile dementia: Unequivocal diagnosis by a specialist. The degree of severity must require daily supervision for the insured person.

Severe heart attack: The death of heart muscle to a degree of severity of at least Class 4 of the Canadian Cardiovascular Society's classification of cardiac impairment.

Severe stroke: Significant, permanent neurological impairment as determined by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Applying for Coverage

You may apply at any time and provide Evidence of Insurability to the insurance company. Coverage is not effective until approved.

One Year Waiver of Premium

While insured under this plan, should you become totally disabled from engaging in any occupation as a result of accident or sickness, prior to attaining age 65 and you remain so disabled for at least six consecutive months, your Critical Illness Insurance may be continued in force for One Year from the date last worked.

Termination of Coverage

Life-Link insurance terminates on your attainment of age 65 or termination from active employment, whichever is earlier.

General Limitations and Exclusions

Critical Conditions benefits are not payable for any condition due to or resulting, directly or indirectly, from any of the following:

- An accident, except for severe burns.
- Self-inflicted injury or sickness, while sane or insane. Insurrection, war (declared or not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion.
- Driving a vehicle when the blood of the insured person contained in excess of 80 milligrams of alcohol per 100 millilitres of blood. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat).
- Committing or attempting to commit a criminal offense, or provoking an assault.

How to Submit your Claims [top](#)

Basic Group Life, Dependent Life, Optional Life, Basic and Optional Accidental Death and Dismemberment Insurance

Life, dismemberment or loss of use claims:

Your Group Administrator will co-ordinate claim forms and advise procedures.

Waiver of Premium:

- Notice of Disability/Sickness should be provided to your Group Administrator no later than 2 months from your last day worked.
- Once the Group Administrator and the Carrier have been notified, all forms for application of benefit will be sent to you for completion. Please return these forms to your Group Administrator.

Optional Long Term Disability Insurance

- If you are participating in the long term disability insurance plan and it appears that you will be off work for a period of more than 119 days, you should obtain the appropriate claim forms (**Early Notice Form and Proof of Claim**) **within 2 months from last day worked** from your Administrator. Upon completion, all forms must be returned to your Group Administrator.

Notice and Proof of Claims

1. Notice of Claim

To permit prompt assessment of Waiver of Premium and Long Term Disability Benefits and early participation in rehabilitation programs, written notice of claim must be received by the insurance company (**Early Notice Form**) within ten (10) months from the last day worked.

It is recommended that the Notice of Claim (Early Notice Form) be completed within two (2) months from the last day worked and forward to the insurance company.

Failure to furnish such notice within the time required shall not invalidate nor reduce any claim, if it is not reasonably possible to furnish the notice within such time, provided the notice is given as soon as is reasonably possible.

2. Proof of Claim:

Long Term Disability benefits under this Policy will only be payable for periods for which the insurance company has received satisfactory proof that the Employee is entitled to benefits.

The claimant must provide information required to prove the Employee's entitlement to benefits and must also authorize the insurance company to obtain information from other sources for this purpose. Proof of claim must be submitted within six (6) months of receipt of the notice of claim; thereafter, whenever the company requests information or authorization, it must be submitted within six (6) months.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claims, if it is not reasonably possible to furnish the proof within such time, provided the proof is given as soon as is reasonably possible.

Written proof of disability will not be accepted if received by the insurance company more than ten months after the date of disability, or more than six months after termination of the policy. Please note that even if benefits are payable from Workers' Compensation, which may totally offset the long term disability benefit, a notice of disability should be submitted for long term disability benefits within the specified time period.

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Optional Critical Illness

Your Group Administrator will co-ordinate claim forms and advise procedures

Supplementary Health Insurance

Hospital Insurance:

- Present your identification card upon admission to hospital.
- The hospital will forward your claim directly to the Insurance Company Benefit Payments Office for payment of eligible expenses.

Prescription Drugs:

- Present your identification card to the pharmacist when purchasing eligible drugs.
- You pay the pharmacist's professional fee and any applicable surcharge while the cost of the eligible ingredient is payable under this program.
- For any prescription drug requiring Special Authorization, please refer to the section titled "**Special Authorization**" in this booklet.

Vision Care:

- Obtain a Claims Submission form from your Group Administrator.
- Obtain a completed Vision Care Claim form from the provider of service (i.e. Optometrist and Optician).
- Complete the Claims Submission form, attach a paid-in-full receipt and the completed Vision Care Claim form, and forward to the Insurance Company Benefits Payments Office.

Extended Health:

- Obtain a Claims Submission form from your Group Administrator.
- Attach a paid-in-full receipt which shows:
 - Patient's name,
 - Date and nature of treatment, and
 - Complete itemization of charges.
- Forward the above items to the Insurance Company Benefits Payments Office.

The address of the Desjardins Financial Benefits Payment Office is:

**430 Topsail Road (Village Shopping Centre)
P. O. Box 97
St. John's, Newfoundland
A1E 4N1
Telephone: 1-877-838-7763
Fax: (709) 747-8476**

Note:

All claims must be submitted to the insurance company as soon as reasonably possible but not later than **one** year after the date the claim was incurred.