



Summary of Benefits

CUPE

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INTRODUCTION

The St. Francis Xavier University employee benefits program is designed to provide you and your family with basic income protection in the event of accident, illness, disability or death. The program also includes a comprehensive pension plan to help employees achieve financial security in retirement.

This Summary of Benefits and Pension Plan has been prepared to give you a summary of the main features of your group insurance and pension programs. It 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 Policy and by applicable law.

This Summary of Benefits and Pension Plan is for your reference. Please read it carefully and keep it for future use.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

St. Francis Xavier University is pleased to provide an Employee and Family Assistance Program (EFAP) to our group benefit program, offered by Medavie Blue Cross.

inConfidence, Medavie Blue Cross's EFAP, is available to all employees and their eligible dependents. Services are delivered by the professional counsellors and work/life consultants employed by Shepell-fgi, Medavie Blue Cross's EFAP service partner. *inConfidence* offers a range of services to assist people on a wide variety of personal and work-related issues, such as marital and family, child-related, alcohol/drug, other addictions, emotional, vocational/career-related, financial and legal.

Confidential counseling and work/life services are available, at no cost, to each employee or eligible family member. Should specialized assistance be required, your Shepell-fgi counselor or consultant will make an expert referral to appropriate professionals and agencies in the community. The fees for such referral services are the responsibility of the employee or family member. However, some of these services may be covered by your provincial health plan or your extended benefits plan.

To learn more about the services available and to access any of the counselling or work/life consultation services including child, elder and dependent care; legal and financial support; nutritional counselling and a health information service, call:

1 866 347-2067

- toll-free 7/24/365 service
- crisis counselling
- English- or French-language service

Confidentiality and privacy are assured, within the limits of the law, to each employee and family member who uses *inConfidence*. You are contacting Shepell-fgi directly, and they do not share any information on any individual case with St. FX or with Medavie Blue Cross.

This employee benefit reflects our continued commitment to the physical and emotional well-being of our employees and we trust that this additional form of assistance will serve you well as you contribute in unique and important ways to the success of St. Francis Xavier.

inConfidence™
Employee & Family Assistance Program



HEALTH PLAN

Plan Numbers: 08490 for Supplementary Health and Dental Expenses
08490 for Emergency Travel Assistance

Plan Design in effect as of February 10, 1995.

Eligibility

Permanent, full-time employees will become eligible for coverage on the date employment commences. Retired employees are not eligible for coverage.

Please refer to the General Provisions section of this summary for further information, including
WHEN YOUR COVERAGE STARTS
WHEN YOUR COVERAGE TERMINATES
HOW TO CLAIM

Summary of Supplementary Health Expenses

- | | | |
|------------------|---|--|
| Deductible | - | Cost of dispensing fee per prescription for Drug Expenses. No deductible for all other eligible expenses. |
| Coinsurance | - | 100% of Vision Care Expenses and 100% of all other eligible expenses, in excess of the dispensing fee for Drug Expenses, will be reimbursed. |
| Vision Care | - | Maximum benefit of \$250. for lenses and frames plus \$50. for eye examinations for each person in any period of 24 consecutive months (12 consecutive months for dependent children under 18 years of age). |
| Lifetime Maximum | - | Unlimited |

Semi-private and private hospital accommodations are covered.

Supplementary Health

EMPLOYEE AND DEPENDENT COVERAGE

In the event that you incur any of the Eligible Expenses listed below, you will be paid a percentage of such expenses as outlined in the Summary of Benefits, in excess of the dispensing fee for Drug Expenses.

LIFETIME MAXIMUM BENEFIT

The total lifetime benefit payable in respect of you or your dependents is unlimited.

ELIGIBLE EXPENSES

The following is a list of eligible expenses.

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private or private room and board in a licensed Canadian hospital.

Drug Expenses

Reasonable and customary charges incurred for medically necessary drugs and medicines, generic equivalent unless specified otherwise by the physician as follows:

- 1) all drugs which are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, including anti-smoking patches, subject to a maximum benefit of one treatment per 12 month period and oral contraceptives;
- 2) all drugs which are prescribed by a physician for the treatment of a diagnosed illness or injury;
- 3) all injectables, including serums, vaccines and injectable vitamins;
- 4) extemporaneous compounds prepared by a pharmacist;
- 5) haematinic vitamins properly identified in the Compendium of Pharmaceuticals and specialities;
- 6) most over-the-counter (OTC) products.

No benefit shall be payable for

- 1) charges for brand name drugs in excess of the cost of a lower priced generic equivalent, unless the physician has specified that no substitution is allowed;
- 2) any single purchase of drugs which would not reasonably be used within 100 days from the date of purchase for maintenance drugs and 34 days from the date of purchase for other drugs;
- 3) vitamins (except injectable), patented medicines and GP products, first aid and surgical supplies, atomizers, vaporizers, salt and sugar substitutes, infant formula, dietary foods and aids, contact lens care products, diagnostic aids and laboratory tests, contraceptives other than oral, lozenges, mouthwash, toothpastes and cosmetics, non-medicated shampoos, skin cleansers, skin protectors, emollients and soaps, any benefit provided by government plan.

The Insurer has provided you with a prescription drug card. This card must be presented each time a claim is made at any pharmacy in Canada. The card is not eligible outside Canada and, if any drugs are required while outside Canada, or for any reason if there is a problem using the card at any pharmacy within Canada, those drugs should be purchased. To arrange for payment for an eligible expense under this Policy, please complete the Health Care Expense form which can be found online at <http://www.stfx.ca/administration/hr/links.htm>. The card is valuable and should be protected like a credit card. If it is lost or stolen you should report the fact to Human Resources.

Out of Province Expenses

If you are referred by a physician for non-emergency treatment outside your province of residence, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by any provincial government plan.

1. reasonable and customary charges for ward accommodation. (Coverage for charges in excess of the ward rate is specified under the Preferred Accommodation Benefit);
2. reasonable and customary charges for the services of a physician;
3. reasonable and customary charges for hospital services and supplies furnished during hospitalization, subject to a maximum benefit of \$1,000 per hospital admission and for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Extended Health Expenses

1. Charges for the services of a licensed physiotherapist, subject to a maximum of 20 treatments, in excess of the provincial plan, per calendar year per individual;
2. Charges for the services of a Registered Nurse (RN), Registered Nursing Assistant (RNA.), Certified Nursing Assistant (CNA) or a member of the Victorian Order of Nurses (VON) which are rendered while the covered individual is not confined to a hospital subject to an overall maximum eligible expense of \$5,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if medically necessary;
3. Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer;
4. Charges for rental (or, at the Insurer's option, purchase) of braces and crutches and the purchase of prostheses. Charges for repair and adjustments of prosthetic appliances are covered subject to a maximum eligible expense of \$50.00 per calendar year;
5. Charges for professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment, subject to a maximum eligible expense of \$50.00 per calendar year;

Emergency transportation within the individual's province of residence by airline to and from the nearest hospital qualified to provide the necessary treatment. If medically required, travel expenses of a Registered Nurse (RN) who is neither a resident in your home nor a relative of your family are covered, subject to a maximum eligible expense of \$300 per calendar year;

6. Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while protected under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 180 days of the accident to be considered a covered medical expense;
7. Charges for orthopedic shoes are covered, subject to a maximum eligible expense of \$40 in any calendar year. Charges for molded arch supports are covered when prescribed by a physician, subject to a lifetime maximum eligible expense of \$70.00;

8. Charges for laboratory tests and x-rays not covered by any provincial government plan;
9. Charges for purchase of hearing aids (excluding batteries), subject to a maximum eligible expense of \$600.00 per person in any three consecutive years;
10. Charges for diabetic supplies on a reimbursed basis;
11. Charges for ancillary hospital services subject to a maximum benefit of \$1,000 per hospital admission;
12. Charges for essential diagnostic and outpatient services:
 - a) In the Atlantic Provinces in a hospital or private facility approved by the Insurer;
 - b) Outside the Atlantic Provinces in a general hospital up to an amount payable for similar services in the Atlantic Provinces.
13. Charges for blood or blood products when not provided by the Canadian Red Cross of other agencies;
14. Charges for essential ostomy supplies;
15. Charges for oxygen;
16. Charges for x-ray, radium and isotope therapy.

Vision Care Expenses

Charges for vision care as follows:

- i) charges for refractive eye examinations performed by a qualified optometrist will be covered at 100% up to \$50. No more than one eye examination will be covered in any period of 24 consecutive months (12 consecutive months for dependent children under 18 years of age);
- ii) charges for lenses and frames for eyeglasses or medically required contact lenses will be covered at 100% of the cost up to a maximum of \$250.00 per person in any period of 24 consecutive months (12 consecutive months for dependent children under 18 years of age).

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

1. charges that are considered an insured service of any provincial government plan;
2. charges for general health examinations, and examinations required for use of third party;
3. charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
4. charges for medical treatment or surgical procedure by a physician other than as provided under Out of Province Expenses;
5. charges for transport or travel, other than as specifically provided under eligible expenses;
6. charges not specified in the foregoing list of eligible medical expenses;

7. charges for services or supplies that are furnished without the recommendation and approval of a physician acting within the scope of his license;
8. charges that are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
9. charges that are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;
10. charges which would not normally have been incurred but for the presence of this coverage or for which you are not legally obligated to pay;
11. charges which the Insurer is not permitted, by any law or regulation, to cover;
12. charges for dental work where a third party is responsible for payment for such charges;
13. charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
14. charges for services or supplies resulting from any intentionally self-inflicted wound;
15. charges for a convalescent care facility;
16. charges for elastic stockings;
17. charges for drugs, sera, injectable drugs or supplies that are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;
18. charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
19. charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.

DENTAL PLAN

Employee and Dependent Coverage

You must apply for Dental Expense coverage within 31 days of your date of eligibility to be covered for maximum dental coverage. If you apply for dental coverage for yourself and/or your dependents more than 31 days following the date you are eligible to apply, the maximum benefit for the first twelve consecutive months of coverage is \$100 for Minor and Major treatment combined. No coverage is provided for Orthodontic treatment. After such twelve consecutive months, the maximum benefit will be as indicated below.

As the wording of this dental coverage is technically oriented the Insurer suggests you take this summary with you when you visit your dentist.

In the event that you incur any of the eligible expenses listed below, you will be paid a percentage of such expenses as outlined in this summary..

Maximum Benefit

The total benefits payable are subject to the maximums specified in this summary.

Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Administrative Services Agreement or after your protection under this coverage ceases except to complete the installation of dentures within 30 days of the termination of coverage provided the impression was taken prior to termination.

DENTAL CLAIM FORM REQUIRED

No payment will be made unless a Dental Claim Form, satisfactory to the Insurer, is submitted to a claims office of the Insurer.

ALTERNATE BENEFITS AND SUBMISSION OF TREATMENT PLAN

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Insurer reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, the Insurer will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan form, including pretreatment x-rays if the proposed treatment involves crowns or bridgework.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide for General Practitioners of the Dental Association. Benefits are paid in accordance with the fee guide in effect in the province or territory where the service is rendered on the date the charge is incurred.

Minor Services - Eligible at 100%

1. Diagnostics: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care that may be required subject to the following limitations:
 - (a) oral examinations: standard oral examination limited to once every 12 months (every six months up to and including 18 years), complete oral exam and diagnosis is covered;
 - (b) x-rays: single diagnostic x-rays; complete series or equivalent once every 12 months;
 - (c) bitewing x-rays: two every 6 months;
 - (d) study casts: once per year;
 - (e) consultations.
2. Preventive Therapy: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
 - (a) scaling and polishing (prophylaxis) once every 12 months (every six months up to and including 18 years), topical fluoride;
 - (b) passive space maintainers, those that do not move the teeth, for dependent children only.
3. Extractions: Uncomplicated removal of teeth.
4. Anaesthesia: Anaesthesia where reasonably and customarily required in connection with other covered procedures.
5. Repairs of Dentures: Repair of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

Minor Services - Eligible at 80%

1. Basic Restorative Dentistry: The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings). In addition, sedative dressings are covered.
2. Endodontics: Emergency endodontics procedures and conservative root canal therapy.
3. Oral Surgery: Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

Major Services - Eligible at 80% up to \$500 per Calendar Year

1. Relining, and Rebasing of Dentures: Relining and rebasing of dentures (once every 3 years), including addition of new teeth, but not including the cost of dentures, their replacement or duplication.
2. Removable Prosthetic Devices: The initial installation of partial or full dentures.

Replacement of existing dentures is not covered except if:

- (a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth or
- (b) The existing denture is at least 5 years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

3. Extensive Restorative Dentistry: Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.

4. Fixed Prosthetic Devices: The initial installation of fixed prosthetic devices.

Recementing and replacement of the facing or veneer of the fixed prosthetic device.

The replacement of existing fixed prosthetic devices is not covered except if:

- (a) the replacement is required because of extraction, loss or fracture of one or more sound natural teeth or
- (b) the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

Periodontics - Eligible at 100% to Lifetime Maximum of \$5,000.

- (a) Adjunctive Services as follows: scaling, root planing, acute infections, occlusal adjustment, provisional splinting;
- (b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- (c) Special periodontal appliances.

Orthodontics - Eligible at 50% up to Lifetime Maximum of \$3,500.

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances, those for the purpose of repositioning or moving of the teeth.

Exclusions and Limitations

Payments will not be made for any dental procedure in respect of any injury or dental disease for which the employee or dependent was advised to receive treatment or for which treatment first began before the employee or dependent became covered for that dental procedure.

No benefit is payable for the following:

1. Services or supplies that are primarily for cosmetic dentistry;
2. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
3. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
4. Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;
5. Any charge resulting from any intentionally self-inflicted injury;

6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the Insurer is not permitted by law to cover;
7. Any charge for services which would not normally have been incurred, but for the presence of this coverage, or for which you are not required to pay;
8. Any hospital charges for board and room and related services and supplies;
9. Any dental examinations required by a third party;
10. Diagnostic procedures in connection with any benefit categories excluded as eligible expenses;
11. Services or supplies for implantology.

EMERGENCY TRAVEL ASSISTANCE (ETA)

World Access Canada Inc., a multi-service corporation which assists travellers, has contracted with our Insurer to provide you with timely, efficient assistance when you travel. Be sure to carry your identification card with you when you travel.

NOTE: Only individuals under age 65 are eligible for coverage. Coverage is limited to a period of 180 days from the date you leave your province of residence (12 months, for you and your dependents, once per lifetime while on sabbatical leave, provided you are covered by a provincial government plan). Dependent children who are attending school outside Canada are eligible for coverage only while travelling to and from their province of residence and the school.

Should an emergency occur anywhere in the world:

1. Dial the number of the back of your identification card. Immediately, you will be connected with the World Access Operation Centre. Be prepared to give your NAME, GROUP POLICY NUMBER, ID NUMBER, YOUR LOCATION AND YOUR PROVINCIAL MEDICAL INSURANCE PLAN NUMBER to the World Access Operator.
2. Explain your problem to the World Access Operator. World Access has a network of multilingual professionals who are ready to attend to your emergency medical needs.

Employee and Dependent Coverage

In the event that you incur any of the eligible expenses listed below, you will be reimbursed in accordance with the following provisions. Charges for only the services and supplies specified shall be considered eligible expenses provided the charges are reasonable and customary and the medical services and supplies are necessary and prescribed by a physician.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect of you or your dependents is unlimited.

Eligible Expenses

The following benefits are covered in the event of an emergency which occurs while travelling for non-medical reason outside your province of residence.

- 1) The Insurer will provide the following Assistance Services:
 - a) Multilingual assistance by toll-free telephone, telex and facsimile services, 24 hours a day, 365 days a year, for insured individuals and providers of medical services to obtain aid and assistance in matters relating to the Emergency Travel Assistance Insurance coverage provided by the Insurer
 - b) Referral of insured individuals to a legally qualified physician, dentist, or an appropriate medical care facility;
 - c) Referral of insured individuals to a local legal advisor and assistance in arranging a cash advance from credit cards or family and friends to post bail and pay legal fees;
 - d) Assistance in replacement of necessary travel documents or tickets in the event of theft or loss for insured individuals. Assistance does not include the cost of such tickets or documents;

- e) Multilingual telephone interpretation services in the event of an emergency;
 - f) A centre for communication of messages between insured individuals and family, friends or business associates. Messages are held for 15 days;
 - g) Medical consultation and monitoring of medical care and services for insured individuals who are hospitalized. The Insurer will provide contact with the patient, the attending physician and the patient's personal physician and family if necessary.
- 2) The following eligible expenses are covered by the Insurer:
- a) Charges incurred for medical and surgical fees, hospital accommodations and prescribed drugs;
 - b) Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in Canada. Upon written recommendation of a physician, such charges shall include a medical attendant if necessary who is neither a resident in the employee's home nor a relative of the employee or the employee's spouse;
 - c) Charges incurred for the return of a deceased employee or dependent to the place of former residence in Canada. This benefit is subject to a maximum benefit of \$5,000 per individual;
 - d) Charges incurred for the return of dependent children to their residence in Canada in the event the employee or employee's spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary;
 - e) Charges incurred for delay of the return trip of an insured individual due to the hospitalization of another insured individual with whom the individual is travelling, limited to the cost of one way economy class transportation;
 - f) Charges incurred for transportation of an immediate family member to visit a hospitalized insured individual. Such individual must have been travelling alone and confined to a hospital for more than 7 days. The cost of transportation is limited to return economy fare for one family member. An immediate family member is defined as a spouse, parent, child, brother or sister or a person with whom the insured individual normally resides;
- NOTE: Charges incurred in connection with d), e) and f) are limited to a combined maximum benefit of \$5,000 per emergency.
- g) Charges incurred in connection with the return of an employee's vehicle in the event the employee is unable to return it himself due to his illness, injury or death, subject to a maximum benefit of \$500. The vehicle will be returned to the employee's residence or nearest appropriate rental agency. Such charges shall not include commercial transport vehicles;
 - h) Charges incurred for commercial accommodation and meals for insured individuals while staying with a hospitalized insured family member when their return trip is delayed due to an illness or accident. Such charges are subject to a maximum benefit of \$700 per family;

- i) Charges incurred for accommodation for insured individuals requiring convalescence following hospitalization. Such charges are subject to a maximum benefit of \$75 per day for not more than 5 days for each individual.

Exclusions

The foregoing list of benefits shall not include any of the following:

- 1) charges which are considered an insured service of any provincial government plan;
- 2) charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- 3) charges for transport or travel, other than as specifically provided under eligible expenses;
- 4) charges not specified in the foregoing list of benefits;
- 5) charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- 6) charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- 7) charges which would not normally have been incurred but for the presence of this insurance or for which the employee or dependent is not legally obligated to pay;
- 8) charges which the Insurer is not permitted, by any law or regulation, to cover;
- 9) charges for dental work where a third party is responsible for payment of such charges;
- 10) charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- 11) charges for services or supplies resulting from any intentionally self-inflicted wound;
- 12) charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;
- 13) charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- 14) charges which are not incurred as a result of an emergency while travelling;
- 15) charges in connection with childbirth and medical complications resulting from childbirth when the delivery takes place after the beginning of the 32nd week of pregnancy.

For services requiring payment of \$200 or less, please make payment and keep all receipts. The original claim is to be submitted to your provincial health insurance plan. When you receive payment from your provincial plan, please submit a copy of your claim along with the original statement of the payment received from the government to the Insurer.

GENERAL PROVISIONS

Health, Dental and Emergency Travel Assistance

WHEN YOUR COVERAGE STARTS

Your coverage comes into effect on the latest of the following dates if you are actively at work on that date.

- the date you become eligible;
- the date you apply; or
- if evidence of good health is required the date it is approved by the Insurer.

EVIDENCE OF GOOD HEALTH

Evidence of good health is required if:

- you apply for coverage more than 31 days after becoming eligible to apply; or
- you reapply after your coverage has terminated due to non-payment of premium.

TERMINATION OF COVERAGE

Your coverage terminates in the event of:

- non-payment of premium;
- a change in your classification to one not covered;
- termination of your employment;
- termination or amendment of the Master Policy and/or Administrative Services Agreement;
- your commencing active duty in any armed forces;
- your attainment of age 65 with respect to Emergency Travel Assistance;
- your retirement.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your coverage may continue for a period as outlined in the Master Policy and/or Administrative Services Agreement, but only if the required premiums are paid.

COORDINATION OF BENEFITS

Payment of Supplementary Health, Emergency Travel Assistance and Dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, the Insurer has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

DUAL COVERAGE EXCLUDED

Eligible children shall be covered as dependents of only one employee even though both parents may be covered as eligible employees. A spouse cannot be covered for supplementary health and dental expense coverage as a dependent if also covered as an employee.

ELIGIBLE DEPENDENTS

Dependent shall include only the following persons who are residents in Canada:

- a) each child of an employee. A dependent child shall include children of the marriage, legally adopted children and step children. To be considered a dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 20* years of age (21 years of age if the child qualifies as a dependent according to the Federal Income Tax Act). A child age 20 to 24 inclusive will be considered a dependent if in full-time attendance at an accredited school, college or university. A student whose normal residence is in Canada, except when attending school outside Canada, will also be considered a dependent.

*up to December 31st of the year in which the dependent child attains the age of 19.

Any mentally or physically handicapped child who was insured as a dependent shall remain insured to December 31st of the year in which the child attains age 25, provided the child is incapable of self-sustaining employment and is wholly dependent upon the employee for support and maintenance.

- b) the spouse of an employee, which includes a person married to the employee as a result of a valid civil or religious ceremony; or

a person who can establish to the satisfaction of the Insurer that there existed a relationship with the employee for a period of 12 consecutive months immediately prior to the date of services for which claim is made. Such relationship must include continuous cohabitation and public representation of married status.

If the employee has been married to more than one person, the term spouse shall mean only the person to whom the employee was most recently married, using the above criteria.

CHANGE IN AMOUNTS OF COVERAGE

A change in the amount of your coverage shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are.

DEFINITION

Full-time Employee - A permanent Employee who works a regularly scheduled work week of at least 20 hours.

How to Claim

When you have a claim you should complete the proper form (i.e. Supplementary Health Expense Form) and mail it to:

Medavie Blue Cross
PO Box 2200 Halifax NS
B3J 3C6
Inquiries: 1-800-667-4511

These forms are available from your provider or online at
<http://www.stfx.ca/administration/hr/links.htm>

In order to quickly process your claim, all claim forms should clearly indicate the following:

- full name and address.
- the name of your Employer.
- Certificate Number (Employee ID)
- Group Plan Numbers (08490)

TIME LIMITATIONS

Claims for benefits must be submitted within 12 months of the date incurred.

Plan Member e-Services

Medavie provides access to complete information on your group benefits in a secure environment: claims history, eligibility for specific products or services and online registration for direct deposit of your claims. You can register at www.medavie.bluecross.ca

If you have any questions or need assistance registering for this service, please contact the Medavie toll free number on the back of your card.

This Summary of Health plan has been prepared to give you a summary of the main features of these programs. It 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 Policy and by applicable law.

GROUP LIFE INSURANCE

Eligibility

All regular, full-time union staff must participate in the Group Life Insurance Plan as a condition of employment.

Life Insurance for Members

The amount of your Life Insurance benefit will be \$25,000. paid to your beneficiary upon your death, regardless of the cause.

When you enroll in the plan, you should name a beneficiary to whom you wish your Life Insurance proceeds paid. Your estate will be your beneficiary if you do not name one. Subject to provincial laws, you may change your beneficiary at any time.

Claims Procedure

Life claim forms will be provided by Human Resources.

Keep this summary in a place where your beneficiary may refer to it. Taking a lump sum settlement is only one of the ways of settling a Life claim. A settlement option such as a life income should be considered. If you do not make a settlement option election, your beneficiary may do so at the time of claim. Make sure that your beneficiary knows that these options are available.

Life claims must be submitted within three months of the loss.

LONG TERM DISABILITY

Eligibility and Classification

Class A - All full-time Employees actively at work for a minimum of 15 hours per week who are participating in the employer's defined contribution pension plan (this excludes maintenance and cleaning personnel).

Class B - All full-time Employees actively at work for a minimum of 15 hours per week who are not participating in the employer's defined contribution pension plan (this excludes maintenance and cleaning personnel).

Schedule of Benefits

Income Benefit - 60% of regular monthly salary rounded to the next higher \$1.00, if not already a multiple thereof.

Maximum Income Benefit - \$10,000 per month (no evidence limit)

Elimination Period - 105 days

Maximum Benefit Duration - To age 65

For Class A employees only, 13% of monthly salary shall be paid direct to the Employer's Pension Plan.

All Source Maximum

An employee's total monthly income while disabled cannot exceed 85% of net monthly earnings as of the date disability commences. If total income exceeds 85%, the Long Term Disability income benefit will be reduced by the amount of such excess.

With respect to a disabled employee participating in a program of rehabilitation, total monthly income while disabled cannot exceed 100% of net monthly earnings as of the date disability commences. If total income exceeds 100%, the Long Term Disability income benefit will be reduced by the amount of such excess.

Description of Benefit

If you are totally disabled by accident or sickness while insured under the Plan, this insurance will provide the disability benefit specified in the Schedule of Benefits.

The benefits will commence after the elimination period shown in the Schedule of Benefits and will continue while you are totally disabled or until you attain age 65. Income benefit payments will be paid monthly at the end of the month for which they are due.

Totally disabled, for the first 24 consecutive months of benefit payment, shall mean the employee is not able to perform any and every duty of the employee's occupation or employment. After 24 months, totally disabled shall mean the employee is not able to perform any and every duty of any occupation or employment for which the employee is reasonably qualified by education, training or experience.

Benefits payable under this Policy shall be reduced by the amount of benefits paid or payable to you (excluding benefits for which your dependents may qualify) for permanent or temporary total disabilities under:

- (a) Workmen's/Workers' Compensation Act; and
- (b) the disability or retirement provisions of the Canada/Quebec Pension Plan, which shall be the initial amount that you are entitled to as of the commencement date of disability under such plan; and
- (c) any disability benefit or retirement benefit paid under any group insurance or retirement plan available through the employer.

If during or immediately following a period of disability for which benefits were payable, you engage in rehabilitative employment, the Insurer will pay your monthly benefit less 50% of the amount of compensation or income received by you from the rehabilitative employment. Rehabilitative Indemnity will continue for the period you are employed, but not beyond age 65.

Exclusions

- (1) suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
- (2) insurrection or war, whether war is declared or not, or active full-time service in the armed forces of any nation;
- (3) services or supplies in respect to benefits not specifically included under this Policy.

Termination of Employee Insurance

Your coverage terminates under the following circumstances:

- (1) When you are no longer in an eligible class either by virtue of being transferred to an ineligible class or by termination of active full-time employment;
- (2) When the Policy providing the coverage terminates;
- (3) When you are on a leave of absence without pay;
- (4) When you reach age 65.

For employees who are on Sabbatical or other approved paid leave, coverage is to remain in full force at the amount the employee would have been eligible for had he/she not been on leave.

Waiver of Premium

The Insurer will waive the payments of premium for an insured employee for the period during which benefits are payable under this Policy and the insured employee's insurance will remain in force during such period, subject to all other provisions of this Policy.

Claiming and Payment of Benefits

Preliminary claim forms are available from Human Resources. Should subsequent claim forms be required, they will be sent to you as needed.

Instructions for completion are indicated on the claim forms. However, should you have any difficulties, please do not hesitate to contact Human Resources.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Eligibility

All permanent, active, full-time employees of St. Francis Xavier University and their spouses under the age of 65 and dependent children who are over 14 days old but under 21 years of age and unmarried, are eligible to participate in the Program. A child attending university or other school on a full-time basis will be eligible up to the 25th birthday, provided that the individual is not married and is dependent on the Insured Employee.

Coverage

All accidents resulting in Death, Dismemberment, Loss of Speech, Loss of Hearing or Paralysis are covered - anywhere in the world - anytime - 24 hours per day.

Schedule of Insurance Benefits

If within one year after the date of an accident, an Insured Person suffers a loss listed below, the Insurer will pay:

For Loss or Loss of Use of:	Percentage of Principal Sum
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	75%
One Leg	75%
One Hand	66%
One Foot	66%
Entire Sight of One Eye	66%
Speech	66%
Hearing in Both Ears	66%
Thumb and Index Finger or at Least Four Fingers of One Hand	33%
 For Loss of:	
All Toes of One Foot	25%
Hearing in One Ear	25%
 For Total Paralysis of:	
Both Upper and Lower Limbs (Quadriplegia) ...	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	200%

Only one benefit, the largest to which you are entitled, is payable for all losses resulting from any one accident to a maximum of \$1,000,000.

Repatriation Benefit

If you or your insured dependents die as the result of a covered accident occurring at least 50 kilometers from home, the Insurer will pay up to \$10,000. for expenses incurred for the return home of the body (including preparation charges for transportation).

Child Education Benefit

In the event of your accidental death, up to 5% of the principal sum (to a maximum of \$5,000.) will be payable for each insured qualifying child for post-secondary education expenses (provided the child is already in the program or will soon be entering the program). This is payable annually for each year for up to four consecutive years.

Rehabilitation Benefit

The Insurer will pay for your approved occupational training, up to a maximum of \$10,000., within three years of the accident.

Spouse Occupational Training Benefit

The Insurer will pay up to \$10,000., within three years of your accidental death, for formal occupational training for your spouse.

Extended Family Benefit

Coverage for your dependents will be continued without further payment of premiums for six months following the date of your death from any cause.

Amount of Principal Sum

- a) The employee may purchase, in units of \$10,000., any amount of insurance between a minimum of \$10,000 and a maximum of \$250,000.
- b) An employee's spouse and dependent children may be covered as follows:
 - 1) The amount of insurance on the spouse is 40% of the amount purchased by the employee and for each dependent child it is 10% of the amount purchased by the employee.
 - 2) For an employee who has no dependent children the amount of insurance on the spouse is 50% of the amount purchased by the employee.
 - 3) For an employee who has dependent children but no spouse the amount of insurance for each dependent child is 20% of the amount purchased by the employee.

Monthly Cost

The rate for an employee is \$0.13 monthly for each \$10,000. of Principal Sum and the rate for an employee and family is \$0.23 monthly for each \$10,000. of Principal Sum of the employee. Your premiums are paid through payroll deductions.

Examples of Cost (Per Pay)

Amount of Principal Sum	Employee Only Plan	Employee & Family Plan
\$ 10,000.	.08	.13
20,000.	.15	.27
30,000.	.23	.40
50,000.	.38	.67
70,000.	.53	.94
100,000.	.75	1.34
150,000.	1.13	2.01
200,000.	1.50	2.68
250,000.	1.88	3.35

How May I Enroll

You may enroll by completing an application card and returning it to Human Resources. The Accidental Death and Dismemberment Application form can be found on the StFX HR website. Insurance as to each eligible person who makes or for whom application is made shall become effective as follows:

- a) On the effective date of this Policy with respect to those employees whose application for insurance is received by the policyholder on or before the effective date of this Policy;
- b) On the first of the month coincident with or next following the date their application for insurance is received by the policyholder, with respect to those employees who apply after the effective date of this Policy.

Termination of employment, non-payment of premium, attainment of age 65 or retirement automatically terminates insurance at the end of the month in which the event occurred. The Family Option terminates on the same date that the Employee's insurance terminates.

Limitations

No coverage will apply:

- a) While on service in the armed forces of any country;
- b) As the result of declared or undeclared war or act thereof;
- c) As the result of air travel, except as a passenger in any aircraft having a current and valid certificate of airworthiness;
- d) As the result of flying in any aircraft owned, operated or leased by your employee.
- e) In case of suicide or self-destruction or any attempt thereat while sane or insane.

Beneficiary

The employee Loss of Life Benefit will be paid to the beneficiary designated on the application or revision card. All other employee benefits and all dependent benefits will be paid to the employee.

Claims Procedure

Written notice of claim must be given to the Insurer, within 30 days after the occurrence of the accident or as soon thereafter as it is reasonably possible. Forms on which to make claim will be sent to you. For assistance with all claims contact Human Resources.

GROUP TRAVEL ACCIDENT INSURANCE

Group Travel Accident insurance provides accident coverage world-wide, provided you are required to travel on the University's business away from the premises of the University where you are permanently assigned.

- Coverage takes effect on the actual start of a planned trip, whether you leave from your place of work, home or another location. Coverage stops upon return to your place of work, home or the location you left from, whichever occurs first. Commuting travel is not covered.
- Benefits are payable regardless of any other benefits that you may receive from any other insurance company.
- Air travel coverage is limited. It only applies while riding as a passenger and not as a pilot, operator or member of the crew in or on, including boarding or alighting from any transport type aircraft of the Canadian Armed Forces or a similar service of another country, or any civil aircraft that is not owned, operated or leased by you, a member of your household, the University or any subsidiary or affiliate of the University. The aircraft must
 - (a) be operated by a duly licensed pilot,
 - (b) have a current unrestricted airworthiness certificate, and
 - (c) not be used to fight fires, inspect pipelines, take aerial photographs or explore.
- The amount of insurance for loss of life is \$250,000. The beneficiary under this plan for losses other than life, is yourself and for loss of life, your designated beneficiary in effect at the time of payment, or your estate.
- Your coverage terminates upon attainment of age 70.
- The Schedule of Losses is extensive, covering loss of use of and paying double should paralysis occur as a result of an accident. For benefits payable for dismemberment, paralysis or loss of use, the benefits are outlined in your Policy.
- The insurance does not cover losses caused in any way from suicide or any suicide attempt; self-inflicted injuries; nuclear war or war between a country of North America and/or the states of the former Soviet Union, China, France or the United Kingdom; full-time active service in the armed forces of any country; travelling as a pilot or crew member of any aircraft or travel in the University's owned or leased, operated aircraft.
- Please contact the Human Resources Department if you require additional information on this Group Travel Accident benefit.