Chambers of Commerce Group Insurance Plan®

Redd on
May 2012

# GROUP INSURANCE BENEFIT GUIDE

For
**KEKINOW NATIVE HOUSING SOCIETY**

A member of
**CLOVERDALE DISTRICT CHAMBER**

This Firm Benefit Guide has been prepared to give you an informal summary of the main features of your group insurance program.

This booklet is not an insurance policy, and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policies issued to the Chamber Insurance Corporation of Canada, by Desjardins Financial Security, ACE INA Insurance and Western Life Assurance Company.

**BENEFIT SUMMARY FOR**
KEKINOW NATIVE HOUSING SOCIETY

Benefits currently held by the firm:

**EMPLOYEE LIFE INSURANCE (Option: 1X)**
One Times Annual Earnings

**ACCIDENTAL DEATH & DISMEMBERMENT (Option: 1X)**
One Times Annual Earnings

**LONG TERM DISABILITY (Option: L1)**
Benefits from the 121st day of disability for up to 2 years. "Disability" means employees are unable to perform all regular duties of their own job during the first 24 months.

**LONG TERM DISABILITY (Option: L3)**
Benefits from the 121st day of disability up to age 65. "Disability" means employees are unable to perform all regular duties of their own job during the first 24 months, then unable to perform any gainful job they could become qualified to do.

**EXTENDED HEALTH (Option: E17)**
80% coverage of prescription drugs listed on the ASSURE National Formulary
50% coverage of prescription drugs NOT listed on the ASSURE National Formulary
100% coverage of all other eligible benefits

Prescription drug benefits are paid using the ASSURE drug card system and have a $50,000 / person / calendar year maximum.

**DENTAL (Option: D5)**
$0 deductible
80% coverage of Basic services
80% coverage of Endodontic and Periodontal procedures
Benefit Maximum of $1,500 per person per calendar year

## GROUP LIFE

### Insurance Amount
The amount of employees' coverage is shown on their *Certificates of Insurance*. This is called the face amount.

Life insurance coverage decreases to 25% of the face amount on the Policy Anniversary (April 1) on or after an employee's 65th birthday.

### Benefit
Group Life provides 24-hour coverage of death at any time or place, from any cause.

If an employee's insurance ends and the employee dies within 31 days, benefits are payable equal to the amount of life insurance the employee was entitled to under the Conversion Option.

### Beneficiary
A beneficiary is the person assigned to receive the Group Life benefit in the event of an employee's death. If there is no living beneficiary when an employee dies, the life insurance proceeds are payable to the employee's estate.

Life insurance benefits are not taxable. However, the beneficiary or the estate is responsible for tax on any interest which accrues on the benefit, from the date of the employee's death to the date the funds are paid by the Insurance Company.

### Change of Beneficiary
Employees can change the beneficiary at any time, subject to any limits set by law. To do so, they complete an *Employee Change Request* and mail the completed request to the Plan Administrator.

### Waiver of Premium
Employees who become totally disabled before age 65 and while insured for this benefit keep this life insurance coverage as long as they remain disabled. This is subject to any reduction in face amount of age limit under *Insurance Amount*. After 6 months of continuous, total disability, and on approval from the Insurance Company, no further life insurance premiums are required. Partial disability does not qualify the employee for any waiver of premium.

To be considered totally disabled, the employee must be unable, as a result of sickness or injury, to engage in any gainful occupation for which he or she is or may become reasonably qualified by training, education, or experience. Proof of continuous total disability will be required periodically.

### Claims
A completed claim form must be submitted to the Plan Administrator within 90 days of death. Before settling any claim, written proof of the occurrence, cause and circumstances of the death will be required. Written proof means a completed claim form accompanied by either an original funeral director's statement or original death certificate. Notarized copies of the funeral director's statement or death certificate will be accepted if originals can not be submitted.

### Living Benefit
A terminally ill employee may request an advance of life insurance benefits equal to the lesser of $25,000 or 50% of the face amount. The employee must provide satisfactory evidence to the Insurance Company that death will most likely occur within 12 months, be totally disabled for at least six months and be approved for Life *Waiver of Premium*. The employer and any designated beneficiary must consent to the payment. At the employee's death the advanced funds plus interest are deducted from the face amount.

**Termination**
Insurance for the employee will terminate on the Plan Anniversary Date following the employee's 75th birthday.

**Conversion Option**
Life insurance ends 31 days after the date of termination of coverage. An employee under the age of 66 may apply to the Insurance Company to convert the group life coverage to an individual policy including level term to age 65, 1 year non-renewable term or ordinary life coverages. No medical evidence is required as long as written application is submitted and the first premium is paid within 31 days of the date of termination. If the employee is converting this insurance due to the firm's termination, the firm must have been insured continuously with this plan for five years prior to termination.

**Extension of Benefit**
If an employee dies within 31 days of the termination of the insurance under this benefit, the amount of life insurance the employee was eligible to convert will be payable.

*All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.*

## BEST DOCTORS

When you're faced with a serious illness or injury, managing your medical care can be a daunting task. There are so many details to coordinate, treatment options to consider, and decisions to make. A health crisis presents countless choices, and you want to feel confident you're making the right ones. With help from Best Doctors, you can make informed, effective decisions.

As long as you are insured under the Chambers of Commerce Group Insurance Plan, you and your dependents will have unlimited access to Best Doctor services if you and your own physician suspect any of the following conditions:

**AIDS, Alzheimer's Disease,**
**Blindness, Benign Brain Tumour,**
**Cancer, Cardiovascular Conditions, Coma,**
**Deafness, Kidney Failure, Loss of Speech,**
**Major Organ Transplant, Major Trauma, Motor Neuron Disease (ALS, Lou Gehrig's),**
**Multiple Sclerosis, Paralysis, Parkinson's Disease,**
**Severe Burns, and Stroke.**

Best Doctors supports you with three outstanding services:

**InterConsultation*** offers a comprehensive review of your medical files to help develop or confirm your diagnosis and identify the course of treatment currently recognized as most effective by the international medical community. You and your physician will receive an *InterConsultation Report* with the diagnosis and treatment protocols. Your own physician then has access to Best Doctors for further consultation on your case.

**FindBestDoc*** offers a customized search of a global database to identify specialists near the location of your choice.

**FindBestCare*** helps you access healthcare and specialized treatment centres near your home, in the country or, if need be, around the world.

** Best Doctors services are available without charge to all Chambers Plan insured employees and their dependents. Employees are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.*

### ACCESSING BEST DOCTORS SERVICES

If you suspect you have one of the covered conditions, contact Best Doctors at **1-888-362-8677**. Please have your Firm and Certificate numbers ready to identify yourself as a Chambers of Commerce Group Insurance Plan member. When you contact Best Doctors you will be assigned a Personal Advocate, a dedicated nurse linking you to the doctors reviewing your case. Your Advocate will keep you informed about their progress and answer your questions.

### INTERCONSULTATION "Problem Solver"

InterConsultation is an in-depth review of your medical files. The service is designed with two purposes in mind: to reduce the possibility of complications from any misdiagnosis, and help your physician determine your course of treatment.

- You'll need to complete a *Release of Medical Information* authorization form in order to start this service. Best Doctors will gather all your medical records on your behalf. Your Personal Advocate will help you throughout the whole process.

- Once Best Doctors receives your complete medical records, your case will be reviewed by a round table of experts affiliated with Harvard Medical School. This team of renowned physicians will create a profile of your case's key issues, ensure all the pertinent questions have been asked about your condition, and define the type of expert (by specialty and focus) needed for your custom consultation.

- Based on the round table's findings, Best Doctors will contact the world leading expert(s) for your medical condition about your case. You will receive an InterConsultation Report that identifies the diagnosis, outlines the most effective treatment protocols, and gives your local treating physician access to Best Doctors for further consultation.

- The entire InterConsultation process typically takes 7 to 10 days but may require an additional 2 weeks if further medical tests are needed.

*Interconsultation* is the most utilized service in the program as it can confirm your diagnosis, and helps your treating physician determine the best treatment plan for your condition. In addition, Best Doctors offers the following services.

**FINDBESTDOC "Physician Locator"**
Best Doctors can provide you with a list of surgeons, other specialists and facilities that have the experience to treat your condition.

- A Best Doctors nurse will conduct a search for experts based on your geographic preference. The Best Doctors global database will provide a list of appropriate Best Doctors physicians.

- 3 to 5 business days after your initial request, you will receive a FindBestDoc report. It will include the specialist's professional background, availability, and the information required to see a doctor. Details of the doctors and facilities are taken from Best Doctors database of 50,000 medical specialists throughout the world.

- If you select a Best Doctors physician in Canada, Best Doctors provides the report to your General Practitioner for referral, upon your request. If you select a physician outside of Canada, Best Doctors coordinates all the arrangements.

**FINDBESTCARE "Access Vehicle"**
If you choose to travel from home to receive treatment, Best Doctors will assist with reservations and accommodations for you and your family. Your Best Doctors Personal Advocate will also provide you with a list of recommended facilities and an estimated cost of treatment.

- **You chose where to go.** Please remember that you must meet your own costs of travel and lodging plus any medical expenses not covered by your provincial or other health care plans. Your use of FindBestCare is conditional on your ability to pay for all such expenses.

- A Best Doctors Personal Advocate will coordinate all medical appointments and a travel itinerary for you. You'll receive travel and medical appointment confirmations as well as a patient welcome kit prior to departure.

- FindBestCare includes even broader personalized services for you and your family if you travel outside Canada for care. Best Doctors will arrange for access to identified medical centres, hospital estimates, pre-admission arrangements, medical appointments, interpreter services, and coordination of enquiries.

- Upon your arrival at the treatment city, a Best Doctors Personal Advocate will contact you and get you ready for the medical appointment, then monitor and coordinate your care with the appropriate physicians. Best Doctors will review relevant information provided by the medical specialists involved in your case and will monitor the treatment process to ensure your medical priorities are being met.

**In healthcare, knowledge saves lives and knowledge is at the core of Best Doctors services. That's why your coverage includes services offered by Best Doctors with its extensive network of over 50,000 doctors, each recognized by peers as a leader. With access to the best medical expertise available today, you are empowered to address your health concerns. Contact Best Doctors toll-free,**

24 hours a day, 7 days a week

**1-888-362-8677**

## GROUP ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

You are automatically covered for a Principal Sum equal to the amount of insurance shown on your *Certificate of Insurance*. Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents. Your coverage is in force around-the-clock - at work, at home or at play, anywhere in the world.

### Beneficiary Designation

For your accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation then the benefit will be paid to your estate. All other benefits will be payable to you.

### Benefits and Coverages

### Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

**Principal Sum for Loss of:**

Life
Both arms
Both legs
Both hands
Both feet
Entire sight of both eyes
One hand and one foot
One hand and the entire sight of one eye
One foot and the entire sight of one eye
One arm
One leg
One hand
One foot
The entire sight of one eye
Speech and hearing
Speech or hearing

**Half of the Principal Sum for Loss of:**

Hearing in one ear

**One-third of the Principal Sum for Loss of:**

Thumb and index finger of the same hand
Four fingers of one hand

**One-quarter of the Principal Sum for Loss of:**

All toes of one foot

**Two Times the Principal Sum for Loss of Use of:**

Both arms
Both hands
Both legs
Both feet

**The Principal Sum for Loss of Use of:**

One arm and one leg
One hand and one foot
One hand and the entire sight of one eye
One foot and the entire sight of one eye
One arm
One leg
One hand
One foot

**One-Third the Principal Sum for Loss of use of:**

Thumb and index finger of the same hand
Four fingers of one hand

**Paralysis - Two times the Principal Sum up to a maximum of one million dollars:**

Quadriplegia (total paralysis of both upper and lower limbs)
Paraplegia (total paralysis of both lower limbs)
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

**Permanent and Total Disability Indemnity**

If you suffer injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable for the same loss. Permanent and Total Disability means as a result of an injury, you are unable to perform at least two of the *Activities of Daily Living* described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

*Activities of Daily Living are:*

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.

**Rehabilitation Benefit**

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within three years of and as a result of an injury for which you receive a benefit under the Plan.

**Home Alteration and Vehicle Modification Benefit**
Pays a benefit of up to the greater of $10,000 or 10% of the Principal Sum to a maximum of $50,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

**Workplace Modification and Accommodation Benefit**
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

**Psychological Therapy**
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

**In-Hospital Benefit**
Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

**Family Transportation**
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

**Repatriation Benefit**
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

**Identification Benefit**
Pays a benefit of up to $15,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

**Seat Belt Benefit**
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

**Day Care Benefit**
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a commercial and licensed day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

**Dependent Child Educational Benefit**
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $10,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years. If you do not have a Dependent Child eligible for this benefit, an amount of $1,500 will be paid to your beneficiary following your covered accidental death.

**Spousal Educational Benefit**
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

**Funeral Expense**
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

**Bereavement Benefit**
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require grief counselling within one year of the accident.

**Felonious Assault Benefit**
Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, other than an act of a fellow employee or a member of your family or household.

**Serious Illness Benefit (Non-Cancer)**
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:
- Major Burns (3rd degree)
- Multiple Sclerosis
- Necrotizing Fasciitis
- Parkinson's Disease
- Major Organ Failure Requiring Transplant
- Motor Neuron Disease
- Major Organ Transplant

You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This benefit is payable only once even if you are diagnosed with more than one covered serious illness.

**Coma Benefit**
Pays a monthly benefit of 1% of the difference between the Principal Sum and any other amount payable under the Plan in connection with the injury for up to 100 months, if you suffer an injury for which you receive a benefit under the Plan, and within 90 days of the date of the covered accident are disabled by coma which lasts for at least 6 consecutive months and is then determined by a physician to be permanent.

**Disfigurement Benefit**
If an Insured Person suffers Injury resulting in the destruction of his or her skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with Loss of fluid (3rd degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation, the Company will pay, up to $25,000 per Insured Person, based on a percentage of the Insured Person's Principal Sum, provided that the Insured Person survives for a period of at least 30 days after the date of the accident causing the burn. The Company will pay depending on the area of the body which is burned and determined in accordance with the table below.

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the Insured Person's Body Part that is burned and then multiplying the resulting percentage (not to exceed the Maximum Percentage for that Body Part (B)) by the Principal Sum for such Insured Person.

The maximum amount payable for this benefit for all Injuries resulting from any 1 accident is $25,000 per Insured Person.

| Body Part | (A) Body Classification | (B) Maximum % for that Body Part |
|---|---|---|
| Face, Neck, Head | 11 | 99% |
| Hand & Forearm | 5 | 22.5% |
| Either Upper Arm | 3 | 13.5% |
| Torso (front or back) | 2 | 36% |
| Either Thigh | 1 | 9% |
| Either Lower Leg (below knee) | 3 | 27% |

**Waiver of Premium**
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance benefit.

**Conversion Privilege Benefit**
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

**Policy Exclusions**
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:
- suicide or any attempt thereat by you while sane;
- self inflicted injury or any attempt thereat by you while sane or insane;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
- mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - riding as a passenger in an aircraft owned or leased by the Policyholder;
- infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
- injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 milliliters of blood; and
- natural causes.

**Termination**
This benefit terminates on the Plan Anniversary Date following the employee's 75th birthday.

*All benefits described here are governed by the Master Contract underwritten by ACE INA Insurance.*

## LONG TERM DISABILITY

### Definition of Total Disability

Employees are considered to be totally disabled if they are unable, as a result of illness or injury, to perform the whole duties of their regular occupation, and they do not work at any other compensatable job.

After 24 months of such disability, employees are considered to be totally disabled if the disability prevents them from engaging in any gainful occupation for which they are or may reasonably become qualified based on their training, education or experience.

### Insurance Amount & Benefit

Upon approval by the Insurance Company, the Long Term Disability (LTD) pays a regular monthly income, subject to the Elimination and Benefit Period shown on the *Certificate of Insurance*, to employees who are absent from work for long periods as a result of illness or injury. Benefits are available to insured employees who become totally disabled, provided they are under the regular and personal care of a physician. No benefits are payable for partial disabilities and dependents are not eligible for coverage.

The date of disability and the Elimination Period begins the date the employee visits his or her physician who certifies that the employee is totally disabled. The employee must then serve a waiting period of 120 days, referred to as the Elimination Period, during which time no benefits are payable. Benefits will commence once the waiting period has been satisfied and the employee remains totally disabled, up to the maximum Benefit Period according to the guidelines set by the Insurance Company. The Benefit Period is the length of time during which benefits are payable, but not beyond the employee's 65th birthday.

The LTD benefit is based on a percentage of the employee's gross monthly earnings subject to benefit maximums. If the benefit is a Taxable Benefit (i.e. the employer pays any portion of the LTD premium), the benefit will be calculated at 66 2/3% of the monthly income. If the benefit is a Non-Taxable Benefit (i. e. the employee pays the entire LTD premium), the benefit will be calculated at 67% of the first $2,000 of salary and 50% of the excess. The amount payable is the lower of the insured amount or the percentage of the employee's monthly earnings at the date of disability. Any payment for a period of less than one month will be at a daily rate of one-thirtieth of the monthly payment.

LTD benefits are reduced (offset) by any amount payable to the employee because of the disability from Workers' Compensation, the Canada Pension Plan, the Quebec Pension Plan and any other similar legislated program, except for CPP/QPP dependents' benefits and cost of living increases.

However, all the benefits you receive as a result of your disability should be in proportion to your normal earnings. Therefore, if your disability income from all sources exceeds the applicable limit below, the monthly income under this benefit will be further reduced so that your total disability income from all sources equals such limit.

- If your monthly income under this benefit is to be included in determining your income tax, the limit is 85% of your gross monthly earnings at the time you became disabled.
- If your monthly income under this benefit is to be excluded in determining your income tax, the limit is 85% of your take-home pay at the time you became disabled.

Your disability income from all sources will include:
- any monthly income payment from this benefit;
- any earnings or payments from your employer;
- any disability benefits payable under the Canada/Quebec Pension Plans, excluding dependents' benefits and cost of living increases;

- any disability benefits payable under any Workers' Compensation Act (or similar legislation) or any other government plan excluding benefits payable under the Unemployment Insurance Act;
- any disability benefits payable under any other group, association or franchise insurance plan;
- any benefits payable from a retirement or pension plan;
- any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

**Posaction Plus**
Employees covered for Long Term Disability benefits are eligible for *Posaction Plus.* Posaction Plus is a confidential problem solving service that offers up to 12 hours of counselling time with a trained professional. These professionals help employees, who are off work, with personal difficulties (stress, depression, burn-out, etc.), substance abuse, work related difficulties (changes, trauma) and marital and family difficulties.

Employers who identify employees experiencing difficulties can refer such employees to the service by simply giving them a Posaction Plus brochure. Employees who are off work for six weeks and are insured for Long Term Disability benefits will also be sent a letter informing them they are eligible for this benefit.

**Exclusions**
Disability benefits are not payable under any of the following circumstances:
- intentionally self-inflicted injuries while sane or insane;
- war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit, a criminal offence, including driving while impaired;
- medical or surgical care which is cosmetic (except cosmetic care provided as a result of an accident);
- disabilities as a result of excessive use of alcohol or drugs, unless the employee takes active part in a continuous, medically supervised recovery program beginning within the first 120 days of total disability.

**Pre-existing Conditions**
Benefits are not payable for any disability which begins within the employee's first 12 months of coverage, if that disability is due to a pre-existing condition. That is, any condition for which the employee was treated or attended by a physician or was prescribed drugs that were taken during the 3 month period immediately prior to the effective date of coverage.

**Rehabilitation**
For up to two years, an employee may take part in rehabilitative employment approved by the Insurance Company and still be considered totally disabled under this benefit. Monthly benefit payments will continue, reduced by the ratio of rehabilitative earnings to former earnings. Total income from all sources, however, must not exceed 100% of former earnings.

**Recurrent Disability**
If an employee's disability recurs within 6 months of returning to work after a period in which benefits were paid, is due to the same or related cause, and upon submission of medical evidence, LTD payments will resume immediately for the balance of the benefit period. This is in accordance with the guidelines set by the Insurance Company.

**Waiver of Premium**
If you become totally disabled before your 65th birthday and if the total disability has existed continuously for 180 days, the Insurance Company will waive all disability premiums after that time, during the term of the total disability.

**Claims**
A completed claim form must be received by the Plan Administrator within five months of the date of total disability. Proof of a continuing total disability will be required periodically. In the case of owners and employees whose income is derived in whole or in part from commissions, the insuring company will require financial information for the two years prior to total disability. Charges incurred for the completion of claim forms are the employee's responsibility.

**Termination**
LTD coverage terminates on the earliest of the date the employee's employment ends or the employee's 65th birthday.

If an employee is totally disabled and receiving LTD benefits on the date this group insurance ends, LTD coverage will continue as if the benefit were still in force, provided the employee's disability remains continuous. All LTD benefits terminate on the earliest of the date on which payments have been paid up to the end of the Benefit Period or the employee's 65th birthday.

*All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.*

## EXTENDED HEALTH CARE

### General

This plan covers reasonable and customary charges for supplies and services used to treat injury or illness. There is no overall lifetime maximum benefit, but certain types of expenses are subject to limits and conditions. Any benefit maximum applies to a calendar year (January through December).

To receive benefits, employees and dependents must be registered with their provincial health plan. If an employee or dependent is hospitalized before the effective date of this coverage, no benefits are payable for any charges during the hospitalization and coverage will begin the first of the month following the date of discharge.

Each employee's plan has a coinsurance amount which is shown on the *Certificate of Insurance.* This coinsurance amount will be applied to prescription drugs only.

## BENEFITS

### Prescription Drugs

Prescription drug expenses will be handled on a card system. The card is referred to as the Assure Card. The Managed Health Care (MHC) program pays only for prescriptions which are considered the most cost-effective medications, based on Emergis' National Formulary. This list is carefully built and maintained through an independent board of physicians, pharmacists and scientists. These professionals determine which drugs will be included in the formulary, based on the medications' medical and cost effectiveness. As a result, the list includes many less expensive generic alternatives to brand name products. The drug formulary faces constant review to keep it current as new products are introduced. When insureds are covered under the National Formulary, eligible drugs listed are covered according to the coinsurance chosen by the firm. Should an eligible drug not be listed in the Plan's formulary, it will be paid at 50%. The pharmacist can confirm that the medication is listed in the National Formulary before the insured has the prescription filled.

Coverage includes drugs approved in Canada, available only by prescription and administered for medical necessity. Oral contraceptives are considered eligible drugs. Coverage also includes serums, vaccines (not for travel purposes) and injectables which are only available on a reimbursement basis.

All drugs must be prescribed by a physician, surgeon, dentist or dental surgeon or, where legal, by a licensed, certified or registered health practitioner. The drug must be dispensed by a licensed organization or registered pharmacist. The maximum limit available per person is $50,000 per calendar year.

This coverage does not include proprietary or patent medicines, drugs available over-the-counter or off-the-shelf, experimental drugs, vaccines for travel purposes, drugs used in the treatment of infertility and hair loss, dietary or health foods, vitamins, nutritional products, nicotine patches or smoking cessation drugs and programs, and charges for the administration of drugs, serums or vaccines. Prescriptions are limited to a one month supply, except for "maintenance prescriptions" such as oral contraceptives which are limited to a three month supply.

If you are a resident of Quebec, this plan will reimburse you for all drugs normally provided under the Quebec Universal Drug Plan. If a brand name drug is purchased where a generic substitute is available, the plan will cover the cost of the brand name drug up to the maximum coinsurance currently allowed under the Quebec Universal Drug Plan.

### Hospital

This plan pays the additional cost charged by the hospital for a semi-private room over a standard public ward. It will also cover the additional cost of a private room, if the attending physician provides a written recommendation of its medical necessity. Coverage does not include care or treatment for substance abusers.

**Hostel Accommodation**
The plan pays the reasonable and customary charges in the province of residence for the patient's hostel accommodation associated with the hospital performing diagnostic testing or treatment and recommended by a physician up to 180 days. The hostel must be in the province of residence and located more than 60 km from the insured's home.

**Convalescent/Rehabilitation Hospital**
The benefit provides $30 per day for up to 180 days per confinement for the cost of room and board in a convalescent hospital approved by a province's appropriate hospital authority. The insured must be admitted to the convalescent facility within 14 days of discharge as an in-patient at a hospital.

Coverage excludes nursing homes, homes for the aged and chronically ill, homes for the mentally ill, rest homes, or any place for the care or treatment of substance abusers.

**Ground Ambulance**
This benefit allows charges for licensed ground ambulance service when used to transport an insured person as a result of emergency or in-patient treatment:
- from the place the insured suffers injury or illness to the nearest hospital where adequate treatment is available;
- from one hospital to another;
- from a hospital to the insured's residence when condition of patient warrants it.

Proof of the medical necessity of an ambulance may be required from the attending physician.

**Emergency Air Transportation**
Emergency transportation by a licensed air ambulance is covered to the nearest hospital qualified to provide the necessary treatment when certified as essential by the attending physician.

**Medical Equipment**
This group plan includes charges for:
- purchase, but not repair, of a spinal brace (at the discretion of the Insurance Company) or artificial limb or eye where the loss occurs while the individual is insured; replacement is covered only when required because of changes to the insured's body;
- purchase or rental, but not repair or replacement, of a brace (at the discretion of the Insurance Company) for a limb truss or crutch. Braces prescribed solely for athletic purposes are not covered;
- rental, purchase or repair of a wheelchair; rental or purchase of a hospital bed up to a lifetime maximum of $5,000 each (at the discretion of the Insurance Company);
- respirator and oxygen purchase or rental to a lifetime maximum of $1,000 per person;
- purchase of colostomy, ileostomy or uretherostomy supplies;
- purchase of one glucometer on the written recommendation of a physician;
- purchase of reagent strips and other eligible diabetic supplies;
- purchase of a breast prosthesis as a result of a total or radical mastectomy performed while the patient is insured, to a maximum of $200 per person every calendar year;
- purchase of two surgical brassieres each calendar year when required as a result of a total or radical mastectomy;
- purchase of an aerochamber inhaler for a child under 7 years of age;
- purchase of two pair of surgical elastic stockings per year, on the written recommendation of a physician;
- plasma, blood or blood substitutes and their administration;
- purchase of wigs required as a result of chemotherapy or accidental injury to a lifetime maximum of $1,000 per person;
- rental or purchase of other prescribed, approved, medical equipment up to a lifetime maximum of $250 per person.

**Orthopaedic Supplies**
Coverage includes:
- purchase, but not repair of, one pair of custom designed orthopaedic shoes from a recognized orthopaedic supplier each calendar year. This does not include off-the-shelf, regular stock shoes or shoes for athletic purposes.
- purchase of a custom-made foot orthotic or arch support, to a maximum of $200 per person per calendar year.

**Hearing Aids**
The plan allows for the purchase and installation of, but not batteries for or repair of, hearing aids on the written recommendation of a physician. The benefit is limited to $500 per person in any 5 year period. For charges incurred after April 1, 2010, the benefit is limited to $700 per person in any 5 year period.

**Private Duty Nursing**
On the written recommendation of the insured's doctor, charges will be covered for nursing visits in the insured's home. They must be provided by a professional nurse who is not related by blood, or connected by marriage, not a close friend or does not normally reside in the insured's home. Nursing services must be consistent with the insured's diagnosis and treatment of the condition and not primarily for custodial care. A Nursing Care Questionnaire is required and approval is at the discretion of the Insurance Company.

Maximum payment is $25,000 per insured in any consecutive 24 month period.

**Paramedical Services**
The plan will pay up to a maximum of $500 per person each calendar year per practitioner listed below provided such practitioner is operating within the scope of his licence. Charges for group sessions are not eligible expenses.
- naturopaths, excluding food supplements or vitamins;
- licensed clinical psychologists;
- licensed physiotherapists;
- chiropractors, including one diagnostic x-ray per year;
- practitioners registered in the Christian Science Journal;
- osteopaths;
- podiatrists or chiropodists;
- licensed speech therapists;
- qualified acupuncturists;
- audiologists;
- registered massage therapists.

Please Note: Where applicable, expenses will not be paid until the insured's expenses exceed the maximums under the provincial health plan. In Ontario, proof that the provincial plan maximum is exhausted will be required.

**Nutritional Counselling**
To a maximum of $500 per person per calendar year, this plan covers the services of a registered dietician upon written referral from a physician. This does not include the fees for weight loss programs.

**Cardiac Rehabilitation**
When prescribed by their attending physician, cardiac patients may participate in a recognized rehabilitation program after a heart attack, bypass surgery, valve replacement or management of angina pectoris. The benefit has a lifetime maximum of $300 per individual.

**Athletic Therapist**
This plan covers $10 per visit to a certified athletic therapist for a sports related injury, when recommended by a physician, to a calendar year maximum of $100.

**Eye Exams**
Eye exams are covered to $50 per person when performed by a qualified ophthalmologist or licensed optometrist. Adults are covered for one such exam in any 24 month period while dependent children are covered once in any 12 month period.

**Medical Travel**
The benefit will provide up to $750 per person each 24 months to transport an insured from their normal place of residence to a medical facility (in Canada) for medically necessary treatment under the following conditions:
- The treatment cannot be available in the normal place of residence and must be ordered by a physician;
- The treatment must take place within 60 days from the date of the physician's referral; and
- The round trip distance must be 300 kilometers or more.

Covered expenses include:
- Expenses for the person requiring the treatment and one traveling companion;
- Cost of transport including economy class of a scheduled flight, rail, bus or ferry, or automobile fuel expenses; and
- Cost to accommodate the patient in a commercial facility for up to $75 per day for a maximum of 5 days either before or after medical treatment. Telephone and meal expenses are not covered.

**Dental Accidents**
The services of a dentist required for the repair and replacement of sound natural teeth injured by an accidental blow to the insured's mouth while insured under this benefit. This coverage does not include damage resulting from an object wittingly or unwittingly placed in the mouth. Treatment must begin or a treatment plan must be sent to the Plan Administrator within 90 days of the injury. No benefits are payable for treatment more than 2 years after the date of the accident. An Accidental Dental claim form must be submitted.

**Health Access Line**
The Health Assistance service lets you speak in complete confidence to health care professionals and obtain immediate information about health, nutrition, physical fitness, vaccinations, child care, lifestyle and regional resources. The service is available 24 hours a day, 7 days a week.

Call toll free 1-877-875-2632 or in Montreal call 514-875-2632.

**Out-Of-Province/Out-Of-Country**
An insured and any invididual who is classified as a student who incurs charges for emergency medical treatment outside their province of residence is covered. An individual must be covered under their government health and hospital insurance plans to be eligible for coverage and the individual's provincial health plan must be prepared to pay a portion of any claim.

The Plan covers the first:
- 180 days of a trip for certificate holders up to age 65,
- 90 days of a trip for certificate holders age 65 to 69,
- 60 days of a trip for certificate holders age 70 to 74, and
- 30 days of a trip for certificate holders age 75 to 80.

All totally disabled employees who qualify for *Waiver of Premium* under the life insurance benefit will not be covered for any Out-of-Province/Out-of-Country expenses.

The emergency expenses must be reasonable and customary for the area in which they are charged. This plan will pay for eligible expenses that exceed the provincial health insurance plan schedule in the insured's home province. Covered services include:
- semi-private hospital room;
- hospital medical services and supplies;

- physicians' services;
- prescription drugs;
- licensed ground or air ambulance to the **nearest** hospital equipped to provide the required treatment.

In addition to the services listed above, this coverage includes a Voyage Assistance Program. In the event of an emergency, Voyage Assistance must be contacted to access 24-hour multilingual telephone confirmation of coverage and to have access to other covered services. The Voyage Assistance phone numbers are found on the back of your *Certificate of Insurance* wallet card.

Chambers Plan coverage does not pay for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence for the employee without endangering life or health, even if such service is provided as a result of a sudden illness or accident requiring emergency treatment, or if the purpose of the trip is to obtain medical services advised as necessary, but not readily available in the province of residence.

Claims for hospital and medical expenses incurred while travelling must be submitted to the Plan Administrator. Complete a Travel Health claim form and send it along with itemized receipts for all services received. The insurance company will coordinate payments on your behalf with your provincial governement plan. The provincial health plan must be prepared to pay a portion of any claim. All foreign bills must be translated prior to submission. Eligible claims are payable on a reimbursement basis in Canadian currency at the conversion rate in force on the date of the service.

**Survivors' Benefit**
There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured.
- the end of a 24 month period following the death of the Employee,
- the date on which the spouse remarries,
- the date on which the spouse becomes an employee or dependent under this or any other group plan,
- the date on which the Member Firm is no longer insured under this benefit,
- the date on which this benefit terminates.

**Exclusions and Limitations**
Extended Health benefits are not payable under any of the following circumstances:
- experimental services, treatments or supplies;
- drugs, injections or products for treatment of obesity;
- travel vaccines;
- services or treatment provided by anyone related by blood or marriage or living in the employee's residence (this might come up, for example, if an insured lives with a dentist or pharmacist);
- services, treatment or supplies provided to the employee by the employer;
- services, treatment or supplies not included in the list of eligible expenses;
- expenses as a result of intentionally self-inflicted injuries while sane or insane;
- cosmetic treatment expenses, except as a result of an accidental injury;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- personal comfort items and erectile dysfunction drugs/items;
- patent medicines;
- general health exams;
- physicians' fees;
- services, treatment or supplies which the individual received without charge;
- charges for services which are not medically necessary;
- travel time, broken appointments, transportation costs, telephone or other indirect consultations;

- amounts in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate;
- expenses related to temporomandibular joint dysfunction;
- expenses related to implants;
- out of province referrals.

**Coordination of Benefits**
If the employee and their spouse both have group benefits through their respective employers, insurance companies will pay health and dental benefits following a standard procedure.

When the employee is the patient, send the claim to the employee's plan first. When the employee's spouse is the patient, send the claim to the spouse's plan first. When a dependent child is the patient, send the claim to the plan of the parent whose birthday falls earlier in the year. If the first plan does not pay the whole amount, send the explanation of benefits provided by the first plan along with a claim form to the second plan.

In situations where parents are separated/divorced, then the following order for claims submission for children applies:
1. the plan of the parent with custody of the child;
2. the spouse of the parent with custody;
3. the parent not having custody of the child;
4. the spouse of the parent not having custody.

**Claims**
All claims should be sent to the Plan Administrator and **signed by the employee**. Completed claim forms must be submitted within one year from date of service. Original receipts are required. Upon termination, claims must be submitted within 120 days after the termination date.

**Termination**
All extended health benefits will cease at the end of the month from date of termination, but no later than the Anniversary Date following the employee's 80th birthday.

*All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.*

**Preferred Vision Services (PVS)**
PVS, Preferred Vision and Hearing Services is an added feature of your Extended Health Care Coverage through the Chambers of Commerce Group Insurance Plan.

PVS discounts for eyewear are up to 20%, when you make your purchase. However the discount may not apply on top of special promotion store sales that may be taking place at the time. The PVS discount for hearing aids and hearing devices is 10%, resulting in considerable savings for you and your family who make use of PVS hearing correctional service. PVS discounts are also available through LASIK MD, a national provider of laser eye surgery. Individuals and their dependents are eligible for a 10% discount up to a maximum of $150 (for both eyes).

**How do I get a PVS discount?**
Your Chambers Plan wallet card is proof you are eligible to receive the PVS discount. Simply visit the PVS website at *www.pvs.ca*, or call the toll free customer service line at 1-800-668-6444, to find the location of a PVS provider near you. When you visit the practitioner, show your wallet card identifying yourself as a PVS member, and pay the reduced PVS price.

Practitioners are not obligated to give you a PVS discount if you identify yourself as a PVS cardholder **after** the moment of purchase. ***Moment of purchase*** means when you find out the price of the product and agree to make the purchase. If you bought your eyeglasses, but forgot to show your wallet card (entitling you to a discount), you may not be able to get a discount *after the fact.*

**Any other questions?**
If you have any questions at all about the PVS service or the locations nearest you, please visit their website at *www.pvs.ca*, or call them at 1-800-668-6444. They'll be glad to help you.

## DENTAL CARE

### General

Dental benefits paid by the plan are based on the last approved Fee Guide established by the Provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the Fee Guide. If the dentist charges more than the Fee Guide, you are responsible for the excess charges.

The maximum benefit is $1,500 per person per calendar year (January through December) for all services combined based on reasonable and customary charges (plans for 1 & 2 person firms have a $2,500 per calendar year family maximum). *Late Entrants* have a maximum benefit of $250 per person for their first 12 months of coverage.

A deductible is the dollar amount for which the employee is responsible. Each employee's plan deductible and/or coinsurance percentage is on the employee's *Certificate of Insurance*. This amount is applied to eligible expenses incurred each calendar year prior to reimbursement by the plan.

If the employee or dependent needs more than $500 of treatment at one time, the employee should send the dentist's Treatment Plan, to the Plan Administrator for review by the Insurance Company. The Insurance Company will confirm how much the plan will pay and what the employee's share of the expenses will be, if any. Treatment Plan decisions will not be given verbally over the phone. These Treatment Plans are only valid for 90 days.

### Benefits

Dental services are categorized as **Basic, Major** and **Orthodontic** Services. This plan is primarily designed to cover dental expenses that occur most often. Please note that your plan covers **Basic** Services only.

**Basic** services, covered at the coinsurance level shown on the *Certificate of Insurance*, include:

*Oral examinations*
- two recall oral exams (check-ups) in any calendar year
- one complete oral exam (exam and medical and dental history) once every three years
- emergency or specific oral exams

*X-rays*
- one complete series of periapical films and panoramic film in any 24 month period
- bitewing films and x-rays, excluding duplicate x-rays and x-rays for temporomandibular joint procedures

*Laboratory examinations*

*Consultations and Special Visits*
- consultations with another dentist
- house or hospital call and after-hours office visit

*Preventive*
- one unit of polishing, scaling twice each calendar year
- topical application of fluoride twice each calendar year
- pit and fissure sealants
- space maintainers for missing primary teeth (except when used for orthodontic purposes)

*Restorative services*
- amalgam, acrylic, silicate or composite restorations
- duplicate fillings on the same tooth will not be covered within one year
- repair, rebasing and relining of partial or complete dentures, not including the replacement of teeth on a denture
- repair of fixed bridgework

*Endodontic*
- treatment of disease of the pulp chamber and canals (root canal therapy)

*Periodontal*
- treatment of the soft tissue (gums) and bone supporting the teeth
- additional scaling units above those provided in preventive services, to a reasonable and customary amount

*Oral surgery*
- including uncomplicated removal of erupted or impacted teeth or residual roots

*Anaesthesia (if performed in conjunction with oral surgery)*
- general anaesthesia
- neuroleptanalgesic
- conscious sedation

**Survivors' Benefit**
There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured:
- the end of a 24 month period following the death of the employee;
- the date on which the spouse remarries;
- the date on which the spouse becomes an employee or dependent under this or any other group plan;
- the date on which the Member Firm is no longer insured under this benefit;
- the date on which this benefit terminates.

**Exclusions**
Dental benefits are not payable under any of the following circumstances:
- charges for services not previously listed;
- charges for services that are not reasonable and customary;
- treatment for full mouth reconstruction, vertical dimension correction, occlusion restoration, temporomandibular joint (TMJ) correction or permanent splinting of teeth;
- any dental treatment which is not yet approved by the Canadian Dental Association or which is experimental in nature;
- replacement of lost, stolen or mislaid dentures and appliances;
- oral hygiene instruction, plaque control programs, nutritional counselling, chlorzoin treatment and sterilization of equipment;
- implant expenses or services related to implant procedures;
- non-emergency dental treatment provided outside of Canada;
- treatment for cosmetic purposes, i.e. veneers, bleaching, etc.;
- services or treatment provided by anyone related by blood or marriage or living in the employee's residence (this might come up, for example, if the insured lives with a dentist);
- services, treatment or supplies provided to the employee by the employer;
- expenses as a result of intentional self-inflicted injuries while sane or insane;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- services, treatment or supplies which the individual received without charge;
- travel time, broken appointments, transportation costs, charges for completion of claim forms, telephone or other indirect consultations;
- facility fees.

**Limitations**
Reimbursement will not be made over the suggested charge in the appropriate Fee Guide for the least expensive treatment that will provide a professional result.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services. Total reimbursement will not exceed 60% of the suggested fee in the appropriate Fee Guide.

**Coordination of Benefits**
If the employee and their spouse both have group benefits through their respective employers, insurance companies will pay health and dental benefits following a standard procedure.

When the employee is the patient, send the claim to the employee's plan first. When the employee's spouse is the patient, send the claim to the spouse's plan first. When a dependent child is the patient, send the claim to the plan of the parent whose birthday falls earlier in the year. If the first plan does not pay the whole amount, send the explanation of benefits provided by the first plan along with a claim form to the second plan.

In situations where parents are separated/divorced, then the following order for claims submission for children applies:
1. the plan of the parent with custody of the child;
2. the spouse of the parent with custody;
3. the parent not having custody of the child;
4. the spouse of the parent not having custody.

**Claims**
Completed claim forms must be submitted within one year of the date the expense was incurred. Upon termination, claims must be submitted within 120 days after the termination date. All claims must be sent to the Plan Administrator and **signed by the employee.**

**Termination**
All dental benefits will cease at the end of the month following the date of termination, but no later than the Anniversary Date following the employee's 80th birthday.

*All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.*