NSTU GROUP INSURANCE TRUST

INSURANCE PROFILE

NSTU Group Insurance Plan

Public School, PSAANS & APSEA

2023

Directory

IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

Nova Scotia Teachers Union
3106 Joseph Howe Drive
Halifax, Nova Scotia
B3L 4L7

Local: (902) 477-5621
Toll Free: 1-800-565-NSTU
Fax: (902) 477-3517

Medavie Blue Cross
Box 2200
Halifax, Nova Scotia
B3J 3C6

Local: (902) 468-9700
Toll Free: 1-800-565-8785
Fax: (902) 468-3967
(Total Care Medical/Total Care Dental)

Plan Benefits Service/Claims & Home/Auto

Johnson Inc. Regional Office
20 Hector Gate, Suite 200
Dartmouth, Nova Scotia
B3B 0K3

Johnson Inc. Regional Office Telephone Numbers:

	Local	Toll Free
NSTU Group Insurance Inquiries (Dartmouth)	(902) 453-9543	1-800-453-9543
NSTU Long Term Disability Claims Inquiries (Dartmouth)	(902) 453-9502	1-800-490-9502
Home/Auto Inquiries (Dartmouth)	1-877-738-7189 (Mention Group Code 62)	

NSTU Group Insurance Trustees E-mail Address:

insurance@nstu.ca

Johnson Inc. E-mail Address for NSTU members:

nstu@johnson.ca

Website:

Additional information with respect to the following can be found on the NSTU Group Insurance Trust website at **www.nstuinsurance.ca**

- Current Trustees
- The Role of the Trustees
- Underwriter Information
- Administrator/Consultant/Broker Information

The Plan Administrator, Johnson Inc., maintains the new "My Insurance" website that enables you to view and interact with your group insurance plan. To register, go to **https://www.johnson-insurance.com/Members-Only/**. Enter your Members Only username and password in the "New to this?" section and click "Register". If you do not remember your Members Only username or password, click "Register" in the "New to this?" section. If you need further assistance please visit **pages.johnson.ca/myinsurance**.

Disclaimer

The Insurance Profile is provided solely for the purpose of explaining the principal features of the NSTU Group Insurance Plan. It does not create or confer any contractual or other rights. All rights with respect to benefits of a member of the Plan will be governed solely by the master policies issued by the underwriters.

This Booklet contains important information concerning Group Insurance coverage and, therefore, should be kept in a safe place.

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Current Underwriter / Insurer NSTU Insurance Trustees

Type of Plan	Current Underwriter/Insurer
Provincial Master Life Insurance Policy #901259	Manulife
Provincial Master AD&D Insurance Policy #1JN80	SSQ Insurance Company Inc.
Group Optional Life Insurance Policy #39297	Manulife
Voluntary Accidental Death and Dismemberment Insurance Policy #1JN90	SSQ Insurance Company Inc.
Group Total Care – Medical Policy #11300 – Active Policy #11351 Retired under age 65 Policy #11352 Retired over age 65	Medavie Blue Cross
Group Total Care – Dental Policy #11300 – Active Policy #11351 Retired under age 65 Policy #11352 Retired over age 65	Medavie Blue Cross
Long Term Disability Insurance ASO Policy #111129	Manulife
Hospital Cash Policy #11301	Medavie Blue Cross
Optional Critical Illness Insurance Policy #140848	Desjardins
NSED Group Travel Plan Policy #11580	Medavie Blue Cross
NSED Trip Cancellation / Trip Interruption Policy #11581	
Individual Auto Insurance as per individual policy	Unifund Assurance
Individual Property Insurance as per individual policy	Unifund Assurance

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BENEFITS

Your Benefits At A Glance

The Trustees of the Nova Scotia Teachers Union are charged with the responsibility of administering and monitoring the Group Insurance Policies of the NSTU. The Union has a number of policies that are considered "group" — group meaning that those insured under these policies:

1. get a preferred rate
2. share risk as a group for the benefit of an individual

The group policies and programs administered by the NSTU Group Insurance Trustees are:

Total Care — Medical and Dental
Provincial Master Life/Accidental Death & Dismemberment Insurance
Optional Life Insurance / Spousal Life Insurance
Voluntary Accidental Death & Dismemberment Insurance
Optional Critical Illness Insurance
Long Term Disability Insurance
NSED Group Travel Plan
NSED Trip Cancellation / Trip Interruption
Member Assistance Program -
Manulife Employee and Family Assistance Program (EFAP)
NSTU Counselling Services
Early Intervention Program (EIP)
Carepath - Chronic Disease Program
Carepath - Elder Care Program
Carepath - Mental Health Program

These group insurance policies and programs offer a preferred rate and group sharing of risk as a direct benefit of being a member of the Nova Scotia Teachers Union.

The following is a brief explanation of each group insurance benefit.

Total Care — Medical

Under the Teachers' Provincial Agreement, PSAANS or APSEA Agreement, the Employer pays **100%** of the monthly premium of the single or family plan.

- **Hospital Benefits — 100%** of semi-private room – no maximum.
- **Extended Health Benefits — 80%** reimbursement for such items as the following *(benefit maximums may apply)*:
  - Home nursing care;
  - Physiotherapy;
  - Prosthetic appliances;
  - Ostomy equipment;
  - Wheelchairs, walkers, hospital beds, breathing appliance, etc.;
  - Accidental dental;
  - Hearing aids;
  - Cochlear Implant upgrades, parts and accessories
  - Eyeglasses;
  - Continuous Glucose Monitor (CGM) Systems
  - Diabetic supplies;
  - Paramedical services;
  - Massage therapy;
  - Psychologist.
- **Prescription Drugs** — **$5.00** co-pay for each prescription.

Complete details on pages 8 – 17.

Total Care — Dental

Under the Teachers' Provincial Agreement, PSAANS or APSEA Agreement, the Employer pays **65%** of monthly premium of the single or family plan. Member pays **100%** of the Prosthodontic and Orthodontic benefit.

- **Basic Preventative Services** — **80%** reimbursement for such items as the following *(benefit maximums may apply)*:
  - oral examinations;
  - cleanings, pit and fissure sealants;
  - fillings;
  - root canal therapy;
  - periodontic services;
  - denture repairs or relining;
  - extraction of teeth.

- **Major Restorative Services — 60%** reimbursement for the following major restorative services to a maximum payment of $1,500 per person per calendar year:
  - crown restorations;
  - inlay and onlay restorations;
  - gold fillings when teeth cannot be restored with other material.

- **Prosthodontic Services — 50%** reimbursement to a maximum payment of $1,500 per person per calendar year.
- **Orthodontic Services — 50%** reimbursement to a maximum payment of $2,000 per person lifetime.

Complete details on pages 18 – 22.

Provincial Master Life Policy/Accidental Death & Dismemberment Insurance

- Under the Teachers' Provincial Agreement, PSAANS or APSEA Agreement, the Employer pays **100%** of the monthly premium for all active members.
- Public School, PSAANS and APSEA — Provides $50,000 Provincial Master Life Insurance
- Public School, PSAANS and APSEA —Provides $50,000 Accidental Death & Dismemberment Insurance.
- Critical Illness – $2,000 lump sum payment for specified conditions (heart attack, coronary artery bypass surgery, stroke, life threatening cancer).
- Hospital Cash Benefit, outside the insurance contract
- Waiver of Premium if totally disabled prior to age 60.
- If retired prior to age 65, coverage continues to age 65 with the monthly premium deducted from your Nova Scotia Teachers' Pension.
- Spouse covered for $3,000 and dependent children covered for $1,500.
- Conversion option available when your insurance terminates.
- Retiree Life policy available after age 65 to death.

Complete details on pages 23 – 30.

Optional Group Life Insurance

- Members under **age 65** may apply for coverage.
- Initial amount $100,000 member / $50,000 spouse. The initial amount of $100,000 / member or $50,000 / spouse Is not subject to medical evidence of Insurability. However, a 24 month pre-existing condition clause applies.
- Additional amounts available in units of $5,000.
- The overall maximum amount of optional life insurance available is $300,000.
- At age 70, the benefit will reduce to a maximum of $50,000. **Anyone who has less than $50,000 of coverage would continue with the lesser amount.**
- Coverage can be continued to age 85.
- Conversion option available when coverage ceases or reduces prior to age 65.
- Spouse covered for $10,000 and dependent children covered for $5,000.
- Spousal Life Insurance available equal to or less than your optional life insurance in units of $5,000 with a minimum of $10,000.

Complete details on pages 31 – 34.

Voluntary Accidental Death and Dismemberment Insurance

- If under age 70 coverage available in amounts from $5,000 to $300,000.
- If age 70 to 74 inclusive, the coverage available is $5,000 to $100,000, however, there is no coverage for Permanent Total Disability, Home-Maker Weekly Indemnity and Hospital Indemnity.
- Coverage for loss of life, loss of limbs or loss of use of limbs, etc., as per schedule.

- For members with a spouse and/or dependent children, family coverage as per schedule.
- 24 hour, 365 day coverage.
- Repatriation Benefit.
- Education Benefit.
- Day Care Benefit.
- Rehabilitation Benefit.
- Spousal Retraining Benefit.
- Workplace Modification Benefit.
- Child Enhancement Benefit.
- Permanent Total Disability.
- Family Transportation Benefit.
- Identification Benefit.
- Common Disaster Benefit.
- Seat Belt Benefit.
- Home Alteration and / or Vehicle Modification Benefit.
- Hospital Indemnity Benefit.
- Escalation Benefit.
- Extension of Family Coverage.
- Cosmetic Disfigurement Benefit.
- Comatose Benefit.
- Business Venture Benefit.
- Home-Maker Weekly Indemnity Benefit.
- Retirement.
- Waiver of Premium if totally disabled prior to age 60.
- Can be continued to age 75.
- Conversion option available when your insurance terminates.

Complete details on pages 35 – 48.

Optional Critical Illness Insurance

- All eligible active / retired members covered under the NSTU group insurance plans and all permanent active employees of the NSTU or Teachers *Plus* Credit Union under age 75. As long as you are enrolled under the critical illness insurance you may apply for coverage for your eligible spouse under age 75 and eligible dependent children. Pre-existing conditions clause applies unless you submit a medical questionnaire and are approved for coverage.

- 29 conditions covered for member and spouse. 20 conditions covered for dependent children - coverage $10,000.

- Available in units of $10,000 up to $50,000 with no medical evidence of insurability (proof of health for member / spouse). Additional amount available to a maximum of $300,000 with medical evidence of insurability required.

- Lump sum tax free payment if diagnosed with one of the eligible critical illnesses. After benefit has been paid, coverage terminates and no additional premiums are payable. If member survives, coverage can be maintained for the eligible spouse and dependent children as long as the member is still eligible for benefits under the NSTU group insurance plans.

Complete details on pages 49 – 60.

Long Term Disability Insurance

- All active members of the NSTU and all permanent full-time or part-time employees of the NSTU or Teachers *Plus* Credit Union under **65 years** of age (see page 61 for guidelines).
- Provides an income in the event of absence from work because of total disability resulting from accident or sickness.
- **70%** of gross monthly salary at time claim commences. Benefit is taxable.
- For long-term claims, benefit reduced by Teachers' Pension, Workers' Compensation and/or Canada Pension.
- Rehabilitation Benefit.
- Cost-of-living Benefit, outside the insurance contract.
- Elimination period of 90 calendar days (approximately 60 sick leave days), or accumulated sick leave, whichever is greater.
- Benefits payable to age 65.

Complete details on pages 61 – 67.

NSED Group Travel Plan

- Out of Province/Canada Emergency Medical Insurance Plan.
- Base Plan allows unlimited travel up to a maximum of 35 consecutive days per trip during the policy year.
- Supplemental Plan provides coverage for trips in excess of 35 consecutive days on a per trip basis and includes the annual **Base Plan** coverage.
- Benefits are provided for such eligible expenses as:
  - Emergency Medical Expenses;
  - Air Emergency Transportation or Evacuation;
  - Bedside Transportation;
  - Private Nursing Expenses;
  - Physiotherapy;
  - Emergency Dental Services;
  - Board and Lodging;
  - Repatriation;
  - Return of Vehicle.

Including access to assistance 24 hours a day, 7 days a week. Pre-existing conditions clause.
Complete details on pages 68 – 75.

NSED Trip Cancellation / Trip Interruption

Helps protect travelers against unforeseen circumstances that may prevent or discontinue a trip.

- Annual plan.
- Trip Cancellation – up to maximum $5,000 per insured member per annual coverage period.
- Trip Interruption – up to maximum $5,000 per insured member, for each covered trip.
- Baggage & Personal affects – up to a maximum of $1,000 during a covered trip. Personal effects to a maximum of $500 or actual cash value, whichever is less. Lost or stolen documents to a maximum of $200. Baggage delays to a maximum of $400.
- Must be enrolled in NSTU NSED Group Travel Plan before you are eligible.

- Including access to assistance 24 hours a day, 7 days a week.
- Pre-existing conditions clause.

Complete details on pages 76 – 77.

Member Assistance Program

Manulife Employee and Family Assistance Program

- The Manulife Employee and Family Assistance Program is available for active NSTU members who have a permanent, probationary or term contract. Through this program you can reach a team of experienced counsellors from Homewood Health who will listen to the issue, offer sound advice, and help you create an action plan to address issues.

Complete details on pages 78 – 80.

NSTU Counselling Services

- The NSTU has two counsellors on staff that provide short-term counselling services to NSTU members, their partners, and dependent children.

Complete details on page 80.

Early Intervention Program (EIP):

- This program is for active NSTU members only who are working or absent from work and experiencing injury or illness and struggling to remain at work or return to work.

Complete details on page 80.

Carepath – Chronic Disease Program

- Formerly know as the HealthCare Assist / Cancer Assistance Program, members have access to the Chronic Disease Program which provides comprehensive and personalized support to employees and their families in the event of illness or other health crises. This navigation service provides NSTU members, their spouses and dependent children answers, guidance, and support before, during and after treatment.

Complete details on page 81.

Carepath – Elder Care Program

- The NSTU Group Insurance Trustees are pleased to offer the Elder Care Program, through Carepath. This service connects you and your family to registered nurses who specializes in senior care assistance.
- As an active or retired NSTU member, Carepath will work with you and your family one on one to help you understand and navigate the health care system so you can make informed decisions and appropriate arrangements for care.

Complete details on page 81.

Carepath – Mental Health Program

- Carepath's Mental Health program was designed to promote prevention and early intervention for mental health issues, including acute mental illness and chronic mental health conditions. The program provides timely access to confidential support for those who need it, as well as return-to-work planning for members on sick leave or long-term disability.
- The Mental Health program is committed to addressing gaps in access to community-based mental health services. This means all members will have:
    - An initial assessment within 24-48 hours
    - Access to care from anywhere in Canada, thanks to the use of distance technologies

Complete details on page 82 - 83.

I. Total Care

The Total Care Plan consists of two options, Medical and Dental, the terms of which are outlined separately.

The plan is defined by a contractual agreement between the Employer and the Nova Scotia Teachers Union. Some of the benefits are subsidized by the NSTU Group Insurance Trust Fund over and above the coverage provided under the contract with the Employer and are highlighted where applicable.

MEDICAL

Hospital and Extended Health

Total Care provides you and your eligible dependents with extensive hospital and medical coverage while you are at work, at home or on vacation. The plan has been designed to work together with your Government Hospital and Medical Services Insurance Plan.

Eligibility

All active members of the NSTU and all permanent employees of the NSTU and Teachers *Plus* Credit Union are eligible to apply for this benefit. A member of the plan who is on approved leave of absence and becomes an Associate Member of the NSTU may continue benefits on a pay-direct basis by contacting the Administrator, Johnson Inc.

You may apply for Total Care-Medical coverage, at any time, if actively at work. Coverage will take effect the first of the month following receipt of your application by the Administrator, Johnson Inc.

As an NSTU member you are entitled to have only one family plan under the NSTU Total Care – Medical regardless of Employer.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child, upon reaching the maximum

age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. with proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

Online Learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Claims for over-age dependent children cannot be processed by Medavie Blue Cross until the over-age dependent is registered with Johnson Inc.

The over-age dependent can use your benefit card. An additional card can be issued upon your request.

Hospital Benefits

This benefit is designed to supplement your Government Hospital Insurance Plan. The following services are covered:

Semi-Private — the plan pays for hospital accommodation charges **within Canada** in excess of basic ward rates up to the semi-private level. There is no limit on the number of days allowed and no dollar limit.

Exclusion:

1. Charges for hospital accommodation incurred during any time the patient is not under the active treatment and care of a Physician;
2. Charges for chronic, convalescent, respite or custodial care, regardless of whether such care is provided in a chronic care bed or active treatment bed of a hospital, and;
3. Charges for any period beyond the date which the patient can be medically discharged from the hospital as determined by the Physician.

Additional Hospital Benefits Outside Canada — in addition to hospital room charges for semi-private accommodation, the plan pays up to $1,000 per disability for ancillary hospital services provided while an in-patient in a hospital outside of Canada. (see Out-of-Province Services)

Out-Patient Hospital Services — the plan pays for any out-patient services not covered by your Government Plan. (see Out-of-Province Services)

In addition to the above coverage for Hospital expenses, the plan covers:

Professional Ambulance Services — the actual charges for licensed professional ground ambulance transportation to or from the nearest hospital able to provide the care required when, due to the medical condition of the patient, no

other form of transportation can be utilized.

Where a government program or plan for ambulance services exists, coverage will be limited to ambulance user fees applicable under such government program or plan. **Charges for transportation to and from scheduled appointments are excluded.**

Diagnostic Services — the full cost of diagnostic services including the services of a private radiological (x-ray) facility. (see Out-of-Province Services)

Extended Health Benefits

This benefit provides comprehensive protection against the cost of health services and supplies not covered by Government Programs. The plan reimburses you for **80% of the usual and customary charges**, subject to the limits stated, of the following covered expenses when ordered by the attending physician. (Extended Health Benefits are provided for expenses incurred either in or outside the province of residence.)

Home Nursing Services – Charges for Nursing Services of a Registered Graduate Nurse for medically necessary nursing care provided in a participant's home on **the written order of the attending physician (provided the Nurse is not a resident of the participant's home or related to the participant or the participant's family) AND IS SUBJECT TO PRIOR APPROVAL BY MEDAVIE BLUE CROSS. Periodic reassessment may be required. Coverage is task oriented and must constitute the practice of nursing. Services that can be performed by a person of lesser qualifications are not covered.**

Charges for the nursing services of a Certified Nursing Assistant or Licensed Practical Nurse / Licensed Nursing Assistant will only be allowed when a Registered Graduate Nurse is not available provided such service is approved by the attending physician and Medavie Blue Cross.

Reimbursement is based on the reasonable and customary charges within the applicable Province. There is a limit of **$10,000 in any 36 consecutive month period per insured person.**

These services <u>may</u> take the form of:

- changing of dressings
- foot care
- injections
- catheter care

These services <u>may not</u> take the form of:

- housekeeping
- letter writing
- personal care (i.e. hair care, bathing, etc.)
- food preparation
- banking assistance
- other "custodial or respite care" services

Critical Illness Nursing Care – Charges for the services of a Registered Nurse (RN) or Certified Nursing Assistant (CNA)/Licensed Practical Nurse (LPN) for nursing care provided in hospital or at home for an illness that is deemed to be terminal in nature. Medical documentation from the attending physician is required to determine that the medical condition is terminal in nature. **The lifetime maximum benefit is $5,000 per insured person.**

Physiotherapy – Charges for the services of a registered physiotherapist. Not all services performed by physiotherapists are considered eligible for payment. Claims must be submitted using a special physiotherapy claim form which can be

obtained from your provider. The provider will complete the appropriate sections of the form, confirm that the treatment was requested by the physician (or the physician is aware of the treatment) and the form must be signed by the provider prior to claim submission. The physiotherapist must be an approved provider by Medavie Blue Cross.

Oxygen – Charges for oxygen and the rental of equipment for its administration when required due to chronic hypoxemia. This benefit is supplemental to any government program.

Prosthetic and Other Appliances – Charges for artificial limbs, eyes or other prosthetic appliances, crutches, splints, casts, braces and trusses. Replacements are covered only in the event of pathological change. Claims being submitted require physician's documentation including the recommendation and diagnosis. Charges for maintenance are included up to $200 in any 12 consecutive month period. A maximum of $200 is allowed for bite planes when necessitated by a joint dysfunction.

Breast prosthesis will be covered once in any 24 consecutive month period and surgical brassiere two (2) per 12 consecutive month period.

Wig prosthesis for alopecia totallis or hair loss resulting from chemotherapy or radiation therapy (total baldness, not male pattern alopecia) is limited to $400 in any 12 consecutive month period.

Orthopedic Shoes and Shoe Modification Supplies – Limited to one pair in any 12 consecutive month period for orthopaedic shoes; $200 for shoe modification supplies and custom molded foot supports (orthotics) in any 12 consecutive month period, commencing with the date charges are incurred.

Only those shoes or modifications that are custom fit and designed to accommodate, relieve or remedy mechanical foot defects or abnormalities, and that are supplied by a recognized orthopaedic footwear facility and not a retail shoe outlet are considered a benefit. **A written prescription including diagnosis from a medical doctor is required.**

Shoes purchased only to accommodate orthotics and/or comfortable walking shoes such as Nike, Birkenstock, Brooks, Rockport, New Balance, Saucony etc. are not covered.

Ostomy Equipment – Charges for ostomy equipment including appliance, irrigation sets and bags, but excluding deodorants, pads, adhesives, skin creams, and other supplies.

Therapeutic Medical Equipment Rental/Purchase – Charges for the rental or purchase (at the option of the Medavie Blue Cross) of medically necessary therapeutic equipment (limited to the standard level) such as:

- wheelchair;
- iron lung;
- hospital bed/bed rails (detailed information below);
- walker;
- tens machine;
- cervical collar;
- breathing appliance;
- Glucometers: Blood Glucose Monitoring Devices covered up to a maximum of $200 if recommended by the attending physician.
- Two (2) emergency anaphylactic shock kits (anakits/epipens) covered per 12 consecutive month period per insured; based on 80% of the manufacturer's suggested retail price.

When more than one level or range of equipment is available, coverage under the plan will be limited to the standard level as medically required.

At the option of the Medavie Blue Cross, insured equipment may be rented or purchased.

Subject to the specific approval of the Medavie Blue Cross, other equipment may be an insured benefit provided it is

medically necessary and is an accepted method of treatment. Equipment used on a trial or experimental basis or equipment required primarily for comfort or convenience is not an insured benefit.

The insured equipment is limited to original purchase only, unless required as a result of a pathological change or independent consideration as approved by the Trustees. **There is a limit of $20,000 lifetime per insured person.**

Hospital Bed – (included under Therapeutic Medical Equipment) Coverage, if eligible, will be based on the cost of a "standard hospital bed". A request for a hospital bed must include the following:

- A written prescription from the Physician or a letter from the Occupational Therapist (co-signed by the Physician) which indicates prognosis and diagnosis;
- Amount of time patient confined to bed on a daily basis;
- Length of time the bed is required;
- Type of bed required (i.e. electric, manual, rails, etc.); and
- Cost of the bed. (Two estimates are required, along with any literature).

Emergency Transportation – Charges for emergency transportation by air, rail or water to the nearest hospital able to provide the required care; includes return expenses of an accompanying Registered Nurse when medically necessary. Maximum is $400.00 in any 12 consecutive month period.

Blood – Charges for blood and blood plasma, when not provided by a government-sponsored plan.

Out-of-Province Physician Services – Charges for physician services which exceed allowances provided under your government medical plan and are incurred while outside your province of residence for emergency services not related to pre-existing medical conditions. (see Out-of-Province Services)

Dental Services – Services of a dentist for the repair or replacement of natural teeth when incurred as a result of an accidental injury sustained while covered for this benefit. Injury must have been caused by an external blow or force and not by something wittingly or unwittingly placed in the mouth. Services rendered within one year following the date of the accident are covered provided the participant's coverage remains in force. Charges accepted for payment will be limited to the general practice level of the Dental Association Fee Schedule of the province where the participant resides and in effect on date service is rendered.

Laboratory Tests – Charges for laboratory tests carried out by a hospital, government or other laboratory. (see Out-of-Province Services)

X-Ray Therapy – Charges for x-ray therapy, radium and radioactive isotope therapy. (excluding private MRI clinics)

Hearing Aids – Charges for the cost and installation of a hearing aid or hearing aids up to $800.00 in any 36 consecutive month period **(The contract with your Employer provides $750 in any 36 consecutive month period. The additional coverage is provided through subsidization by the NSTU Group Insurance Trust Fund)** per insured person, commencing with the date charges are incurred. Such aid or aids must be purchased after the date of a written recommendation by an otolaryngologist. Medavie Blue Cross also recognizes a licensed audiologist. This benefit is extended to provide for a second hearing aid if it is medically necessary for a member to have a hearing aid for each ear. The charges for the second hearing aid shall be under the same conditions as the charges for the first hearing aid.

If a dependent child has an audio defect which requires additional hearing aid equipment over and above the basic benefit, claims will be reviewed on an individual basis by the Trustees in consultation with Medavie Blue Cross. The determination of the level of benefit will be the decision of the NSTU Group Insurance Trustees. Claims submitted to the Trustees must be supported by medical documentation.

Cochlear Implant Upgrades, Parts and Accessories - Provides coverage for cochlear Implant upgrades (defined as a new speech processor, cable, headpiece, batteries, charger and remote), repairs, parts, and accessories.

Eye Refraction – Usual and customary charges for an eye refraction performed by an ophthalmologist or licensed optometrist, once in any 24 consecutive month period for persons under age 10 and between ages 18 and 64, and once in any 12 consecutive month period for persons age 10 to 17.

Prescription Eyeglasses – Charges for frames and single lenses up to $155.00, or up to $170.00 for frames and bifocal or trifocal lenses. **(The contract with your Employer provides $145 for single lenses, $160 for bifocal or trifocal lenses. The additional coverage is provided through subsidization by the NSTU Group Insurance Trust Fund)**, once in any 24 consecutive month period or once in any 12 consecutive month period for dependents under age 18 commencing with the date charges are incurred for each member of the contract. ***Intra Ocular Lens Implants*** are not covered.

Eye Laser Surgery – In lieu of frames and lenses, coverage for eye laser surgery up to the dollar limit and frequency for frames and lenses, if the maximum benefits for Prescription Eyeglasses has not been used in the previous 24 months.

Contact Lenses – Charges for contact lenses up to $200.00 in any 24 consecutive month period as prescribed by an ophthalmologist for conditions such as: Keratoconus, severe corneal scarring or aphakia; provided vision cannot be improved to a satisfactory level by spectacle lenses. Please note that the Insurer requires a letter from the ophthalmologist in order to approve payment of the $200.00 benefit.

- If eyeglasses have been purchased in the same 24 consecutive month period that the required contact lenses are purchased, the amount payable shall be reduced by the amount paid under the eye glass provision.
- The purchase of contact lenses for reasons other than stated above, shall be considered the same as the purchase of eyeglasses.

Diabetic Supplies – Charges for diabetic supplies-for syringes, needles and testing supplies such as clinitest, clinistix, labstix, and ketodiastix. **Alcohol swabs, cotton balls, preci-jets, auto-injectors and infusion kits are not included as eligible expenses.**

Glucose Monitoring Systems - Charges for Continuous Glucose Monitor (CGM) System, equipment and supplies including readers, receivers, transmitters, and sensors.

Urinary Collection Devices – Charges for urinary collection and retention systems including catheter tubes and pouches but excluding other supplies.

Paramedical Services* – Charges for paramedical services – **80%** of the usual and customary charges per treatment and a maximum of 20 visits per calendar year for the services of a naturopath, acupuncturist, osteopath, chiropractor, speech therapist, podiatrist/chiropodist, or occupational therapist. The provider must be one approved by Medavie Blue Cross.

Psychologist Services* – The services of a psychologist – **80%** of the usual and customary charges to a maximum of 20 visits per year. Charges for active treatment provided by a private practice, duly licensed, certified, or registered psychologist, master of social work, or registered counselling therapist are considered eligible under this benefit. The provider must be one approved by Medavie Blue Cross.

Note: for therapy or counseling in groups, a reduced allowance would apply, to be determined by Medavie Blue Cross.

Massage Therapy* – The services of a registered massage therapist will be covered at **80%** of the usual and customary charges to a maximum of 20 visits per year (August – July). The provider must be one approved by Medavie Blue Cross.

* The above coverage is for office calls only. Prescriptions, medications, X-rays and appliances are not covered if ordered by the paramedical practitioner. They are covered only if ordered by an attending physician, that is, medical doctor and if, they otherwise qualify for coverage elsewhere in the contract.

Out-of-Province Services

Under Hospital and Extended Health Benefits of Total Care/Medical, the following applies:

> **"Out-of-Province benefits are only available as a result of unforeseen illness or accidental injury occurring while you are travelling outside your province of residence."**

Elective services and services related to pre-existing conditions as set out below are excluded or limited under this contract as described.

1. Services received by a person who travelled outside the home province for the purpose of obtaining hospital treatment, medical treatment or advice are not covered.
2. No coverage is provided for services that were obtained outside the province of residence at a person's election, including surgery or other treatment known to be required, that could be deferred until return to Canada.
3. Cardiovascular or peripheral-vascular surgery or other procedures are covered only when such procedures are necessitated by an acute episode of myocardial ischemia or peripheral ischemia that occurs during the term of coverage under this contract and only when such procedures cannot be delayed until return to Canada.
4. Surgery for removal of cataracts is not covered.
5. Known medical conditions, not specifically excluded, will be covered only when the service is necessitated by emergency. Services to monitor, stabilize or continue treatment of existing medical conditions are not covered.
6. Coverage for pregnancy is limited to services related to a naturally occurring miscarriage or to a premature delivery occurring before two months of the expected date of birth. All other services associated with pregnancy are excluded.

IT IS ADVISABLE THAT MEMBERS AND/OR DEPENDENTS PURCHASE INDIVIDUAL TRAVEL INSURANCE IF TRAVELLING OUTSIDE CANADA. (See NSED Group Travel Plan)

How to Claim

Hospital Services

There are no claim forms to complete in order to obtain hospital services. Presentation of your NSTU Total Care Benefit Card assures credit at the hospital for semi-private room coverage. The hospital will submit the claim directly to Medavie Blue Cross.

Extended Health Benefits

Electronic submission of claims or ePay has been established for many service providers. Providers can adjudicate claims online asking you to pay only the applicable co-insurance. Ask your service provider if they can submit claims directly to Medavie Blue Cross. To obtain reimbursement for other services and supplies, you can submit a claim electronically through Medavie Blue Cross' eClaims system on their secure Plan Member Centre site **medaviebc.ca/en/members**, by way of the Medavie Blue Cross mobile app **medaviebc.ca/en/members/medavie-mobile**, or by completing a claim form (obtainable from Medavie Blue Cross or Johnson Inc.) and sending it directly to the insurer along with itemized receipts and the attending physician's prescription. Payment will be made directly to you and if you sign up for direct deposit on the Member Services site, your reimbursement will be automatically deposited into your bank account.

***Glucose Monitoring Systems claims are paid directly at the pharmacy and the plan covers 80% of eligible expenses. Your pharmacist will submit the claim to Medavie Blue Cross for payment of the covered benefit and notify you of any amount payable by yourself.**

Coordination of Benefits

The plan includes a coordination of benefits provision.

If you are the primary cardholder, your personal claims must be submitted to Medavie Blue Cross first. If your spouse has a benefit plan, he or she must submit claims to his or her insurance provider first. You can then submit any unpaid portion to your spouse's plan for coordination of benefits, if eligible, for reimbursement. When you and your spouse have coverage from two separate plans, claims for your dependent children will be processed under the plan of the parent whose birth month falls first in the calendar year.

This provision operates in the event that you or your dependents are covered under more than one group health plan, and ensures that while a claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred.

CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR FROM THE DATE THE EXPENSE IS INCURRED.

Prescription Drugs

Provides you and your family with broad protection against the cost of prescription drugs dispensed on a doctor's prescription.

All over-the-counter drugs (drugs that do not by Federal or Provincial law require a prescription), except life sustaining drugs, are not covered under the Plan. Interchangeable (generic) drugs* — unless medically unsuitable, interchangeable drugs, when available, will be used in place of brand name drugs.

** Interchangeable (generic) drug coverage for prescription drugs will be limited to the cost of the least expensive product when interchangeable products are available from more than one manufacturer.*

Only drugs specified as interchangeable in the Provincial Drug Formulary are affected by this provision. These interchangeable drugs must contain the same drug and have the same dosage that the physician has prescribed. The pharmacist is permitted to select the lower priced brand in accordance with their professional judgement.

There may be situations where the generic drug produces a severe adverse reaction or there are other legitimate concerns about the use of a generic drug in place of a brand name. In this case, the physician can request on the prescription that there be **"no substitution"** and the pharmacist can dispense the higher priced brand-name drug and the plan will cover the cost of the brand-name in place of the generic drug.

RESTRICTED DRUG LIST — ALL NEW DRUGS WILL REQUIRE APPROVAL BY A REVIEW BOARD.

The following is the current procedure for reviewing new drugs for possible inclusion on the approved prescription drug list. New drugs must first be approved for distribution and sale in Canada by Health Canada. These new drugs are then reviewed by Medavie Blue Cross with specific emphasis put on both the cost and therapeutic value of the drug as compared to other similar acting drugs that are already on the market. The Insurer then prepares a recommendation for the NSTU Group Insurance Trustees to consider. The recommendation for each drug will take one of three forms: a recommendation for general approval, a recommendation for approval on an individual basis or a recommendation for decline.

If your physician or specialist prescribes a medication on the restricted drug list that requires individual approval, you will be asked to provide medical information to Medavie Blue Cross for assessment. Your pharmacist will provide the appropriate form(s) to you when you present your prescription at the pharmacy or you may obtain one from Medavie Blue Cross.

Convenient Service Card Feature

When you enroll in the plan, you are issued a "NSTU Total Care Benefit Card" which entitles you and your eligible dependents to obtain prescription drugs under the plan. You must present the card to a participating pharmacy at the

time the prescription is filled.

Co-Pay

Under the plan you are required to pay **$5.00** for each prescription. **Your pharmacist will submit the claim to Medavie Blue Cross for payment of the covered benefit and notify you of any amount payable by yourself which may include the co-pay or any amount not covered by your drug benefit.**

If you are being charged more than the $5.00 co-pay for each prescription, the Insurance Trustees recommend that you contact other pharmacies to get the best value.

The Plan does not cover:

- Proprietary and patent medicines, cosmetic aids;
- Mechanical appliances — canes, crutches, braces, trusses, etc. (This may be covered by Extended Health);
- Bandages, dressings, first aid supplies, prescription accessories;
- Contraceptive devices and appliances (except most prescription contraceptives);
- Preventive or immunizing preparations (except insulin and allergy serums);
- Diagnostic agents or preparations;
- Vitamin preparations except as approved;
- Experimental and research drugs;
- Dietary supplements and food products;
- Preparations routinely purchased without a prescription;
- Fertility drugs;
- Drugs determined to be non-therapeutic or not medically necessary;
- Homeopathic medications;
- Drugs obtained while a hospital in-patient or out-patient, or provided for by a qualified home care program;
- Drugs available through the Emergency Drug Release Program;
- Any portion of the drugs which are eligible for coverage under government programs; and
- Drugs which would not be charged to the patient in the absence of this insurance.

Prescription Quantities

Under the arrangement Medavie Blue Cross has with pharmacies, it is permissible for a subscriber to obtain medications for certain long-term or maintenance-type preparations in quantities sufficient for 100 days. Some of the categories of medications that may be obtained on this basis are listed below. If you or a member of your family are presently receiving any of these types or other types of medications in small quantities, and it is likely they will be required for a long period of time, it would be in your interest to discuss a more convenient supply or quantity with **your physician.**

CATEGORY

Cardiovascular Drugs	Anticonvulsant Drugs
Oral Hypoglycemic Agents	Thyroid Preparations
Antitubercular Agents	Antilipidemic Drugs
Diuretics	Therapeutic Vitamins
Antihypertensives	Antiarthritics
Potassium Replacement Therapy	

It should be understood that not all medications are appropriate in 100-day quantities.

Prescription Drugs (over age 65)

For those insured persons age 65 or over, **there is no prescription drug coverage under the Total Care/Medical** (residents of Nova Scotia are eligible to enroll in the Nova Scotia Seniors' Pharmacare Program). The prescription drug coverage cancels as of the first of month that either the member or spouse turns 65 (whichever is applicable).

For those insured members age 65 and over with a family plan and whose spouse is under 65, drugs for the **spouse only** are covered at 80% after a $25.00 deductible has been satisfied. The deductible must be satisfied each year between June 1 and May 31 of the following year. When drug receipts totalling over $25.00 have been accumulated, please forward to the Insurer for reimbursement.

Waiver of Premium

If you become totally disabled before age 60, your insurance remains in force and the premium is waived after six (6) consecutive months of total disability provided you have been approved for waiver of premium under your provincial master life policy. Coverage will remain in force until the earlier of your return to work, your attainment of age 65, policy termination, termination of employment or the date you cease to be totally disabled.

Retired Teachers' Health Care Plan

Members who retire on a Nova Scotia Teachers' Pension prior to age 65 will be permitted to continue membership in the Total Care – Medical Plan.

Members must apply for coverage within 60 days of receipt of first pension cheque. The monthly premium is paid **100%** by Province of Nova Scotia for single or family plan.

At age 65, the member will be eligible to transfer to the Retired Teachers' Group Insurance Plan. The monthly premium is paid **100%** by Province of Nova Scotia for single or family plan.

DENTAL

Your Dental Plan has been designed to provide reimbursement to you and your eligible dependents for Basic Preventative, Major Restorative, Prosthodontic and Orthodontic services based on the eligible amounts.

Eligibility

All active members of the NSTU and all permanent employees of the NSTU or Teachers *Plus* Credit Union are eligible to apply for this benefit if actively at work, coverage is **not automatic**. A member of the plan who is on approved leave of absence and becomes an Associate Member of the NSTU may continue benefits on a pay-direct basis by contacting the Administrator, Johnson Inc.

As an NSTU member you are entitled to have only one family plan regardless of Employer under the NSTU Total Care – Dental Plan.

If you wish to change your coverage status, notification must be received within 30 days of the actual change. If notification of a change in status is not received within 30 days, the effective date of coverage will be September 1, following receipt of notification.

(a) New members, who commence work prior to October 1, must contact Johnson and enroll no later than October 15th. Coverage will take effect the first of the month following receipt of the application form or request for coverage.

(b) New members, who commence work after October 1, must enroll within 31 days of commencing work. Coverage to take effect the first of the month following receipt of application.

If you elect to participate in the program, coverage will remain in effect for a full twelve-month period, provided you remain an active member of the NSTU, a permanent employee of the NSTU or Teachers *Plus* Credit Union.

Should you elect not to participate in the plan, but wish to participate at a future date, coverage will be effective September 1, following receipt of your application.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or,

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

Online learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Claims for over-age dependent children cannot be processed by Medavie Blue Cross until the over-age dependent is registered with Johnson Inc.

The over-age dependent can use your benefit card. An additional card can be issued upon your request.

Basic Preventative Services

The following services are provided at **80%** of the lesser of the usual and customary charge of the dentist or the Current Dental Association Fee Schedule in effect in the member's province of residence.

The plan will pay for services of a dental specialist at current specialist rates, when the patient has been referred by a dentist to a dental specialist for consultation and/or treatment of a condition deemed to be within the speciality of the specialist.

Diagnostic — clinical oral examinations (one recall exam every calendar year);

Preventative Services — cleaning (8 unit maximum every 12 consecutive months for scaling) and polishing, fluoride treatments (once every calendar year), pit and fissure sealants or permanent molars (up to age 18), space maintainers and protective athletic appliances (one every 24 months for children up to age 16 – one per lifetime over age 16);

Restorative Services — fillings, re-cementing inlays and crowns, removal of inlays and crowns, and cement restorations;

Endodontic Services — diagnosis and treatment of the pulp (nerve) and tissue which supports the end of the root, root canal therapy and emergency procedures;

Periodontic Services — diagnosis and treatment of disease which affects the supporting tissue of the teeth, such as the gums and bones surrounding the teeth (8 unit maximum every 12 consecutive months for root planing);

Prosthodontic Maintenance Services — Removable — denture repairs, denture rebasing and relining (once in 24 months) and tissue conditioning;

Surgical Services — extraction of teeth;

Adjunctive General Services — emergency treatment of pain, local anaesthetic or conscious sedation, and consultation with another dentist.

Major Restorative Services

The following services are provided at **60%** of the lesser of the usual and customary charge of the dentist or the Current Dental Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$1,500 per person per calendar year;**

- Crown restorations, inlay and onlay restorations, gold fillings when teeth cannot be restored with other material (limited to one (1) in any five (5) year period.) This benefit does not include bridgework, prosthetics or crowns, inlays or onlays associated with the placement of bridges or prosthetics (see Prosthodontic Services).

Prosthodontic and Orthodontic Services

The following is a summary of the benefits:

Prosthodontic Services — The following services are provided at **50%** of the lesser of the usual and customary charge of the dentist/prosthodontist or the current Dental Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$1,500 per person per calendar year.**

- Fixed bridgework (limited to one in any 5 year period);
- Partial and complete dentures (limited to one in any 5 year period);
- Restorative services including crowns, inlays and onlays associated with the placement of prosthodontics. (limited to one in any 5 year period).
- Implants and restorations over implants (limited to one in any 5 year period – combined with all crowns, bridgework and dentures).

Limitations

- Replacement is covered only if the existing denture is unserviceable and cannot be made serviceable.
- Coverage is not included for replacement of any lost, stolen or misplaced prosthodontics.

Orthodontic Services — The following services are provided at **50%** of the lesser of the usual and customary charge of the dentist/orthodontist or the current Dental Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$2,000 per person lifetime**.

- Coverage includes orthodontic examinations and diagnostic procedures, extractions and surgical procedures relating to orthodontic services and appliance therapy.
- Charges for orthodontic care do not become allowable until the services relating to such charges are actually rendered.

Pre-Determination Of Benefits — When a planned course of treatment is expected to result in covered dental expenses of $500 or more, a detailed description of the planned procedures with an estimate of the charges is to be submitted by the dentist to Medavie Blue Cross. Medavie Blue Cross will then confirm the level of benefits available.

Exclusions

- Charges related to services for cosmetic reasons;
- Charges for broken appointments, completion of forms or any other non-treatment services;
- Charges for services or supplies that are not dentally necessary or do not meet accepted standards of dental practice;

- Charges for services listed as included when provided to children covered under the Children's Dental Plan of the Province of Nova Scotia or other similar government programs.

How to Claim

To submit dental claims, you should first determine if your dentist is a participating dentist, i.e., one who has agreed to submit claims directly to Medavie Blue Cross for reimbursement. If so, you need only present your Total Care Benefit Card. Your dentist will submit his/her bill for that portion of the charges payable under the NSTU program directly to Medavie Blue Cross for payment.

If your dentist is a non-participating dentist, you will be required to pay for the services rendered. You can submit a claim electronically through Medavie Blue Cross' eClaims system on their secure Plan Member Centre site **medaviebc.ca/en/members**, by way of the Medavie Blue Cross mobile app **medaviebc.ca/en/members/medavie-mobile**, or with a completed dental claim form, together with an official receipt, to Medavie Blue Cross for reimbursement. Payment will be made directly to you and if you sign up for direct deposit on the Member Services site, your reimbursement will be automatically deposited into your bank account.

If your dentist is non-participating but agreeable to an assignment of benefits, submit a completed dental claim form to Medavie Blue Cross and payment will be made directly to your dentist, according to the terms of the NSTU dental program contract.

Coordination of Benefits — The plan includes a coordination of benefits provision.

If you are the primary cardholder, your personal claims must be submitted to Medavie Blue Cross first. If your spouse has a benefit plan, he or she must submit claims to his or her insurance provider first. You can then submit any unpaid portion to your spouse's plan for coordination of benefits, if eligible, for reimbursement. When you and your spouse have coverage from two separate plans, claims for your dependent children will be processed under the plan of the parent whose birth month falls first in the calendar year.

This provision operates in the event that you or your dependents are covered under more than one group dental plan, and ensures that while a claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred.

CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR FROM THE DATE THE EXPENSE IS INCURRED.

Alternate Benefit Clause

In order to maintain reasonable costs, when more than one method of treatment may be provided, or more than one type of material or appliance can be selected that will provide a professionally adequate result, the Insurer may elect to make payment for the less expensive method of treatment. For example, if there are 3 or more missing teeth, the Insurer may pay up to the level of a partial denture instead of a bridge.

Waiver of Premium

If you become totally disabled before age 60, your insurance remains in force and the premium is waived after six (6) consecutive months of total disability provided you have been approved for a waiver of premium under your provincial master life policy. Coverage will remain in force until the earlier of your return to work, your attainment of age 65, policy termination, termination of employment or the date you cease to be totally disabled.

Retired Teachers' Dental Plan

All members enrolled in the Total Care Dental Plan at the time of retirement and who will be in receipt of Nova Scotia Teachers' Pension are eligible to remain in the Plan. If you remain in the plan and cancel coverage, you **cannot** enroll

at a later date. The monthly premium is **100%** paid by the member and deducted from your Nova Scotia Teachers' Pension cheque.

There is no termination age. **This provision was effective January 1, 2010 and is only applicable to those members enrolled in the Total Care Dental Plan at the time of this change.**

If you wish to change your coverage status (i.e. from single to family or family to single), notification must be received within (30) days of the actual change.

Coverage can only be cancelled during September of each year.

II. Provincial Master Life/Accidental Death & Dismemberment Insurance

Life Insurance

PUBLIC SCHOOL — Effective August 1, 2000, every NSTU active member has an automatic $50,000 Term Life Policy.

For Public School members, this increase in benefits from $30,000 was only applicable to those members who were actively at work on August 1, 2000. If you were not actively at work on August 1, 2000, coverage commences when you return to full-time employment.

APSEA — Effective July 1, 2003, every active member has an automatic $50,000 Term Life Policy.

For APSEA members, this increase in benefits from $30,000 was only applicable to those members who were actively at work on July 1, 2003. If you were not actively at work on July 1, 2003, coverage commences when you return to full-time employment.

Dependent Life Insurance

The dependent life benefit provides $3,000 for your spouse and $1,500 for each dependent child.

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

NOTE: A child of the member will be deemed to be dependent for the purposes of this policy, from the date of birth subject to the above conditions. (see Optional Life Insurance).

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson

Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

On-line learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over–age coverage.

Retiree Life

If you retire after age 65, or when you reach age 65, you will be automatically transferred to the retiree life insurance benefit with the option to opt out.

The coverage is in the amount of $10,000. The monthly premium is 100% paid by you and deducted from your Nova Scotia Teachers' Pension cheque. **The amount increased effective September 1, 2009, therefore, the retired member may be insured for a lesser amount.**

In order to be eligible for retiree life insurance, you must have been insured under the provincial master life insurance policy immediately prior to age 65.

If you wish to cancel this policy, please submit your request in writing to the Administrator, Johnson Inc. If you choose to cancel you will not be able to reapply in the future.

Hospital Cash

A daily benefit of $20.00 will be payable to you, **the member**, when such insured member is in a hospital and under the regular care and attendance of a physician, but only in such period of hospitalization:

1. Is necessary for the treatment of injury and,
2. Begins while insurance under the policy is in force as to that member.

The daily benefit will be paid from the first day of hospitalization (one night admission), but in no event for more than three hundred and sixty-five (365) days per injury or sickness, provided the member is in hospital and under the care of a physician.

Recurrent Disability

If a particular condition causes more than one period of hospitalization due to the same or related causes, then the maximum benefit (three hundred and sixty-five (365) days in a hospital) will be reinstated, provided a period of one hundred and eighty-three (183) days have elapsed between periods of hospitalization.

The policy does not cover any period of hospitalization caused or contributed by:

Exclusions

1. Suicide or any attempt thereat while sane or self-destruction or any attempt thereat;
2. Declared or undeclared way or any act thereof;

3. Active full-time service in the armed forces of any country;
4. Normal pregnancy or childbirth.

This benefit is subsidized by the NSTU Group Insurance Trust Fund.

Basic Accidental Death & Dismemberment

PUBLIC SCHOOL — Effective August 1, 2000, this policy provides $50,000 Accidental Death and Dismemberment benefits for every active NSTU member.

This increase in benefit from $30,000 was only applicable to those members who were actively at work on August 1, 2000. If you were not actively at work on August 1, 2000 coverage commences when you return to full-time employment.

APSEA — Effective July 1, 2003, this policy provides $50,000 Accidental Death and Dismemberment benefits for every active member.

This increase in benefit from $30,000 was only applicable to those members who were actively at work on July 1, 2003. If you were not actively at work on July 1, 2003 coverage commences when you return to full-time employment.

The policy also provides a Permanent Total Disability benefit. This coverage is available to the **member only** and not to the member's spouse.

The "Schedule of Loss" is the same as the voluntary accidental death & dismemberment program as listed on pages 37-38. In addition, as a member of the provincial master life, which includes accidental death & dismemberment coverage, only you are insured for the following benefits as outlined in the voluntary accidental death & dismemberment program on pages 35 – 48.

- Repatriation Benefit;
- Identification Benefit;
- Rehabilitation Benefit;
- Child Education Benefit;
- Spousal Retraining Benefit;
- Family Transportation Benefit;
- Hospital Indemnity Benefit;
- Seat Belt Benefit;
- Day Care Benefit;
- Home Alteration and Vehicle Modification Benefit;
- Comatose Benefit;
- Workplace modification and accommodation Benefit;
- Cosmetic Disfigurement Benefit.

Permanent and Total Disability — The insurance company will pay the Principal Sum (less any sum paid under the Loss Schedule) for your permanent and total disability if:

(a) you sustain permanent and total disability because of an injury within three hundred and sixty-five (365) days after the date of the accident;

(b) disability continues for twelve (12) months, and

(c) injury occurring prior to age 70, if actively at work.

For the purpose of this coverage, permanent and total disability means that you are unable to engage in any occupation or employment for which you may be fitted by reason of education, training, or experience for the rest of your life. Permanent and total disability must have existed for twelve (12) consecutive months and be determined by competent medical authorities to be permanent, total and continuous.

Funeral Expense

In the event accidental loss of life is sustained by you, the insurer will pay the following expenses:

- Casket, Professional Funeral Services, plus use of Funeral Home (unit Price);
- Professional Funeral Service;
- Funeral Home facilities and equipment;
- Automotive equipment;
- Casket as selected;
- Outside enclosure;
- Health services Tax;
- Cremation: Urn, Cremation Charges.
- Additional expenses or cash advances:
- Transportation;
- Cemetery;
- Guest register;
- Organist;
- Clergy Honorarium;
- Other Funeral Home charges (when the services of a second funeral home are required).

Reimbursement for such charges will not exceed **five thousand dollars ($5,000)** for all services with respect to any one (1) deceased, less any charges for preparation of the remains for travel which are reimbursed under the section entitled **"Repatriation Benefit"**.

Exposure and Disappearance — If loss results from unavoidable exposure to the elements, such loss will be payable under the terms of the Policy.

The insurer will presume accidental loss of life of an insured if his or her body has not been found within one year after the date of the disappearance, sinking, forced landing, stranding or wrecking of the vehicle in which he or she was an occupant at the time of the accident.

Exclusions — The program does not cover any Loss, fatal or non-fatal, caused or contributed to by:

1. Suicide or intentionally self-inflicted Injury;
2. War, whether declared or not;
3. Participation in a riot, insurrection, civil commotion or disturbance;
4. Active full-time, part-time or temporary service in the armed forces of any country;
5. Riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage";
6. Medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

Termination of Coverage

Your provincial master life and accidental death & dismemberment coverage will cease on the earliest of the following:

1. Termination of Employment.
2. If you no longer satisfy the definition of an employee.
3. If you should die.
4. Termination of the policy, or coverage on the group, division, or class to which you belong.
5. On the date contributions are no longer made towards the cost of your insurance.
6. At the end of the month you reach age 70, if actively employed.
7. On the date you retire, unless you retire on Nova Scotia Teachers' Pension prior to age 65, in which case, coverage ceases at age 65.

NOTE: If you retire after 65, or when you reach 65, your Life coverage reduces to $10,000 and terminates upon your death (see Retiree Life). The amount has increased effective August 1, 2009; therefore, retirees may be insured for a lesser amount.

General

Beneficiary — Your loss of life benefit will be paid to your designated beneficiary(ies) as shown on your application or beneficiary nomination card. If there is no such beneficiary designation, the benefit will be paid to your estate.

Under Accidental Death and Dismemberment, all other indemnities payable will be payable to you, with the exception of indemnities payable under the following sections:

Repatriation,
Education,
Day-Care,
Workplace Modification and Accommodation,
Spousal Retraining,
Family Transportation, and
Identification

Retirement (Public School) — If you retired on a Nova Scotia Teachers' Pension prior to age 65, and before August 1, 2000 and continued coverage, your insurance remained at $30,000 Life, $3,000 Spouse and $1,500 per dependent child and $30,000 accidental death & dismemberment.

If you retire on a Nova Scotia Teachers' Pension prior to age 65 and after August 1, 2000, and continue coverage, your insurance is $50,000 Life, $3,000 Spouse and $1,500 per dependent child and $50,000 accidental death and dismemberment (provided written notification is received within 31 days of retirement).

The coverage ceases at age 65. The monthly premium is 100% paid by you, the member, and deducted from your Nova Scotia Teachers' Pension cheque. **(See Retiree Life)**

Retirement (APSEA) — If you retired on a Nova Scotia Teachers' Pension prior to age 65, and before July 1, 2003 and continued coverage, your insurance remained at $30,000 Life, $3,000 spouse and $1,500 per dependent child and $30,000 accidental death & dismemberment.

If you retire on a Nova Scotia Teachers' Pension prior to age 65 and after July 1, 2003, and continue coverage, your insurance is $50,000 Life, $3,000 Spouse and $1,500 per dependent child and $50,000 accidental death & dismemberment (provided written notification is received within 31 days of retirement).

The coverage ceases at age 65. The monthly premium is **100%** paid by you, the member and deducted from your Nova

Scotia Teachers' Pension cheque. **(See Retiree Life)**

Your notice of retirement should be sent to the Administrator, Johnson Inc.

Waiver of Premium — If you become totally and continuously disabled before age 60, your provincial master life and basic accidental death and dismemberment insurance remains in force and the premium is waived after 6 consecutive months of total disability. If approved for waiver of premium, coverage continues until attainment of age 65 or the date you cease to be totally disabled. The waiver of premium for the basic accidental death and dismemberment ceases upon policy termination, attainment of age 65, date of death or recovery. The waiver of premium for the dependent life ceases upon policy termination, date the waiver of premium for life insurance terminates or the date the dependent is no longer eligible as per terms of contract.

Employees disabled on full sick leave are considered actively at work and, therefore, not eligible for waiver of premium until their sick leave has expired. Employees must then pay the premium for 6 months and if still disabled, must apply for waiver of premium within 12 months of the date the sick leave expires.

Conversion Option – Provincial Master Life

Life Insurance

You may convert your Life Insurance at age 65, or when you retire, and have coverage under an Ordinary Life Plan, One Year Term Plan, or a Term-to-age-65-Plan.

At age 65, when your Life Insurance coverage reduces **(See Retiree Life)** you may convert the amount of coverage that you are losing at the time to an Ordinary Life plan or a One Year Term plan. This conversion is at standard rates and does not require evidence of insurability providing application is made within 31 days of you ceasing to be a member.

The Conversion Option is also available for the spouse under the dependent life benefit, but is not available for the dependent children.

Accidental Death & Dismemberment

If, with the exception of policy termination, your insurance is terminated due to

(1) termination of employment;

(2) cessation of eligibility for insurance under the policy; or

(3) cessation of total disability after which you did not return to work for the employer, and the policy is still in effect, you may convert your own insurance, without evidence of insurability into an individual accident policy. You must apply prior to attainment of age 65 and within 60 days of the termination of your insurance.

The benefits provided are a specific loss schedule available from the insurer at the date of conversion. The amount of insurance that may be converted cannot exceed the lesser of the amount then in effect on the date of termination or $150,000. The premium is calculated at the Insurers' manual premium rates in force at the date of conversion.

Premiums are payable in advance. The individual accident policy takes effect at the latest 60 days after termination of coverage under the policy and is issued on an annually renewable basis.

If you sustain loss of life resulting from Injury within the 60 day period during which conversion is available the Insurer pays your beneficiary a death benefit equal to the maximum you were entitled to apply for under this provision.

Critical Illness

You, **the member**, are automatically insured provided you are a member of the NSTU under the age of 65 and insured under the provincial master life insurance/basic accidental death & dismemberment policy.

Critical Illness is designed to provide a lump sum payment of **$2,000** should you, the member, be diagnosed with one of the following specified conditions:

- Heart Attack
- Coronary Artery Bypass Surgery
- Stroke
- Life Threatening Cancer

Members should note that a pre-existing condition limitation exists.

Definitions

Heart Attack means the diagnosis of the death of a portion of the heart muscles, resulting from the blockage of one or more coronary arteries due to atherosclerotic heart disease. The diagnosis must be based on all of the following criteria occurring at the same time: a) new episode of typical chest pain or equivalent symptoms, b) new electro-cardiographic (ECG) changes indicative of any acute myocardial infarction and c) biochemical evidence of myocardial necrosis (heart muscle death) including elevated cardiac enzymes and/or troponin. Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are specifically excluded.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a cardiologist licensed and practicing in Canada.

Non-surgical techniques **NOT** covered by this definition include:

- Balloon angioplasty;
- Laser embolectomy; or
- Other non-bypass techniques.

Stroke means the unequivocal diagnosis by a neurologist of the death of brain tissue caused by thrombosis, embolism or hemorrhage. The diagnosis must be based on all of the following: a) sudden onset of new neurological symptoms, b) new objective neurological deficits on clinical examinations persisting continuously for at least thirty (30) days following the diagnosis of the stroke and c) new findings on CT scan or MRI, if done, consistent with the clinical diagnosis. This definition specifically excludes Transient Ischemic Attacks (TIA's).

Life Threatening Cancer means the diagnosis of a malignancy, which is characterized by the uncontrolled growth of cancer cells with invasion of tissue. The following conditions are excluded under this definition:

- Early prostate cancer, diagnosed as T1A NO MO and T1B NO MO or equivalent staging;
- Non-invasive cancer (in situ);
- Pre-malignant lesions, benign tumours or polyps;
- Any skin cancer other than invasive malignant melanoma greater than 0.75 mm;
- Any tumour in the presence of any Human Immunodeficiency Virus (HIV).

There shall be no coverage under this definition if within ninety (90) days following the insured person's effective date of coverage: a) diagnosis of Cancer is made or b) any symptoms or medical problems commenced and initiated investigations leading to the subsequent diagnosis of any cancer.

Principal Sum means the amount stated under the section titled "Amount of Insurance".

Diagnosis means the certified diagnosis of a critical illness by a medical practitioner or specialist who is licensed and practicing medicine in Canada, other than the insured person, a business associate or a relative.

Survival Period means thirty (30) days following the date of diagnosis of the Coronary Artery Bypass Surgery.

Pre-existing condition means: a) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within twenty-four (24) months period preceding the insured person's effective date of coverage, or b) an illness or condition for which the insured person, during twenty-four (24) months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

Exceptions

The Principal Sum will not be paid if a critical illness results directly or indirectly from any one or more of the following causes:

1. Within ninety (90) days following the effective date of coverage of the Insured Person a) diagnosis of Cancer is made, or b) any symptoms or medical problems commenced and initiated investigations leading to the subsequent diagnosis of Cancer.
2. An intentionally self-inflicted injury or sickness, whether the insured person is sane or insane.
3. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
4. From a pre-existing condition except if such critical illness is diagnosed twenty-four (24) months after the insured person's effective date of coverage.

Area of Diagnosis

Should a critical illness occur or be diagnosed outside of Canada, payment of the principal sum may be considered upon your return to Canada for medical assessment and confirmation of the diagnosis of a critical illness.

Claims

In the event of a claim, the Administrator, Johnson Inc., should be contacted immediately.

Written notice of the claim must be given to the Insurer within thirty (30) days after the date of the diagnosis and written proof of loss must be submitted ninety (90) days after the date of diagnosis.

Failure to furnish such notice or proof within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible, but in no event later **than one (1) year after the date of the diagnosis.**

III. Optional Group Life Insurance

This plan provides important life insurance coverage to protect you and your family in the event of death.

Eligibility

All active members of the NSTU and all permanent members of the NSTU or Teachers *Plus* Credit Union under age 65 are eligible to apply for this benefit. A member of the plan who is on approved leave of absence and becomes an Associate Member of the NSTU may continue benefits on a pay-direct basis by contacting the Administrator, Johnson Inc.

You may apply for optional life insurance at any time, if actively at work. Coverage will take effect the first of the month following receipt of application if medical evidence of insurability is not required and approved by the underwriting company, or; the first of the month following approval by the underwriting company, if medical evidence of insurability is required. The premium is **100%** paid by the member.

Effective May 1, 2019, the initial amount increased to $100,000 member / $50,000 spouse. The initial amount is not subject to medical evidence of Insurability, however, a 24 month pre-existing condition clause applies.

Optional Life Insurance — Initial Amount

The initial amount is $100,000 for the member and $50,000 for the spouse. **The initial amount of optional life insurance has increased over the years, therefore, you may be insured for a lesser amount.**

Optional Life Insurance — Additional Amount

You are eligible to apply for an additional amount of coverage in units of $5,000, at any time, if actively at work. The overall maximum amount of optional life coverage you may apply for is $300,000. At age 70, the benefit will reduce to a maximum of $50,000**. Anyone who has less $50,000 of coverage would continue with the lesser amount**. Optional life coverage above $100,000 ($50,000 for the spouse) is subject to you providing satisfactory medical evidence of insurability.

Coverage — These plans provide lump sum death benefits to your beneficiary(ies) in the event of your death from any cause. Coverage is on a 24 hour basis, whether or not you are working.

Suicide Clause — No optional life insurance will be paid for any suicide claim within 2 years of the effective date, reinstatement date or the effective date of any increase of any amount of optional life insurance.

Pre-Retirement — If you are an active member not currently enrolled in the optional life insurance/spousal life insurance plans, or would like to increase your coverage, you should apply at least three months prior to your 65th birthday. You must be actively at work on the effective date of coverage and medical evidence of insurability is required.

Retirement — If you retire on a Nova Scotia Teachers' Pension, your insurance coverage remains in force. Retired members can apply for or increase coverage (subject to medical evidence of insurability) provided they are under age 65. Members may also decrease coverage by submitting a request in writing to Johnson Inc. Coverage terminates at the end of the month in which you reach age 85. The monthly premium is **100%** paid by the member and deducted from your Nova Scotia Teachers' Pension.

Conversion — Providing application is made within 31 days of you ceasing to be a member, your insurance may be

converted, without medical evidence, to a nonconvertible term plan maturing at age 65; or a non-renewable 1-year convertible term plan (provided the member is under age 65); or any permanent plan issued by the insurer at the date of conversion. The maximum amount eligible for conversion is the lesser of $200,000 or amount in force at time of termination.

Cancellation — Your optional life insurance will cease on the earliest of the following:

1. Termination of employment.
2. If you should die.
3. If you enter the armed forces on a full-time basis.
4. Termination of the policy or coverage on the Group, Division, or Class to which you belong.
5. On the date you no longer make the required contribution towards the cost of your insurance, where applicable.
6. On the date you retire, unless you retire on a Nova Scotia Teachers' Pension prior to age 65.
7. At the end of the month in which you reach age 85, if actively employed.

Dependent Life Insurance

Your spouse is insured for $10,000 and each dependent child for $5,000. If you are currently insured under the optional life insurance benefit and wish to change your coverage status from single to family, notification must be received within 31 days of actual change to avoid having to submit medical evidence of insurability.

The underwriter has the right to accept or reject dependent life coverage for all late applications subject to medical evidence of insurability.

Cancellation — Your dependent life insurance will automatically terminate on the earliest of the following:

1. The date your coverage ceases.
2. The date you are no longer eligible for dependent coverage.
3. The date your dependent no longer satisfies the definition of dependent.
4. The date dependent life insurance coverage is terminated under the policy.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

NOTE: A child of the member will be deemed to be dependent for the purposes of this policy, from the date of birth subject to the above conditions.

Birth, as used in this provision, means the complete expulsion or extraction of a child from its mother, in which, after such expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord, or unmistakable movement of voluntary muscle.

If you are not actively at work or your dependents are in a hospital at the time of enrollment, you or your dependents are not entitled to coverage. Coverage will commence when you return to work or, in the case of a hospitalized dependent, when he/she is discharged from the hospital.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

Online learning reviewed on an individual basis.

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Spousal Life Insurance

Your spouse may apply for spousal life insurance equal to or less than your optional life insurance amount, in units of $5,000 to a maximum of $300,000 (minimum of $10,000), if under age 65. At age 70, the benefit will reduce to a maximum of $50,000**. Anyone who has less $50,000 of coverage would continue with the lesser amount**.

The coverage is subject to "medical evidence of insurability", which means the underwriting company has the right to accept or reject the application based on your spouse's medical history.

Spousal optional life insurance benefits will cease on the earlier of:

1. The end of the month in which spouse attains age 85.
2. The day your insurance is terminated under the optional life insurance.
3. You request in writing to terminate spousal life coverage.
4. Your spouse no longer satisfies the definition of spouse.

Conversion Spousal Life Insurance

If your spouse's life insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy without medical evidence. Application for the individual policy must be made, and the first premium paid within 31 days of the termination date.

If your spouse dies during the 31 day period the amount of spousal optional life insurance plus the spouse's portion of the dependent optional life available for conversion will be paid to you, even if your spouse doesn't apply for conversion.

For more information on the conversion privilege, please contact the Administrator, Johnson Inc.

Beneficiary

The optional life benefits will be paid to the designated beneficiary(ies) as shown on the application or beneficiary nomination card. If there is no beneficiary designation, the benefit will be paid to your estate. dependent life insurance will be payable to you (the member). The spousal life insurance will be paid to you (the member) provided the insurer receives proof of your spouse's death.

IV. Voluntary Accidental Death and Dismemberment Insurance

This plan provides coverage for any accident resulting in death, dismemberment, paralysis, loss of use of limbs, loss of sight, speech or hearing anywhere in the world – 24 hours a day – on or off the job.

Eligibility

All active members of the NSTU and all permanent employees of the NSTU or Teachers *Plus* Credit Union are eligible to apply for this benefit, if actively at work.

A member of the plan who is on approved leave of absence and becomes an Associate Member of the NSTU may continue coverage on a pay-direct basis by contacting Johnson Inc.

If you are not actively at work or your dependents are in a hospital at the time of enrollment, you or your dependents are not entitled to coverage. Coverage will commence when you return to work or, in the case of a hospitalized dependent, when he/she is discharged from the hospital.

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

NOTE: A child of the member will be deemed to be Dependent for the purposes of this policy, from the date of Birth subject to the above conditions.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

On-line learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Enrollment

You may enroll in the program by completing an application, select the amount of insurance desired which best suits your needs and return to Johnson Inc.

If you have a spouse and/or eligible dependent children, you are automatically insured for the Family Plan.

Coverage will commence on the first of the month following receipt of your application by Johnson Inc.

You may increase or decrease your coverage or change your plan by submitting a request in writing to Johnson Inc.

What amounts are available?

A. Employee Only Plan

   You may select an amount of insurance from a minimum of $5,000 a maximum of $300,000 in units of $5,000.

B. Employee: Family Plan

   You may select an amount of insurance from a minimum of $5,000 a maximum of $300,000 units of $5,000 and your family will automatically be insured for the following:

   i. Spouse

      Your Spouse will be insured for 60% of the benefit you select for yourself if you do not have any Dependent Children, or 50% of your benefit if you do have Dependent Children.

   ii. Children

      Each Dependent Child will be insured for 15% of your benefit if you have a Spouse, or 20% if you do not have a Spouse, up to a maximum of $60,000*.

***** In the event a husband and wife (or partners), who are both Members of the Policyholder, are covered under the family plan with children, the maximum Principal Sum payable for Loss of Life or Dismemberment to children shall not exceed $90,000 under both family plans combined.

To whom are benefits paid?

Your Accidental Death Benefit will be paid to the beneficiary designated on your application. If there is no such beneficiary designation, such benefit will be paid to your Estate.

All other indemnities payable will be payable to the Insured Person (including those payable for the dependents), with the exception of indemnities payable under the following sections:

Repatriation Benefit;
Education Benefit;
Day-Care Benefit;
Workplace Modification and Accommodation Benefit;
Spousal Retraining Benefit;

Family Transportation Benefit;
Identification Benefit;
Extension of Family Benefit.

Specific Loss Accident Indemnity

When Injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the Accident, the Insurer will pay:

For Loss of

Life ..... The Principal Sum
The Entire Sight of Both Eyes ..... The Principal Sum
Speech and Hearing in Both Ears ..... The Principal Sum
One Hand and the Entire Sight of One Eye ..... The Principal Sum
One Foot and the Entire Sight of One Eye ..... The Principal Sum
The Entire Sight of One Eye ..... The Principal Sum
Speech ..... The Principal Sum
Hearing in Both Ears ..... The Principal Sum
Hearing in One Ear ..... Two-Third of the Principal Sum
All Toes of One Foot .....One-Third of the Principal Sum

For Loss or Loss of Use of

Both Hands ..... The Principal Sum
Both Feet ..... The Principal Sum
One Hand and One Foot ..... The Principal Sum
One Arm ..... The Principal Sum
One Leg ..... The Principal Sum
One Hand ..... The Principal Sum
One Foot ..... The Principal Sum
Thumb and Index Finger of Same Hand .....Two-Thirds of the Principal Sum
Four Fingers of one Hand .....Two-Thirds of the Principal Sum

For Paralysis of

Both Upper and Lower Limbs (Quadriplegia).....Two Times the Principal Sum
Both Lower Limbs (Paraplegia) .....Two Times the Principal Sum
Upper and Lower Limbs of One Side of
Body (Hemiplegia) .....Two Times the Principal Sum

“Loss of life” means the death of the insured person.

“Loss” as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb means the complete severance of one (1) entire phalanx of the thumb; as used with reference to finger means the complete severance of two (2) entire phalanges of the finger; as used with reference to toes mean the complete severance of one (1) entire phalanx of the big toe and all phalanges of the other toes; as used with reference to eye means the irrecoverable loss of the entire sight thereof.

“Loss” as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

“Paralysis” means the loss of ability to move all or part of the body.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

“Loss” as above used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for twelve (12) consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all Losses sustained by any one (1) Insured Person as the result of any one (1) Accident will not exceed the following:

(a) with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

(b) with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within ninety (90) days after the date of the Accident.

In no event will indemnity payable for all Losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same Accident.

Definitions

“You” and “Your”, means the Eligible Employee and/or Member who is enrolled with the Policyholder.

“We”, “Us”, “The Insurer” and “SSQ” means SSQ Insurance Company Inc.

“Policy” means the Group Policies which are on file with the Policyholder.

“Injury” means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

“Accident” means any unlooked for mishap or untoward event which is not expected or designed.

“Sickness” means an impairment of normal physiological function and includes illness and infections.

“Disease” means any unhealthy condition of the body or any part thereof.

“Principal Sum”, when referring to you, means the amount indicated on your application which you have completed and filed with the Johnson Inc.

“Principal Sum”, when referring to your Insured Dependents, means the percentages outlined in this Profile.

"Policyholder" means NSTU Group Insurance Trustees.

"Insured Person" means an Employee and/or Member and his/her Dependent(s) insured under the Policy.

"Member of the Immediate Family" means a person at least 18 years of age, who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), grandson, granddaughter, grandfather or grandmother.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

"Regular Care and attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practise medicine by:

1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or
2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Accommodation" means lodging in the vicinity of the Hospital where the Insured Person is confined.

The male pronoun will be construed as the feminine when the person is a female.

Repatriation**

If you or your Insured Dependent(s) sustain Loss of Life resulting from Injury not less than 50 kilometres from you or your Insured Dependent(s) normal place of residence and indemnity for such Loss becomes payable under the program, we will pay the reasonable and customary expenses actually incurred for the transportation of the body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to you or your Insured Dependent(s) normal place of residence. The repatriation benefit up to **$20,000** will be paid for expenses incurred for the return home of the body (including charges for the preparation of the body for such transportation).

Education**

If you sustain Loss of Life resulting from Injury and indemnity for such loss becomes payable in accordance with the terms of this Program, we will pay the Education Benefit stated below for each of your Dependent Children for education expenses provided the child is:

(1) enrolled as a full-time student in any Institution for Higher Learning* or

(2) will enroll as a full-time student in any Institution for Higher Learning*, within 365 days of your accidental death.

Online learning reviewed on an individual basis.*

This benefit is equal to the lesser of the following amounts: (a) 5% of your Principal Sum or (b) $5,000 for each year (up to 4 consecutive years) such child remains enrolled as a full-time student in an Institution for Higher Learning.

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled as a full-time student in an Institution for Higher Learning.

If your Dependent Child satisfies the above requirements, any benefits payable will be paid to such child.

“Institution for Higher Learning” includes any university, college, CEGEP or trade school.

“Dependent Child” means a natural children, adopted children, or stepchildren. The child is unmarried, under twenty seven (27) years of age and dependent upon the Insured member for maintenance and support.

Day Care**

If you or your Insured Spouse sustain Loss of Life resulting from Injury and indemnity for such Loss becomes payable in accordance with the terms of this Program, we will pay the Day-Care Benefit stated below for each of your Dependent Children who:

(1) are enrolled in a Day-Care Centre on the date of such Loss; or

(2) will enroll in a Day-Care Centre within three hundred and sixty-five (365) days after the date of your death.

This benefit is equal to lesser of the following amounts: (a) 5% of your Principal Sum or (b) $5,000, for each year your Dependent Child remains enrolled in a legally licensed Day-Care Centre (up to four consecutive years).

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled in a Day-Care Centre.

In the event that your Dependent Child does satisfy the requirements indicated above, the Day-Care Benefit will be payable to your surviving Spouse if your Spouse has custody of the child. If there is no surviving Spouse or your child does not reside with your Spouse, benefits payable under this provision will then be paid to your child’s guardian who has been legally appointed to manage the person of the child.

If none of your Dependent Children satisfy the requirements as shown under either the section entitled “Education Benefit” or this section, we will pay an amount equal to 5% of your Principal Sum or $2,500, whichever is less, under one of the policies issued to the Policyholder by the Insurer to your beneficiary.

The following definitions are applicable only to this benefit:

“Day-Care Centre” means a facility which is operated according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will neither include a hospital, the child’s home, care provided during normal school hours while a child is attending grades one (1) through twelve (12) nor any other day-care facility which does not charge a fee for services rendered.

“Dependent Children” mean persons that are either natural children, adopted children, or step-children. The children are under 13 years of age and dependent upon you for maintenance and support.

Rehabilitation**

If you or your Insured Spouse sustain an injury which results in a Loss payable under the section entitled “Specific Loss Accident Indemnity” under this program and such injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the accident to a maximum of **$20,000**. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Spousal Retraining**

If you sustain an injury and indemnity for such loss becomes payable in accordance with the terms of this program, we

will pay the reasonable and necessary expenses actually incurred, within 3 years from the date of such Loss by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which your spouse, would not otherwise have sufficient qualifications, up to a maximum of **$20,000** for all such expenses. No payment will be made for room, board or other ordinary living, travelling or clothing expenses. If your spouse satisfies the requirements stated above, it is presumed that your spouse is the beneficiary.

Workplace Modification and Accommodation Benefit

In the event you sustain an injury which results in a Loss payable under the section entitled "Specific Loss Accident Indemnity" of this policy and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active employment as an employee and/or member, and the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:

1. The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs.
2. The Policyholder acknowledges in writing that the performance of the essential duties of your job may be altered.
3. The proposed special adaptive equipment and/or workplace modification must have prior written approval by the Insurer.
4. The Insurer has the right to examine you to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to the Policyholder upon your return to active employment as an employee and/or member and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder will not exceed ten thousand dollars (**$10,000**) as a result of any one (1) Accident.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

Child Enhancement

With the exception of Loss of Life, the benefit amounts shown under the section entitled "Specific Loss Accident Indemnity" are doubled with respect to your Insured Dependent Children, subject to a maximum of **$240,000.**

This provision is not applicable if Loss of Life occurs within 90 days after the date of the accident.

Permanent Total Disability

The Principal Sum is payable in a lump sum, less any other amounts paid or payable under the "Specific Loss Accident Indemnity" as a result of the same accident, if you become totally disabled and the following conditions are met:

1) The disability results from an Injury occurring prior to age 70.
2) The disability commences within 365 days of the accident.
3) The disability prevents you from engaging in each and every occupation or employment for compensation or profit for which you are reasonably qualified by education, training or experience.
4) The disability has continued for 12 consecutive months, remains total and is deemed to be permanent at the end of such period.

Family Transportation**

If any Specific Loss covered under the "Specific Loss Accident Indemnity" confines you or your Insured Dependent(s) as an inpatient in a hospital or if any other Injury confines you or your Insured Dependent(s) to a hospital for 4 days and such hospital is located at least 150 kilometres from your or your Insured Dependent(s) residence, this benefit will refund expenses incurred by any Member(s) of the Immediate Family for hotel accommodation and transportation (via the most direct route) to you or your Insured Dependent(s) bedside, to a maximum of **$15,000**. Private transportation expenses are limited to **$0.35** per kilometre travelled.

Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification*

If you or an Insured Dependent sustain Loss of Life resulting from Injury, and the police require the identification of the body by a Member of the Immediate Family, and indemnity for Loss of Life subsequently becomes payable under the Policy, we will refund expenses incurred by such family member for:

1) lodging and board (up to a maximum of 3 consecutive nights) while en route and/or during the stay in the city or town where the body is located, and
2) transportation via the most direct route to this location, provided this location is not less than 150 km from the family member's usual residence.

Private transportation expenses are limited to **$0.35** per km travelled and the total maximum refundable for all expenses is limited to **$15,000**. Payment will not be made for ordinary living, travelling or clothing expenses other than stated above.

Common Disaster

If you and your Insured Spouse both sustain Loss of Life which becomes payable under the program as the result of a "Common Accident", your Spouse's amount of coverage will be increased to the same level as yours to a combined program maximum of **$1,000,000.**

"Common Accident" means the same accident or separate accidents occurring within the same 24 hour period.

Seat Belt**

If, at the time of the accident, you or your Insured Dependent(s) were wearing a properly fastened seat belt and driving or riding in a "vehicle" driven by a driver who has a valid driver's license and who was neither "intoxicated" nor under the "influence of drugs" (unless taken as prescribed by a physician), and a loss becomes payable under the "Specific Loss accident indemnity", the applicable amount of principal sum will be increased by **25%** for those wearing a seat belt.

Due proof of Seat Belt use must be provided as part of the written proof of loss.

"Intoxicated" and "being under the influence of drugs" is as defined by the jurisdiction in which the accident occurs.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts, which are part of a stretcher, used in the transportation of sick or injured persons by ambulance.

"Motorized Vehicle" means a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type

of motorized vehicle used by municipal, provincial or federal police forces.

Home Alteration and/or Vehicle Modification**

If you or your Insured Dependent(s) sustain the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and you or your Insured Dependent(s) subsequently require the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the accident, to a maximum of **$20,000** per accident;

(a) for the cost of alterations to your or your Insured Dependent(s) principal residence for the purpose of making it accessible and/or;

(b) the cost of modifications to 1 motor vehicle utilized by yourself or your Insured Dependent(s), when such modifications are approved by licensing authorities where required, for the purpose of adapting it to your or your Insured Dependent(s) needs.

Hospital Indemnity**

If any Loss covered under the "Specific Loss Schedule" section of the Policy confines you or your Insured dependent(s) to a Hospital and such person is under the Regular Care and Attendance of a Physician, you or your Insured Dependent(s) will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization, up to a maximum of **$2,500** per month and for a maximum duration of 365 days per accident.

Hospitalization required for treatment of any Injury other than for a Specific Loss is also covered in accordance with the above terms, provided such hospitalization begins within 365 days of the date of the accident which caused the Injury and insurance is in force. The daily benefit is payable from the 1st day of hospitalization if the Insured Person is hospitalized for at least 4 days.

Hospitalization is either a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same accident, provided each such confinement is separated by a period of less than 90 consecutive days. All confinements must occur within 730 days of the date of the accident.

Only one hospitalization, as defined above, will be payable for all Injuries sustained by the Insured Person as the result of the same accident.

Escalation

In the event you sustain an Injury which results in the benefit being payable under either Specific Loss Accident Indemnity or Permanent Total Disability, the Insurer will pay an Escalation benefit which is equal to 3% of the amount of benefit payable, for each year your insurance remains in force without interruption, subject to a maximum of 15%.

For benefit calculation purposes, the anniversary date of this benefit or your effective date of insurance, whichever occurs last, is used and each subsequent anniversary date thereafter.

If you discontinue your coverage and subsequently re-apply, you are considered as a person becoming insured for the 1st time in the year you re-apply for coverage.

NOTE: Benefits marked with an asterisk (*) are only payable under one of the policies issued to the policyholder by the Insurer.

Benefits marked with 2 asterisks (**) are payable under all other policies with similar benefits issued to the

policyholder by the Insurer subject to the maximum amount stated in the policies.

Extension of Family Coverage

In the event of your death from any cause, coverage for your Insured Dependent(s) will be continued without payment of premium for a period of 6 months.

Cosmetic Disfigurement

If you or an Insured Dependent(s) suffer cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement benefit provided that such burn is classified as a third degree burn.

The amount of benefit payable under this section is based on the percentage of the Principal Sum, as shown in the Cosmetic Burn Schedule below, which is determined by the Area Classification factor times the percentage of body surface actually burned.

Maximum allowable percentage for body surface burned, as shown in the following Cosmetic Burn Schedule, is based on **100%** of the specific body part being burned. The attending physician will determine the actual percentage applicable to each burn.

If you or an Insured Dependent(s) suffer burns to more than one body part as a result of any one accident, benefits payable for all such burns will not exceed **100%** of the Principal Sum.

Cosmetic Burn Schedule

Body Part	Area Classification Factor	Maximum Allowable % for Body Surface Burned	Maximum % of Principal Sum Payable
Face, Neck, Head	11	9.0%	99.9%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18.0%	36.0%
Torso (Back)	2	18.0%	36.0%
Thigh (Right)	1	9.0%	9.0%
Thigh (Left)	1	9.0%	9.0%
Lower Leg – below knee	3	9.0%	27.0%

In the event benefits are payable under this section and the sections entitled Specific Loss Accident Indemnity or Permanent Total Disability, the total benefits payable will not exceed 100% of the Principal Sum (or 200% for Paralysis).

Comatose Benefit

When, as a result of Injury, you or your Insured Dependent(s) become Comatose, the Insurer will pay the Principal Sum less any other amount paid or payable under the Schedule of Losses, as the result of the same accident, provided:

1. the Insured Person becomes Comatose within 365 days after the date of the accident; and
2. the Insured Person has been Comatose for 60 consecutive days.

"Comatose" means being in a state of total unconsciousness from which the person cannot be aroused. Such person is unresponsive to any external stimuli or internal needs and continuously requires the use of life support systems.

Aircraft Coverage

You and your Insured Dependent(s) are covered while riding as a passenger, but not as a pilot, operator or member of the crew, in any aircraft provided the aircraft has a current and valid certificate of airworthiness and is flown by a licensed pilot, except any aircraft that is owned, operated, leased or chartered by or on behalf of the Policyholder. You and your Insured Dependent(s) are also covered while flying as a passenger in any military aircraft and when boarding or alighting from or being struck by any aircraft.

Exposure and Disappearance

If, by reason of an accident covered by this program, you or your Insured Dependent(s) are unavoidably exposed to the elements and such exposure results in a covered Loss, such Loss will be covered.

If you or your Insured Dependent(s) are not found within one year of the disappearance, sinking or wrecking of a conveyance in which you or your Insured Dependent(s) were riding at the time of the accident, it will be presumed you or your Insured Dependent(s) have suffered Loss of Life resulting from Injury at the time of such disappearance, sinking or wrecking.

When does Insurance coverage terminate?

Your insurance coverage will terminate on the earliest of the following dates:

1) on the date the Policy is cancelled;
2) on the premium due date if the Policyholder fails to pay your premiums to the Insurer, except as the result of an inadvertent error;
3) on the premium due date next following the date you give notice of cancellation to the Policyholder;
4) on the premium due date next following the date you reach age 70, if actively employed and 75 years of age, if retired.

The insurance coverage for your Insured Spouse and/or Insured Dependent Children stops on the earlier of:

1) the date such person ceases to be an eligible dependent;
2) the date your insurance coverage stops.

If your insurance and/or the insurance of your Spouse or Dependent Children should terminate, you can still file a claim under the Policy for Losses arising from an accident which occurred prior to the termination date, subject to the terms and provisions of the Policy.

Waiver of Premium

Provided you have been approved for waiver of premium and remain eligible for such under the terms and conditions of the provincial master life insurance/accidental death & dismemberment policy, you need not pay any further premiums under the policy for yourself, your Insured Spouse and/or Insured Dependent Children, while you remain disabled, until the earliest of the following dates:

(1) the Policy terminates;

(2) you reach age 65;

(3) you cease to be totally disabled.

All terms and provisions of the Policy apply during the period premiums are waived, including provisions relating to reductions in amounts of insurance.

Pre-Retirement – If you are an active member and not currently enrolled in the voluntary accidental death & dismemberment benefit you should apply for this benefit or increase coverage at least two months prior to retirement as you must be actively at work on the effective date of coverage. Once retired you cannot apply for coverage or increase your current coverage.

Retirement – If you retire on a Nova Scotia Teachers' Pension prior to age 75, your insurance will remain in force at the same coverage, by payment of premium at the regular premium rate, until the end of the month during which you reach 70 years of age.

Once retired members may decrease coverage by submitting a request in writing to Johnson Inc. (retired members cannot increase coverage).

Coverage with respect to your Insured Spouse and/or Insured Dependent Children will be continued while your insurance remains in force, provided payment of premium is continued.

Retirees from age 70 to 74 will have the same premium rates, limitations and coverage as retirees under age 70, except for the following:

(1) The maximum amount of Principal Sum available is $100,000;

(2) There will be indemnities payable under the following benefits:

  (a) Permanent Total Disability,

  (b) Home–Maker Weekly Indemnity

  (c) In–Hospital Indemnity

(3) Coverage will terminate at the end of the month during which you reach 75 years of age.

No indemnity will be payable under the section entitled "Permanent Total Disability Indemnity" on or after the date of retirement, insurance cannot be increased after the date of retirement and any excess premium inadvertently accepted by the Insurer will be returned to the Insured Member.

Business Venture Benefit

You, the member, will qualify for coverage under this section if you sustains an Injury which results in a Loss payable under the section entitled "Loss Schedule".

The Business Venture Benefit covers the Initial Costs applicable to the development of a new independent business enterprise in Canada.

The Initial Costs must be incurred by you within the second (2nd) year following the date Total Disability begins, and are subject to the lesser of a maximum of twenty percent (20%) of your Principal Sum or fifty thousand dollars ($ 50,000).

The Initial Costs will not include more than your equitable share of the expenses of facilities if you operate your own business in a partnership, or in accordance with an agreement hereunder any facilities for such operation or practice are shared by more than one person.

To qualify for benefits under this section, you must:

1. be unable to perform your Own Occupation as a result of Total Disability beginning within three hundred and sixty-five (365) days following the date of Injury;
2. remain totally disabled for a continuous period of one (1) year;
3. provide due proof of disability to the Insurer within said one (1) year period; and,
4. submit to the Insurer a Business Plan at the end of said one (1) year period.

"Initial Costs" includes land, buildings, fixtures, machinery, supplies, vehicles, pre-opening expenses, but excludes Daily Operating Costs.

"Daily Operating Costs" means expenses incurred in the operation of the Insured Member's business for rent, electricity, heat, water, laundry, depreciation, members' salaries and other fixed expenses arising out of the conduct and operation of such business.

"Total Disability" means the inability of yourself, due to Injury, to perform each and every duty of his Own Occupation.

"Own Occupation" means each and every occupation or employment engaged in by you immediately prior to the date of Injury.

"Business Plan" means a report which includes cash flow forecasts, a statement of personal assets and liabilities and market research results.

Home-Maker Weekly Indemnity

When an Insured Spouse who is neither gainfully employed nor receiving employment insurance benefits sustains an Injury and, as a result of such Injury and commencing within 30 days from the date of the Accident, becomes totally and continuously disabled and is prevented from performing any and all of his/her regular household and/or child-caring duties, the Insurer will pay $150 dollars, provided that the disability has continued for a period of 7 consecutive days, for the period the Insured spouse is so disabled, including the 7 day period, while under the Regular Care and Attendance of a Physician, subject to a maximum period payable of 26 weeks or to age 70, whichever first occurs.

Conversion Privilege

If, with the exception of policy termination, your insurance is terminated due to

(1) termination of employment,

(2) cessation of eligibility for insurance under the Policy, or

(3) cessation of total disability after which you did not return to work for the policyholder,

and the Policy is still in effect, you may convert your own insurance (but not your Spouse's and/or Dependent Children's), without evidence of insurability, into an individual accident policy.

You must apply prior to attainment of age 75 and within 60 days of the termination of your insurance.

The benefits provided are a Specific Loss schedule available from the Insurer at the date of conversion. The amount of insurance that may be converted cannot exceed the lesser of the amount then in effect on the date of termination or $300,000. The premium is calculated at the Insurer's manual premium rates in force at the date of conversion.

Premiums are payable annually in advance. The individual accident policy takes effect at the latest 60 days after the termination of coverage under the Policy and is issued on an annually renewable basis.

If you sustain Loss of Life resulting from Injury within the 60 day period during which conversion is available, the Insurer

pays your beneficiary a death benefit equal to the maximum you were entitled to apply for under this provision.

Exclusions

The Program does not cover any Loss, fatal or non-fatal, caused or contributed to by:

1. suicide or intentionally self-inflicted Injury;
2. war, whether declared or not;
3. participation in a riot, insurrection, civil commotion or disturbance;
4. active full-time, part-time or temporary service in the armed forces of any country;
5. riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled “Aircraft Coverage”;
6. medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

In the Event of Claim

You or your beneficiary must notify the Administrator, Johnson Inc., immediately.

In the case of claim, written notice of Injury must be given to the Insurer within 30 days after the date of the accident and written proof of loss must be furnished to them within 90 days after the date of such Loss. Failure to furnish such notice or proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible, **but in no event later than one year after the date of the accident.**

V. Optional Critical Illness Insurance

Critical Illness is a one-time, lump sum tax free cash benefit that is paid to an insured member when the member is medically diagnosed with a covered critical illness or injury. This cash benefit may be used in any manner you wish.

Eligibility

All eligible active/retired members covered under the NSTU Group Insurance Plans and all permanent active employees of the NSTU or Teachers *Plus* Credit Union under the age of 75. As long as you are enrolled under the critical illness insurance, you may apply for coverage for your eligible spouse under age 75 and eligible dependent child(ren).

Definition of Dependents

"Spouse" means either:

(a) a member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If you have had more than one spouse, your spouse shall be only the person who was your most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee who are:

a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

Online Learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Claims for over-age dependent children cannot be processed until the over-age dependent is registered with Johnson Inc.

The over-age dependent can use your benefit card. An additional card can be issued upon your request.

Applying for CI Coverage

This insurance provided through your group insurance plan includes an optional critical illness benefit for yourself, your spouse and your dependent child(ren). The premiums are based on age, gender and smoker status.

Plan Member - Units of $10,000 to a maximum of $300,000

Spouse - Units of $10,000 to a maximum of $300,000

Eligible Dependent Child(ren) - Flat $10,000

Guarantee Issue Limit

You and your spouse are eligible to apply for amounts up to $50,000 without submitting evidence of insurability (proof of health). For amounts exceeding $50,000, medical evidence of insurability is required and application may be made by completing a medical questionnaire. This questionnaire can be requested by calling Johnson Inc**. If approved for a higher amount than the $50,000 guarantee issue limit, the pre-existing exclusion will not apply.**

Effective Date of Coverage

Coverage will commence on the first of the month coincident with or next following the date your signed application is received by Johnson Inc. If you are not actively at work (excluding retired members), you will only become eligible to apply for coverage when you return to active employment. If medical evidence of insurability is required, coverage takes effect the first of the month following approval by the underwriting company. **The premiums are paid 100% by you, the member.**

Pre-Existing Conditions Limitation Clause

It is important to note that this critical illness benefit has a 24-month pre-existing condition limitation clause. The limitation states that "no benefit Is payable for an illness or pre-existing condition for which the participation has received care, treatment or services, consulted a physician or taken medication that was prescribed to him/her, in the 24 months prior to the effective date of coverage, unless the illness in question was diagnosed at least 24 months after the effective date of the insurance of the participant, subject to other applicable provisions of this policy".

This provision applies only to the guarantee issue amount of $50,000. If the insured member applies for a higher amount than the $50,000 guarantee issue limit and is approved, the pre-existing exclusion will not apply.

There is a **survival period of 30 days** required following the occurrence of all covered conditions. In addition, there is a **90 day waiting period** after issue of the coverage before Cancer can be a covered condition.

Covered Conditions:

Coverage for plan member and spouse - 100%

- Alzheimer's disease
- Aortic surgery
- Aplastic anemia
- Bacterial meningitis
- Benign brain tumour
- Blindness (loss of sign of both eyes)
- Coma
- Coronary bypass
- Deafness (loss of hearing in both ears)
- Dilated cardiomyopathy
- Fulminant viral hepatitis
- Heart attack (myocardial infraction)
- Heart valve replacement
- HIV infection (occupationally acquired infection)
- Kidney failure
- Life-threatening cancer
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major burns (severe)
- Major organ failure (on waiting list)
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Paralysis
- Parkinson's disease
- Primary pulmonary hypertension
- Stroke (cerebrovascular accident)

Supplemental Coverage	**% Payable**
Critical Illness	
Coronary angioplasty	10% up to a maximum of $25,000
Ductal carcinoma in situ of the breast	10% up to a maximum of $25,000
Stage A prostate cancer (T1A or T1B)	10% up to a maximum of $25,000
Stage 1A malignant melanoma	10% up to a maximum of $25,000

Coverage for dependent children

To provide additional security for parents, dependent children are covered for 20 illnesses or conditions, some of which are often diagnosed early in life.

Conditions covered under the extended coverage - 100%

- Aortic surgery
- Benign brain tumour
- Blindness (loss of sight of both eyes)
- Cancer
- Cerebral palsy
- Coma
- Congenital heart disease requiring surgery
- Cystic Fibrosis
- Deafness (loss of hearing in both ears)
- Down's syndrome
- Heart valve surgery
- Kidney failure
- Loss of limbs
- Loss of speech
- Major burns (severe)
- Major organ failure (on waiting list)
- Major organ transplant
- Serious cerebral lesion
- Serious mental deficiency
- Spina bifida cystic

Waiver of Premium

Critical Illness insurance has no waiver of premium clause so you need to continue paying the premium to maintain coverage.

Claims Payment

A one-time tax free lump sum payment will be payable to the insured member.

Once a benefit has been paid for a critical illness, the coverage terminates and no additional premiums are payable.

Coverage for spouse and dependent child(ren) terminates upon the member's death.

If the member survives, the coverage can be maintained for your eligible spouse as long as you are still eligible for benefits under the NSTU Group Insurance Plan and premiums are continued to be paid.

Coverage can be maintained for eligible dependent child(ren) as long as you are still eligible for benefits under the NSTU Group Insurance Plan and premiums are continued to be paid.

Please contact Johnson Inc. immediately in the event of a claim. Written notice should be given within thirty (30) days of the event.

Termination of Coverage

1. On the date the policy is terminated;
2. On the date you no longer qualify for benefits under the NSTU Group Insurance Plans;
3. On the premium due date if the policyholder fails to pay your premiums to the Insurer, except as a result of an inadvertent error;
4. On the day you give notice of cancellation to the policyholder;
5. On the day you reach 75 years of age;
6. On the day your insured spouse reaches 75 years of age or the day you turn 75 whichever is earlier;
7. On the premium due date your spouse/dependent child(ren) cease to be eligible for benefits per the definition;

Definitions - Member and Spouse

Alzheimer's disease means a definite diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgement that results in a significant reduction in mental and social functioning and requires a minimum of eight (8) hours of daily supervision. The diagnosis of Alzheimer's disease must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic surgery means undergoing surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta, but not its branches. The surgery must be determined to be medically necessary by a specialist in the appropriate field.

Aplastic anaemia means a definite diagnosis of a chronic persistent bone marrow failure confirmed by biopsy that results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion and treatment with at least one (1) of the following:

Marrow stimulating agents; immunosuppressive agents; bone marrow transplantation.

The diagnosis of aplastic anaemia must be made by a specialist in the appropriate field.

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion - No benefit will be payable under this condition if within the first 90 days following the later of:

the effective date of the coverage; the effective date of the last reinstatement of coverage, the Insured Person has any of the following: signs, symptoms or investigations that lead to diagnosis of benign brain tumour, regardless of when the diagnosis is made; diagnosis of benign brain tumour.

This medical Information as described above must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

the corrected visual acuity being 20/200 or less in both eyes; the field of vision being less than 20 degrees in both eyed.

The diagnosis of blindness must be made by a specialist in the appropriate field.

Cancer (life-threatening) means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

carcinoma in situ; stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); any non-melanoma skin cancer that has not metastasized; stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion - No benefit will be payable under this condition if within the first 90 days following the later of:

the effective date of the coverage; the effective date of the last reinstatement of coverage, the Insured Person has any of the following:

signs, symptoms or investigations that lead to diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which period the Glasgow coma score must be four (4) or less. The diagnosis of coma must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for:

a medically induced coma; a coma that results directly from alcohol or drug use; diagnosis of brain death.

Coronary angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined by a specialist to be medically necessary.

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a specialist in the appropriate field.

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist in the appropriate field.

Dilated cardiomyopathy means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of dilated cardiomyopathy must be made by a specialist in the appropriate field and must be confirmed by new, abnormal cardiac function demonstrated in echocardiography with a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

Ductal carcinoma in situ of the breast - the diagnosis of this illness must be made by a specialist and confirmed by biopsy.

Fulminant viral hepatitis means a definite diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

a rapidly decreasing liver size as confirmed by abdominal ultrasound; necrosis involving entire lobules, leaving only a collapsed reticular framework (available histology to be included); rapidly deteriorating liver function tests; deepening jaundice.

The diagnosis of fulminant viral hepatitis must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for:

chronic hepatitis; liver failure caused by alcohol, toxins and/or drugs.

Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in rise and fall of biochemical cardiac markers to levels considered diagnostic for myocardial infarction, with at least one (1) of the following:

heart attack symptoms; new electrocardiogram (ECG) changes consistent with a Heart attack; development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for:

elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waver;

ECG changes suggesting a prior myocardial infarction that do not meet the heart attack definition as described above.

Heart valve replacement means undergoing surgery to replace any heart value with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for heart valve repair.

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function so that regular haemodialysis; peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist in the appropriate field.

Loss of independent existence means a definite diagnosis of:

a total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living; cognitive impairment for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of Loss of independent existence must be made by a specialist in the appropriate field.

Activities of Daily Living are:

bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment;

dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances;

toileting - the ability to get on and off the toilet and maintain personal hygiene;

bladder and bowel continence - the ability to manage bowel and bladder function with or without protection undergarments or surgical appliances so that a reasonable level of hygiene is maintained;

transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment;

feeding - the ability to consume food or drink that already has been prepared and made available, with or without

the use of adaptive utensils.

Loss of limbs means a definite diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist in the appropriate field.

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak, as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the Insured Person's enrollment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist in the appropriate field.

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow and limited to these entitles. The diagnosis of the major organ failure must be made by a specialist in the appropriate field.

Motor neuron disease means a definitive diagnosis of one (1) of only the following:

amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease); primary lateral sclerosis; progressive spinal muscular atrophy; progressive bulbar palsy; pseudo bulbar palsy.

The diagnosis of motor neuron disease must be made by a specialist in the appropriate field.

Multiple sclerosis means a definite diagnosis of at least one (1) of the following:

two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system that shows multiple lesions or demyelination; well-defined neurological abnormalities lasting more than six (6) months confirmed by MRI imaging of the nervous system that shows multiple lesions of demyelination; a single attack, confirmed by repeated MRI imaging of the nervous system that shows multiple lesions of demyelination that developed at intervals at least one (1) month apart.

The diagnosis of multiple sclerosis must be made by a specialist in the appropriate field.

Muscular dystrophy means a definite diagnosis of all of the following:

Clinical presentation including skeletal muscle weakness, muscle pain and myotonia; characteristic electromyography changes; muscle biopsy confirming diagnosis of muscular dystrophy.

The diagnosis of muscular dystrophy must be made by a specialist in the appropriate field.

Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation that exposes the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the coverage or the effective date of the last reinstatement date of coverage.

Payment under this condition requires satisfaction of all of the following:

the accidental injury must be reported to the Insurer within fourteen (14) days of the event; a serum HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative; a serum HIV test must

be taken between 90 days and 180 days after the accidental injury and the result must be positive; all HIV tests must be performed by a duly licensed laboratory in Canada or United States; the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition if:

the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; a licensed cure for HIV infection has become available prior to the accidental injury; HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis means a definite diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist in the appropriate field.

Parkinson's disease means a definite diagnosis of primary idiopathic Parkinson's disease that is characterized by a minimum of two (2) or more of the following clinical manifestations:

muscle rigidity; tremor bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses.)

The diagnosis of Parkinson's disease must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for all other types of Parkinsonism.

Primary pulmonary hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means a definite diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of primary pulmonary hypertension must be made by a specialist in the appropriate field.

The NYHA Classification of Cardiac Impairment (source: *Current medical diagnosis and Treatment-39th Edition)* states the following about Class IV:

"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest".

Exclusion: No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

Severe burns means a definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist in the appropriate field

State A prostate cancer (T1A or T1B) - the diagnosis of this illness must be made by a specialist and confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma means a melanoma less than or equal to 1.0mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis of this illness must be made by a specialist and confirmed by biopsy.

Stroke (cerebrovascular accident) means a definite diagnosis of an active cerebrovascular event caused by intra-cranial thrombosis or haemorrhage or embolism from an extra-cranial source with:

Acute onset of new neurological symptoms; new objective neurological deficits on clinical examination, persisting for more than thirty (30) days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for:

transient ischemic attacks; intracerebral vascular events due to trauma; lacunar infarcts that do not meet the definition of stroke as described above.

Definitions - Dependent Children

Aortic surgery means undergoing surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta, but not its branches. The surgery must be determined to be medically necessary by a specialist in the appropriate field.

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion - No benefit will be payable under this condition if within the first 90 days following the later of:

the effective date of the coverage; the effective date of the last reinstatement date of coverage, the Insured Person has any of the following:

signs, symptoms or investigations that lead to diagnosis of benign brain tumour, regardless of when the diagnosis is made; diagnosis of benign brain tumour.

this medical information as described above must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

the corrected visual acuity being 20/200 or less in both eyes; the field of vision being less than 20 degrees in both eyed.

The diagnosis of blindness must be made by a specialist in the appropriate field.

Cancer (life-threatening) means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

carcinoma in situ; Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); any non-melanoma skin cancer that has not metastasized; stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion - No benefit will be payable under this condition if within the first 90 days following the later of:

the effective date of the coverage; the effective date of the last reinstatement of coverage, the Insured Person has any of the following:

signs, symptoms or investigations that lead to diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for cancer or any critical illness

caused by any cancer or its treatment.

Cerebral palsy means a chronic disorder, diagnosed by a licensed specialist physician, that appears in the first few years of life caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which period the Glasgow coma score must be four (4) or less. The diagnosis of coma must be made by a specialist in the appropriate field.

Exclusion: No benefit will be paid under this condition for:

a medically induced coma; a coma that results directly from alcohol or drug use; diagnosis of brain death.

Congenital heart disease requiring surgery means any serious cardiac malformation present at birth, diagnosed by a licensed specialist physician, for which corrective surgery has been performed.

Cystic fibrosis means a genetic disease, diagnosed by a licensed specialist physician, affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucus leading to chronic progressive respiratory disease and nutritional problems.

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist in the appropriate field.

Down's syndrome means a congenital condition, diagnosed by a licensed specialist physician, caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present

Heart valve replacement means undergoing surgery to replace any heart value with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist in the appropriate field

Exclusion: No benefit will be payable under this condition for heart valve repair.

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function as a result of that regular haemodialysis; peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist in the appropriate field.

Loss of limbs means a definite diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist in the appropriate field.

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak, as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist in the appropriate field.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the Insured Person's enrollment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist in the appropriate field.

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow and limited to these entitles. The diagnosis of the major organ failure must be made by a specialist in the appropriate field.

Severe burns means a definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist in the appropriate field.

Severe burns means a definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist in the appropriate field.

Serious cerebral lesion means any lesion, diagnosed by a Physician that is characterized by an invasive development problem or serious intellectual deficiency that prevents an individual from performing the basic activities of daily living and requires professional specialized services for his treatment, rehabilitation, re-education or schooling on a daily basis.

Serious mental deficiency means a deficiency that when evaluated through standard testing, demonstrates that an individual has an IQ of less than 70.

Spina bifida cystica means a congenital defect, diagnosed by a licensed specialist physician, caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following hydrocephalus, paralysis, bowel and bladder problems.

VI. Long Term Disability Insurance

This option provides income security should you become totally disabled and remain so over a long period of time. In order to receive this benefit you must remain under the continuing care of a physician.

Eligibility

All active members of the NSTU and all permanent full-time or part-time employees of the NSTU or Teachers *Plus* Credit Union under age 65 who reside in Canada. A member of the plan who is on approved leave of absence and becomes an Associate Member of the NSTU may continue benefits on a pay-direct basis by contacting Johnson Inc.

The long term disability plan is mandatory for all members without the ability to opt out unless the following condition is met:

a) Plan member is 65 years of age or 35 years of pensionable service less accumulated sick leave.

b) Plan member is at least 64 years of age and has sufficient accumulated sick leave to reach age 65.

A member will be eligible to apply for the coverage provided the member meets the following requirements:

- Is actively employed.
- Is under age 65.

Definition of Total Disability

Totally disabled member: during the Qualifying Period and the succeeding 24 months, a member is totally disabled when he / she is wholly and continuously disabled due to illness or bodily injury and, as a result, is not physically or mentally fit to perform the essential duties of their normal occupation.

Thereafter, a member is totally disabled provided he / she is wholly and continuously disabled due to illness or bodily injury and, as a result, is not physically or mentally fit to perform the essential duties of:

his / her normal occupation; and

any other occupations, jobs or work:

(i) for which he / she is, or becomes, qualified by their education or training or experience, considered collectively or separately; and

(ii) for which the current monthly earnings are 75% or more of the current monthly earnings for the member's normal occupation.

The availability of such occupations, jobs or work will not be considered in assessing the member's disability.

A member who must hold a government permit or license to perform his / her duties will not be considered totally disabled solely because such permit or license has been withdrawn or not renewed.

Recurrent Disabilities

If you cease to be totally disabled at any time during the qualifying period and become disabled again, due to the same cause, within 2 weeks, the qualifying period will be extended by the number of days during which you cease to be disabled.

A member's total disability can be considered to be a recurrence of his / her previous total disability provided the following conditions are met:

The member has received benefit payments under this policy.

The member becomes totally disabled again after having returned to work on a full-time, part-time, probationary or term contract basis, within 6 months from the end of the period for which benefits were paid.

The subsequent total disability is due to an injury or illness directly related to the causes of the immediately preceding total disability.

If the member was involved in a rehabilitation program:

Subsequently becomes totally disabled due to an injury or illness directly related to the causes of the immediately preceding total disability, or

was unable to continue in such program because of the total disability for which he / she received benefits under this policy,

then, for the purposes of this provision, the member's disability can be considered recurrent.

If the disability is considered to be recurrent, the monthly benefit is subject to all of the provisions of this benefit with the following exceptions:

The member is entitled to recommencement of benefit payments on the date the disability recurred.

The monthly benefit will be based upon the same earnings level as at the original date of disability.

If the disability is not considered to be recurrent, all the provisions of this benefit will apply as they would for a new claim.

Benefit

If you have a full-time contract, benefits are based on **70%** of recorded gross monthly salary earned on the date disability payments commence. If you have a part-time contract, benefits are based on **70%** of the actual recorded gross monthly salary earned on the date disability payments commence.

Earnings are defined as your gross monthly earnings excluding bonuses, commissions and overtime. For members in the Deferred Salary Leave Plan, earnings shall be determined as though the member was not enrolled in the Deferred Salary Leave Plan. Earnings shall be determined, where necessary, on the basis that monthly earnings shall be 1/12th of the annual earnings and daily earnings shall be 1/30th of the monthly earnings.

This amount will be reduced by other income you may be entitled to receive from the following sources. If eligible, a member must apply for the following:

(a) Disability or service benefits payable under a public pension plan (the Canada Pension Plan or Quebec Pension Plan) excluding benefits payable to the employee on behalf of his dependents.

(b) Disability or service benefits payable under the Teachers' Pension Plan (TPP).

(c) Benefits payable under any *Workers' Compensation Act*.

Following the qualifying period, the benefit is paid monthly until recovery or to age 65, whichever occurs first. Monthly salary is recorded at 1/12 of annual salary for calculating premium and benefits.

Teachers who are on an approved Long Term Disability (LTD) claim continue to accumulate pensionable service. To accomplish this, pension contributions are required while in receipt of LTD benefit payments through the NSTU LTD Group Plan. The Province of Nova Scotia will also continue to make required contributions. **This applies to all teachers who are in receipt of LTD benefits on or after August 1, 2014.**

The NSTU Long Term Disability Program is a taxable plan.

Qualifying Period

Ninety (90) calendar days (approximately 60 sick leave days), or accumulated sick leave, whichever is greater.

Members with less than 90 calendar days (approximately 60 sick leave days) of accumulated sick leave should apply for Employment Insurance Sickness and Disability Benefits. Application for Employment Insurance Sickness and Disability Benefits should be made a minimum of 10 teaching days before sick leave benefits expire.

If you are ineligible for Employment Insurance Sickness and Disability Benefits based on the number of working hours required in the last 52 weeks, you may apply for a Long Term Disability discretionary payment under the NSTU Group Insurance Trust Fund. Please contact NSTU Insurance Trustees for details and assistance.

Rehabilitation

A rehabilitation program which is considered beneficial to a totally disabled member will be recommended or approved by the Claims Adjudicator, at their discretion, based on the nature and expected duration of the member's disability, their education or training or experience, and the level of activity required to become actively employed again.

When recommended by the Claims Adjudicator, the rehabilitation program will be developed by the Claims Adjudicator's rehabilitation counselors with the co-operation of the member and the assistance of his physician, the employer and a specialist on the subject of rehabilitation. A rehabilitation program which is not developed by the Claims Adjudicator must be approved by the Claims Adjudicator in order for the provisions of this clause to apply.

A rehabilitation program may include work for the employer as defined in the policy, or any other employer that is acceptable to the Claims Adjudicator.

Monthly benefit payments will not cease for a member who is able to work under a rehabilitation program and who receives rehabilitation income, but will continue as follows:

The amount of monthly benefit, will be reduced by 50% of the member's rehabilitation income.

Benefits will cease when the member's rehabilitation income equals 75% or more of the current monthly earnings for the member's normal occupation.

Benefits will be paid for a maximum period of 24 months, unless payments cease earlier in accordance with above.

If the member cannot continue in a rehabilitation program due to his disability, he / she will again be subject to the regular provisions for benefit payments.

Cost-of-Living Benefit

The Trustees approved the following procedure to consider an annual cost-of-living payment:

(a) In January of each calendar year, the Trustees will decide whether or not a cost-of-living payment is to be made to long term disability claimants.

(b) The Trustees will determine the level of payment, if one is declared.

(c) If a cost-of-living payment is declared, it shall be applied on the following basis:

  (i) the benefit will become payable on January 31 of each calendar year;

  (ii) the benefit will apply to all claimants who were on claim on December 31 of the calendar year previous to the year in which the benefit is paid, provided the claimant had been on claim for two or more consecutive years;

  (iii) the benefit shall not be paid if the claimant has not finalized Canada Pension and Nova Scotia Teachers' Pension applications or if the claimant has an outstanding overpayment of claim.

This benefit is subsidized by the NSTU Group Insurance Trust Fund.

Cessation of Benefit Payment

Your monthly payments will cease on the earliest of the following events:

- The date you are no longer totally disabled.
- The date you reach age 65. However, should you complete the qualifying period after your 64th birthday, but prior to your 65th birthday, the monthly income payments will continue beyond age 65, until a total of 12 monthly payments have been made.
- The date you fail to undergo, when requested by the Insurance Company, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by the Insurance Company.
- The date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program or alcoholism, drug addiction or substance abuse treatment program when recommended by the Insurance Company.
- The date you are incarcerated in a prison or mental institution by authority of a criminal court.
- The date you refuse to complete and return a Reimbursement Agreement/ Direction form or comply with the terms of a signed Reimbursement Agreement/Direction form, when requested, with respect to disability payable under a public pension plan, the Teachers' Pension Plan or Workers' Compensation.
- If you should die.

Exceptions and Limitations

Long Term Disability or Hospital Cash are not payable for the following:

- A disability caused by self-inflicted injuries or illness.
- A disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot.
- Normal pregnancy or childbirth.

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for benefits at any time when you are on pregnancy leave of absence or could be placed on such leave by your employer in accordance with relevant government legislation or the leave agreed upon by you and your employer.

Waiver of Premium

Premiums are due and payable during the elimination period. However, once the elimination period has been satisfied,

premiums falling due while you are receiving Long Term Disability benefits will be waived.

Claim Procedures

WHAT YOU NEED TO KNOW

DO NOT WAIT UNTIL ACCUMULATED SICK LEAVE EXPIRES!!

While an application does not normally get sent to the insurance company until three (3) months before sick leave expires, it is crucial that your claim be submitted early in order to avoid undue delay in processing the information. If you have been on accumulated sick leave for 20 or more consecutive days, and even if you may be expecting to return to work prior to expiry of your accumulated sick leave, please contact the Administrator, Johnson Inc., as soon as possible. The first step will be to determine whether you should indeed submit a claim.

The Claims Specialist at Johnson Inc. will assist members in understanding the process and requirements for Long Term Disability Benefit application. The Claims Specialists, the NSTU Early Intervention Program Manager, or Case Coordinator will assist you in this process as needed.

If a claim is to be submitted, you will be given a Claimant's Statement to complete. There will be an Attending Physician Statement for completion by your family physician, as well as additional Attending Physician Statements for completion by any treating specialists. Depending on the circumstances, and length of time away from work, the insurer may require in accordance with the disability contract provision that you are under the care or treatment by a specialist prior to making a determination of benefit eligibility.

The completed forms are sent to Johnson Inc., and then on to the Insurance Company.

The determination as to whether you are eligible for disability benefits is made by the Insurance Company. Their decision is based on an assessment of your functional level and/or medical impairment, in relation to the demands of your occupation. The information on which this decision is based must be 1) complete, 2) clear, and 3) valid. After analysis of all information, a decision will be communicated to you.

Roles and Responsibilities

THE INSURANCE COMPANY WILL:

- Be responsible for initial and ongoing assessment and management of your claim,
- Continue to collect whatever information, medical or otherwise, is needed in the ongoing assessment and management,
- Coordinate return-to-work efforts as soon as possible, where this is an option, using the services of their Rehabilitation Specialist, and,
- Maintain open lines of communication between yourself, your physician, your employer, (where possible), your Union and Johnson Inc.

YOU, THE CLAIMANT, MUST:

- Provide initial information required for the documentation and initial assessment of your file,
- Advise the Insurance Company if you return to work, or if you are work ready, either on a part-time or full-time basis, for your own employer, another employer, or yourself,
- Visit your physician on a regular basis and follow treatment recommendations in order to achieve maximum benefits from treatment,

- Set goals for return to work, and if appropriate, work in a cooperative manner with the Insurance Company Rehabilitation Specialist.

  Also, you should maintain contact with your employer and fellow employees.

Long Term Disability benefits will be paid as specified in your Certificate of Insurance as long as you meet the definition of "disability" as outlined. At any point, if the insurance company determines that you no longer meet this definition, and are therefore no longer entitled to disability benefits, they will advise you. You will receive a narrative letter, of the rationale behind such a decision. Benefits will not be terminated in arrears, and there will be detailed instructions with respect to the termination and appeal process.

If a claim is declined at the outset, the same procedures are followed, i.e., a detailed letter explaining the rationale behind the declination, along with detailed instructions for appeal. An appeal should be presented in writing, within 60 days of a decision, to decline or terminate benefits. The appeal should be accompanied by additional new medical information not previously on file. This could consist of narrative reports, test results or consultant reports.

Early Intervention Program for Members

The Early Intervention Program is a voluntary program for all NSTU members who are absent from work due to injury or illness. The program provides encouragement, support and opportunity for active participation in order to facilitate an early return to health and work or early application for disability benefits.

Participation in the program is voluntary. Members may contact the Program Manager or Case Coordinator directly at the NSTU if they feel that assistance is required or they are at risk for disability.

Intervention could include occasional telephone contact, assistance with coordinating health services and appointments, for example: physician, therapist, counselor, chiropractor, or facilitation of a return to work plan and vocational rehabilitation services.

The Early Intervention Program is committed to ensuring confidentiality of the members involved in the program. Members' anonymity is maintained unless the member signs a form that authorizes release of information to identified individuals.

The member's file will be kept in a secure location at the site of the Early Intervention Program Manager, the NSTU building in Halifax.

If you or anyone you know has questions about the program, please contact the Early Intervention Program Manager or Case Coordinator at the NSTU to determine if this program may be of assistance to you.

Tel: (902) 477-5621
Toll Free: 1-800-565-6788
Fax: (902) 477-3517
Website: www.nstu.ca
Email: eip@nstu.ca

Termination of Insurance

Your insurance will cease on the earliest of the following events:

- Termination of your employment.
- If you should die.
- On the date you retire. However, coverage will cease at the end of the month for which the last premium was paid.
- If you enter the armed forces of any country on a full-time basis.
- Termination of the Policy or coverage on the Group, Division or Class to which you belong.
- On the date you no longer contribute towards the cost of your insurance.
- On the date you reach age 65 less the qualifying period. However, coverage will cease at the end of the month for which the last premium was paid.

Extension of Benefits

Long Term Disability benefits will extend beyond your termination date, provided you became disabled while you were still insured subject to the Maximum Benefit Period. Benefits will continue to be paid according to the contract provisions, regardless of the subsequent termination of the Group Policy. The Insurance Company reserves the right to require that while you are in receipt of long term disability income, you furnish proof of the continuance of total disability, and submit to an examination by the Insurance Company's medical advisors when requested.

Additional Information

When a change in salary occurs by virtue of the Provincial Agreement, the recorded salary and premium will be automatically adjusted in the month following the date the agreement is signed.

If you wish to have your recorded salary adjusted during the year because of a change other than the Provincial Agreement, you must write by registered mail to Johnson Inc.

Recorded salary cannot be adjusted following disability.

VII. NSED Group Travel Plan

Out of Province/Canada Emergency Medical Insurance Plan

The NSED Travel Insurance Plan offers complete coverage for your travel needs in one convenient package, with options to suit your budget. The Provincial Health Plan provides limited basic coverage for travel outside of your province of Residence. If you have a medical emergency while travelling outside Canada, costs can easily escalate and will not all be covered by the government plan.

You and/or your family must be insured under the Provincial Health Insurance Plan in your Province of Residence to be eligible to join the plan. You can also cover your spouse and your eligible dependent children under the family option.

Take a few minutes now to consider the important features of this plan.

The NSED Travel Plan insures you and your immediate family member(s) for reasonable and customary expenses arising from any sudden and unexpected sickness or injury that takes place during an insured trip and requires immediate medical treatment by a licensed physician. Subject to the maximum amounts shown below, the plan pays for eligible expenses less the amount under any other insurance plan. If you have coverage through other plan(s), Medavie Blue Cross will coordinate benefits with other plan(s) in which you participate. Total reimbursement for expenses will not exceed 100% of the cost.

The NSED Travel Plan Consists of Two Options: The Base Plan and the Supplemental Plan, the terms of which are outlined separately.

The Annual Base Plan

The Annual Base Plan is a continuous plan that provides emergency medical travel coverage for an unlimited number of trips, up to 35 consecutive days per trip during the policy year. Proof of travel is not required unless a claim occurs.

The Supplemental Plan

You may elect coverage under the Supplemental Plan for trips of longer than 35 consecutive days on a per trip basis and increase incrementally by 15 days to a maximum of a 210 day trip limit. **You are required to report the entire period of travel from the first day. The Supplemental Plan options include the Annual Base Plan Coverage.**

Pre-existing Conditions

This plan provides coverage for emergencies only and does not provide coverage for expenses incurred as a result of a pre-existing health condition, unless the condition has remained stable for a period of 6 months immediately prior to the date of purchase of trip. To be considered medically stable you must not have:

- been treated or evaluated for new symptoms or new diagnosis
- had symptoms that increased In frequency or severity, or examination findings indicating the condition has worsened
- been prescribed a new treatment or change in treatment for the condition
- been admitted to or treated in a hospital or referred to a specialist for the condition

- been awaiting new treatment, tests, consultations or referrals regarding the medical condition (does not include routine testing provided the results are within normal limits and no change in treatment is recommended)

This also does not include coverage for expenses incurred as a result of a condition caused by a change in medication within 90 days prior to departure (generally does not include routine changes in medication as part of an established treatment plan, i.e., daily/weekly adjustments of blood thinners or insulin based on blood test results OR a change to a generic product, unless the dosage is modified).

For further clarification on the pre–existing conditions clause, your call will be directed to the provider, who will discuss your medical information with you.

Eligibility

The NSED Travel Plan is available to active and retired members and eligible dependents of the NSTU. To be eligible for coverage, you must be a resident of Canada and covered under your provincial government plan.

How to Enroll

Complete an enrollment form, indicating the coverage required and return it to Johnson Inc.

If you need help in choosing the right coverage, a Johnson Service Supervisor will be pleased to assist you.

Your Annual Base Plan coverage begins the day Johnson Inc. receives your completed and signed enrollment form. Your Supplemental Plan will commence the later of (i) the date shown on your completed signed enrollment form, or (ii) the date you depart your province of residence. Shortly after, you will receive a confirmation of coverage letter, Benefits Booklet and ID Card.

In the first year, for first time NSED members only, the Annual Base plan premiums are pro-rated from the date your coverage is effective until the policy renewal date, which is September 1st.

The Plan automatically renews each year on September 1st. You will receive written notification in advance. Your coverage will continue at renewal for the next policy year, unless you provide Johnson Inc. with written notice of termination within 30 days of the renewal date. Premiums are deducted monthly. Premiums under the Base Plan are non-refundable and non-cancellable.

*Supplemental Plan premiums for any of the per trip options includes coverage for any other trips of 35 consecutive days or less duration. Premiums are deducted monthly during the period remaining from the date coverage begins until the next policy renewal, which is September 1. No portion of the Supplemental Plan premiums will be prorated.

Extension of Coverage — Supplemental Plan Only

The agreement may be extended for one further period, providing benefits were not used during the preceding period. If benefits were used, extension is at the option of the Insurer. Enrollment form for extension must be received before expiry of the first period of coverage. The total period of coverage may not exceed one year. Please note that the Insurer only approves extensions within the last 10 days of the current policy.

Definition of Dependents

"Spouse" means either:

(a) a member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If you have had more than one spouse, your spouse shall be only the person who was your most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee who are:

a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

"Over-age-Dependents" — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

On-line learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

If attending college or university outside Canada, a dependent is covered while travelling outside of the area of residence.

Benefits

Eligible expenses include:

Emergency Medical Expenses — This benefit covers the cost of Emergency hospital, surgical and medical treatment for the following:

- Hospital room and board including an Intensive Care or Coronary Care unit, charges for standard ward

accommodation, semi-private room, or private room charges when certified as medically necessary by the attending physician;

- Other Hospital services and supplies;
- Medical, surgical or anaesthetic treatment by a licensed physician or surgeon;
- X-rays and other diagnostic tests;
- Use of an operating room, anaesthesia and surgical dressing;
- The cost of a licensed ambulance service;
- Out-patient emergency room charges;
- Drugs and medications legally requiring a licensed physician's written prescription; and
- Rental cost of a wheelchair, rental or purchase of minor medical appliances such as crutches, braces and other therapeutic medical appliances when ordered by the attending physician.

Air Emergency Transportation or Evacuation — When medically required covers the following expenses:

- Air ambulance to the nearest appropriate medical facility or to a Canadian hospital;
- Fare for transportation by stretcher to the home departure point including, when medically necessary, the return fare and approved professional charge of an accompanying Registered Nurse or other qualified medical attendant, not a relative of the Insured Person; and
- Charges In excess of booked fare or prearranged charter fare incurred as a result of a change in the planned schedule, including additional fare of an eligible Insured Person covered under this contract who was travelling with the stricken Insured Person.
- Return fare for transporting a member of the immediate family (spouse, parent, child) to attend at the side of an Insured Person who was travelling unaccompanied by an adult family member, following a critical injury or illness necessitating hospitalization. Attendance and return must occur within 10 days of discharge from hospital.

All air transportation expenses must be approved and arranged in advance by Medavie Blue Cross.

Private Nursing Expenses — Charges for services of a Registered Graduate Nurse (R.N.), for private duty nursing care provided in a Hospital or a temporary residence, when medically necessary and ordered by the attending physician. Coverage is not included for nursing service provided by a relative of the participant.

Physiotherapy — Charges for services of a registered physiotherapist when recommended by the attending physician.

Emergency Dental Expenses — This benefit covers the cost of repair of natural, vital teeth or fracture or dislocation of the jaw, as a result of injury from an external blow during the term of the contract. It also covers the cost of emergency extractions, temporary filings and replacement fillings. Coverage is limited to $1,000 per injury and must be provided during the term of coverage.

Board and Lodging — Charges for board and lodging or similar expense up to $150 per day to a maximum of $1,500 for costs incurred by a Participant or by a travelling companion, when related to a period of hospitalization of a Participant.

Repatriation — If a Participant dies while on an insured trip, the cost of transportation of the deceased Participant's remains to their province of residence, up to a maximum of $3,000 per Participant. The cost of a burial coffin is not a covered expense.

Vehicle Return — If a Participant and/or immediate family member is unable to operate their owned or rental vehicle due to sickness, injury or death while travelling outside the Participant's province of residence, this plan will arrange for the return of the vehicle and cover the expenses up to a maximum of $1,000 provided no other person travelling with the Participant insured person is able to operate the vehicle. Benefits will only be payable for return of the vehicle when pre-approved and/or arranged by Medavie Blue Cross.

- To the Participant's normal place of residence; or

- To the nearest appropriate rental agency

Benefit Maximums

The plan reimburses all usual and reasonable expenses incurred following an emergency situation resulting from an accident or an illness, up to a maximum amount payable of $2,000,000 per incident, per covered Participant and a maximum amount payable of $5,000,000 for one occurrence.

Occurrence refers to each related claim arising as a result of one accident or cause, regardless of the number of policies or covered persons involved.

All customary and reasonable expenses and services described in the Travel Benefit are eligible if they are incurred following an emergency resulting from an accident or sudden illness which occurs outside the Participant's province of residence, provided the Participant is covered under the Hospital and health government programs of his province of residence when the emergency occurs.

Eligible treatments and benefits are supplemental to those provided for by government plans or from any other medical reimbursement plan under which you may have coverage. All individual benefit maximums stated within this policy are expressed in Canadian currency.

In case of Emergency

If a medical emergency occurs during travel, please call (or if necessary, have your travel companion call) the Worldwide Travel Assistance phone number on the back of your ID card so they can direct you to a Preferred Provider. If possible, call BEFORE consulting for medical care.

In Canada/U.S.A. call: 1-800-563-4444
From anywhere else call collect: 1-506-854-2222

Medavie Blue Cross provides the following services:

Medical Assistance — If the participant requires hospitalization or a consultation with a physician as a result of an emergency, the travel assistance provider appointed by Medavie Blue Cross will provide the following support services:

- Direct the participant to an appropriate clinic or hospital;
- Confirm with the service provider that the participant Is covered;
- Ensure a follow-up of the medical file and communicate with the participant's family physician;
- Co-ordinate the return home of a child if the participant is hospitalized;
- Repatriation of the participant to the province of residence if the participant meets the eligibility requirements of this expense;
- Arrange for the transportation of an immediate family member to the participant's bedside if the Participant meets the eligibility requirements of this expense; and
- Co-ordinate the return of the participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance — In emergency situations, the travel assistance provider appointed by Medavie Blue Cross will also provide the participant with the following services:

- Transmittal of urgent messages;

- Co-ordination of claims;
- Services of an interpreter for emergency calls;
- Referral to legal counsel In the event of a serious accident;
- Settlement of formalities In the event of death;
- Assistance with the loss or theft of Identity papers; and
- Information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available (although vaccines may not be covered under your medical plan).

Medavie Blue Cross and its travel assistance provider are not responsible for the quality of medical and hospital care provided to the participant or for the availability of such care.

Managed Care

When a medical emergency occurs, you must seek treatment from a physician and/or hospital within the managed care network as referred by Medavie Blue Cross' appointed travel assistance provider. The travel assistance provider will refer you to the physician and/or hospital within the network that is best suited to your needs.

If you do not call the travel assistance provider, your eligible expenses will be reimbursed at 80%, except in extreme circumstances where you are unable to call. In a critical emergency, have someone call the travel assistance provider on your behalf as soon as possible and they will coordinate your benefits as usual.

If you choose not to receive treatment from the Managed Care network recommended by the travel assistance provider, your eligible expense will be reimbursed at 80%.

Automatic Extension

Coverage will be automatically extended beyond your day of return if you, a travelling companion, or your immediate family member travelling with you, is confined to a hospital on your day of return due to a medical emergency. Your coverage will remain in force for as long as you, your travelling companion, or your immediate family member is hospitalized plus an additional period of 5 days following discharge from hospital.

The period of insurance coverage is automatically extended for 72 hours when:

1. The delay of a plane, bus, ship, or train in which you are a passenger causes you to miss your scheduled return to your province of residence;
2. The personal means of transportation in which you are travelling is involved in an accident or mechanical breakdown that prevents you from returning to your province of residence on or before your day of return; or
3. You must delay your scheduled return to your province of residence by the personal means of transportation in which you are travelling, due to extreme weather conditions.

Exclusions and Limitations

The policy does not cover, provide services, or pay claims, for expenses resulting from:

1. a sickness or injury occurring while the policy is not in force as per your trip;
2. eye glasses, contact lenses, hearing aids or prescriptions for same;
3. air travel other than as a passenger in a commercial aircraft licensed to carry passengers for hire;
4. preventative, experimental or patented medicines or vaccines;
5. for elective (non-emergency) treatment or surgery which is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the Participant has returned to Canada or (c) which the Participant elects to have rendered or performed outside of Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the Participant from returning to Canada prior to such treatment or surgery; also check-ups or treatment for cosmetic purposes;
6. pregnancy, childbirth or miscarriage or any complications arising from pregnancy;
7. mental or emotional disorders that do not require hospitalization; abuse of medication, drugs or alcohol; intentional self-injury, suicide or attempted suicide (whether sane or insane);
8. excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:
   a) expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.
9. willful exposure to peril except in an attempt to save human life;
10. expenses covered by any Provincial or Federal Act or Acts;
11. the continued treatment, recurrence or complication of a medical condition following emergency treatment of that medical condition during your trip if the medical advisors of Medavie Blue Cross and its travel assistance provider determine that you are able to return to Canada and you chose not to return;
12. any emergency transplants including but not limited to organ transplants and bone marrow transplants;
13. cardiac procedures, including cardiac catheterization, or surgery unless approved by Medavie Blue Cross prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to Hospital; or
14. expenses incurred for residents travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
15. Any pre-existing conditions unless the condition is stable prior to travel, and when medical attention is not anticipated during the travel period.
16. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered participant, per incidence outside the province of residence. A maximum amount of $5 million will be paid by Medavie Blue for all claims incurred due to any one occurrence.

Coordination of Benefits

Benefits payable under this policy shall be coordinated with any other coverage(s) and are payable in excess of all other benefits in effect on the Insured Person's behalf, so that payment under this policy and any other plan, including but

not limited to the Insured Person's Provincial Health Insurance Plan, individual or group policy, credit card coverage or other insurance, shall not exceed 100% of the eligible charges incurred.

Termination of Travel Benefit

The travel benefit coverage ends at the earliest of:

1. the date you cease to meet eligibility requirements; or
2. the end of the grace period for which premiums have not been paid in full; or
3. the date the policy is terminated.

If you purchased a family plan, coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first. Coverage for any Participant ceases when he is no longer covered under the government health program in his province of residence.

VIII. NSED Trip Cancellation / Trip Interruption

This option helps protect traveller against unforeseen circumstances they may prevent or discontinue a trip and is meant to complement your NSED coverage.

Eligibility

The Trip Cancellation / Interruption coverage offered through the NSTU Group Insurance Program is available to active and retired members plus their eligible dependents who are enrolled in the NSTU NSED Out of Country/Province Emergency Medical Coverage Plan. If covered for family NSED Group Travel, you must take family Trip Cancellation/Interruption.

How To Enroll

Fully complete the enrollment form and return it to Johnson Inc. The coverage will become effective on the date Johnson Inc. receives a completed and signed enrollment form.

For members purchasing Trip Cancellation / Trip Interruption coverage for the first time, premiums are pro-rated from the date your coverage is effective until the policy renewal date (September 1st).

Coverage will renew automatically on September 1st of each year. You will be provided with written notification in advance. Coverage will continue unless Johnson Inc. is provided with written notice of termination within 30 days of the renewal date. Premiums are deducted monthly and are non-refundable and non-cancellable.

Pre–Existing Medical Conditions

This plan provides coverage for emergencies only and does not provide coverage for expenses incurred as a result of a pre-existing health condition, unless the condition has remained stable for a period of 6 months immediately prior to the date of purchase of trip. To be considered medically stable you must not have:

- been treated or evaluated for new symptoms or new diagnosis
- had symptoms that increased In frequency or severity, or examination findings indicating the condition has worsened
- been prescribed a new treatment or change in treatment for the condition
- been admitted to or treated in a hospital or referred to a specialist for the condition
- been awaiting new treatment, tests, consultations or referrals regarding the medical condition (does not include routine testing provided the results are within normal limits and no change in treatment is recommended)

Also, this does not include coverage for expenses incurred as a result of a condition caused by a change in medication within 90 days prior to departure (generally does not include routine changes in medication as part of an established treatment plan, i.e., daily/weekly adjustments of blood thinners or insulin based on blood test results OR a change to a generic product, unless the dosage is modified).

NOTE: The above exclusion applies to you, an immediate family member, a travel companion, a travel companion's immediate family member, a close friend and/or host at destination.

For further clarification on the pre–existing conditions clause, your call will be directed to the provider, who will discuss your medical information with you.

Benefits

- Annual Plan.
- Trip Cancellation – up to a maximum of $5,000 per insured person per annual coverage period.
- Trip Interruption – up to a maximum of $5,000 per insured person for each covered trip.
  - up to a maximum of $3,500 for lodging, meals, car rental, telephone calls and taxi costs ($350 per day).
- Up to a maximum of $1,000 for baggage and personal effects during a covered trip.
  - Personal Effects – actual cash value or $500, whichever is less.
  - Document Replacement – up to a maximum of $200.
  - Baggage Delay – up to $400.

This is intended for informational purposes and is not an insurance policy. It contains some information about the coverages offered for the Trip Cancellation/Trip Interruption but does not list all the conditions and exclusions that apply to the described coverage. For full benefit details please refer to policy wording which governs all situations.

IX. Member Assistance Program

Manulife - Employee and Family Assistance Program

The Manulife Employee and Family Assistance Program is available for active NSTU members who have a permanent, probationary or term contract. Through this program you can reach a team of experienced counsellors from Homewood Health who will listen to the issue, offer sound advice and help you create an action plan to address issues.

In most instances, there are no additional out-of-pocket expenses for you or an eligible family member to use this service. The program is a benefit provided to you by the NSTU Group Insurance Trustees.

What about Confidentiality?

The Manulife Employee and Family Assistance Program is provided by Homewood Health, a national employee assistance provider since 1979. This firm operates independently, and its counsellors guarantee the privacy of all individuals who use its services.

A. Services

1. Counselling services:
    - Stress
    - Marital/family/separation/divorce/custody issues
    - Alcohol and drug abuse
    - Personal adjustment problems
    - Psychological disorders
    - Anger management
    - Retirement planning
    - Aging parents/eldercare concerns
    - Sexual harassment
    - Gambling addiction
    - Conflict resolution
    - Bereavement
    - Weight, smoking and general health issues

    The counselling is designed to:
    - provide support and understanding,
    - help build coping skills, and
    - teach ways to effectively manage issues and problems

2. Lifestyle and Specialty Coaching Services is designed to allow you to take a proactive approach to everyday challenges and life transitions with information and coaching from experts in their field.

These services include:

- Childcare and Parenting Caregiver Support Services
- Elder & Family Care Services
- Legal Advisory Services
- Financial Advisory Service
- Nutritional Coaching
- Career Counselling Service
- Retirement Planning Service
- Smoking Cessation Service
- Shift Worker Support
- Online tools / Courses
- Jumpstart Your Wellness

3. Stress Solutions Provides assistance for individuals suffering from stress.

4. Depression and Trauma Care Services provides assistance for individuals suffering from certain types of depression or if you have experienced any type of Traumatic event,

5. Grief and Loss Coaching Grieving can be an overwhelming and complex process. Every individual reacts differently and experiences grief and loss in unique ways. Homewood's Grief and Loss Coaching Program helps you understand the grieving process by providing you with coaching support and resources to help you manage through the range of emotions and difficulties one experiences when faced with a significant loss.

6. Experiencing Acts of Violence The trauma caused by acts of violence can and most often will have a significant emotional impact on people. The combination of atrocity and magnitude of the event, coupled with its unpredictability, will often lead to an intense feeling of vulnerability for our own safety and the safety of others. The Experiencing Acts of Violence program helps develop recovery and coping strategies to help you through these traumatic times.

B. Access

1. By phone – 1-877-955-NSTU (6788)

   This toll-free line is available 24 hours, seven days a week. For calls originating outside Canada, call 1-604-689-1717 collect for service in English.

   Pour service en français, appelez à frais virés au 1-514-875-0720.

   Counselling can be provided in a way that is most convenient and comfortable:

   - in-person
   - by phone, or
   - through a secure online service

   When you call, the customer service representative will confirm your eligibility by asking if you are an active NSTU member or an eligible spouse or dependent child.

2. Online

   Easy access to online tools resources and support. Informative articles on a wide range of topics including, mental health, stress, addiction, relationships and lifestyle.
   Access to all online features is available by visiting www.manulifeefap.com

To register:

1. Go to www.manulifeefap.com
2. You will see the registration screen. To ensure the privacy and confidentiality of the Health eLinks site a formal registration is required for all members. Enter plan contract number 39146.
3. Enter your first name, last name, email, password and date of birth. When complete, click "Sign Up". It is that simple!

* Note: It is strongly recommended to use a personal email and not a work related email with matters dealing with the Manulife EFAP.

You are now registered and may review the online services available to you.

C. Resources

Manulife EFAP works in conjunction with Manulife's Health eLinks, an online resource of healthcare related material. With Health eLinks, you can take part in an interactive health risk assessment, and a comprehensive library of medical information written by medical experts and even create a personal health improvement program.

You can access Health eLinks through the manulifeefap website, www.manulifeefap.com.

Other resources include:

- Online Cognitive-behavioural therapy (i-Volve).
- Childcare and eldercare resources database.
- Comprehensive and interactive e-Courses.

If you have any questions or concerns, please contact the NSTU Group Insurance Trustee for your region or the NSTU registered nurse at nurse@nstu.ca, or by dialing 1-800-565-6788, press 3.

NSTU Counselling Services

The NSTU has two counsellors on staff that provide short-term counselling services to NSTU members, their partners, and dependent children. This service is designated to provide help and intervention at an early stage of difficulty. Intervention is also provided for schools in conflict and crisis. Members are referred to an appropriate community based resource for long term counselling if the short-term model has not fully addressed the issue(s). This service is confidential.

Early Intervention Program (EIP)

This program is for active NSTU members only who are working or absent from work and experiencing injury or illness and struggling to remain at work or return to work. There are two Early Intervention Coordinators who are Occupational Therapists. Their focus is to maintain or improve a member's independence and help to decrease the incidence and duration of a disability. This is a confidential service and EIP staff can travel to your community.

Carepath - Chronic Disease Program (formerly HealthCare Assist/Cancer Assistance)

The Carepath Chronic Disease Program will help you and your family by:

- Conducting a comprehensive health assessment, including a review of medical records.
- Reviewing your treatment plans to ensure they are consistent with medical best practices.
- Developing a plan of care based on nursing best practices.
- Explaining your diagnosis, test results, and treatment plan.
- Facilitating access to tests, treatments, and clinical trials.
- Preparing you for medical appointments (i.e., developing questions).
- Assist you in understanding information provided by physicians and other health care providers.
- Providing education on how to manage your symptoms to minimize treatment side effects.
- Providing information and access to local community resources (i.e., physiotherapy, occupational therapy, speech-language pathology, dietitian services, pain programs, mental health support) and volunteer organizations that can provide additional support.
- Obtaining a virtual medical second opinion, when needed.
- Providing ongoing virtual nursing support, health education, and coaching throughout navigation to ensure you have the information needed to make informed health care decisions.
- Updating your primary care physician (with consent).
- Providing a copy of a New Life Care Plan and/or Return to Work Plan at the end of the Carepath service, if applicable.

Carepath - Elder Care Program

The Carepath Elder Care Program will help you and your family by:

- Providing Information about hospice organizations and home care support services provided by local and respected organizations and assisting as needed.
- Providing information and access to local community resources (i.e., primary care physicians, physiotherapy, occupational therapy, speech-language pathology, dietitian services, meal delivery, transportation services) and volunteer organizations that can provide additional support.
- Helping navigate and accessing provincially and federally funded benefits, including other insurance benefits.
- Providing one-on-one coaching about how to have difficult conversations in terms of aging care needs and life-changing moments, such as losing a spouse or moving into a retirement home.
- Accessing the Social for Seniors platform to connect seniors with seniors.

Carepath - Mental Health Program

The Mental Health Program helps members and their families suffering from mild to severe mental health disorders, as well as those struggling mentally or emotionally due to another health condition or life event. The program provides psychoeducation and counseling to members and their families, providing multiple levels of support and guidance using distance technologies such as telephone and virtual resources (mobile app, email, and secured video call).

This program provides two levels of intervention: navigation and counselling/psychotherapy.

- **Navigation** is provided by qualified mental health clinicians, generally mental health nurses and clinical social workers, for those with mild to moderate distress. They provide assessment psychoeducation, supportive counseling, and coaching with the goal of enhancing self-care strategies and management of concerns. The role of the navigator is to ensure a smooth integration with the member's existing circle of health/ medical care and to provide assistance in navigating the mental health care system.
- **Counselling** is provided by advanced practitioners, for members and their families (individual, couples) experiencing moderate to severe symptoms, including for chronic illness with mental health/wellness components.
- **Psychotherapy** is provided when navigation is not sufficient and psychotherapy is required for members with more complex needs. The program navigators enlist the services of one of Carepath's advanced practitioners, including Masters/PhD prepared social workers, mental health nurses, or psychologists, each of whom has more than 10 years' experience in psychotherapy. When the situation warrants, access to in-depth psychiatric assessment, consultation, and assistance with care planning is available.

The Mental Health Program is designed to complement broad healthy-workplace strategies and community based mental health services, and to address gaps, improving the timeliness of service delivery. This is made possible by offering solutions that promote prevention and early intervention of mental health issues, acute mental illness, or chronic mental health conditions.

This program provides:

- Initial assessment within 24-48 hours.
- Matching with an experienced psychotherapist skilled In the therapy, psychoeducation or coaching required.
- Routine appointments (weekly to bi-weekly; plan will be personalized to need).
- Access to a psychiatric assessment with family physician consultation for those meeting certain criteria.
- A facilitated iCBT (Internet-based cognitive behavioral therapy) program called "Mind Zone" delivered using mobile technology (iOS and Android).
- Return-to-work planning and support when required.
- Opportunity to follow up for more support as needed.

Top 5 benefits of the Mental Health program:

- No waitlists: You can reach out for support at any time, without the need for a referral, and will be contacted to arrange your first appointment within 24-48 hours.
- Goal-directed therapy: You will have access to therapy for as long as you need to reach your goals – not just

for a set number of appointments.

- Collaboration with a broader healthcare team: With your consent, we will connect with your existing circle of health/ medical care, for example, your primary care physician to ensure no gaps or duplication in the care being provided.
- Family focus: Our program is available to assist you as well as members of your immediate family who may be affected by the same or different issues.
- 24/7 access to tools: From digital educational materials geared toward self-management to mobile therapy apps and modules that measure progress, our program provides mental health support both during and between therapy sessions.

Carepath programs are confidential, and there is no cost to members and their families.

For more Information on any of the Carepath programs, please contact Carepath at: 1-844-453-NSTU (6788)

www.carepath.ca

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INSURANCE SERVICES

Insurance Services at a Glance

The Trustees also provide access to home and car insurance services through Johnson Insurance. Johnson is the preferred insurance provider for Nova Scotia Teachers Union and provides access to exclusive savings and benefits on home and car insurance. You'll also have access to:

Car Insurance

- First accident forgiveness
- Rental vehicle coverage
- Loss of use coverage
- Roadside assistance
- Multi-vehicle discount

Home Insurance

- First claim forgiveness
- Enhanced water coverage [1]
- Identity theft coverage
- Coverage for property of students living temporarily away from home while attending college or university

Extra Benefits

Insurance is there when you need it, but Johnson also offers benefits that help you live your life the way you want.

- Interest-free payroll deduction
- Special offers and promotions

Get a quote today to see how much you could save.

Toll Free: 1-877-738-7189 (mention Group Code 62)

Website: www.johnson.ca/NSTU

Johnson Insurance is a tradename of Johnson Inc. ("JI"), a licensed insurance intermediary, and operates as Johnson Insurance Services in British Columbia and Johnson Inc. in Manitoba. Home and car policies underwritten, and claims handled, by Royal & Sun Alliance Insurance Company of Canada ("RSA") in Quebec and underwritten exclusively, and claims handled, by Unifund Assurance Company ("UAC") in the rest of Canada. Described coverage and benefits applicable only to policies underwritten by UAC or RSA. Car insurance not available in BC, SK, or MB. Home and car insurance not available in NU. JI, UAC and RSA share common ownership. Eligibility requirements, limitations, exclusions, additional costs and/or restrictions may apply, and/or may vary by province or territory. [1]Enhanced Water Coverage is not available in SK, YT, or NT and only available on certain home insurance products.

"My Insurance" Website

As a NSTU member, you can use the internet to access and interact with the group insurance plan in a completely secure and private environment. The new Johnson Inc. "My Insurance" website (formerly the "Members-Only" web-site) will provide a more modern user experience, enhanced security features and easier access to your policy details.

How to get CONNECTED!

The new "My Insurance" website enables you to view and interact with your group insurance plan. To register, go to https://www.johnson-insurance.com/Members-Only/. Enter your Members Only username and password in the "New to this?" section and click "Register". If you do not remember your Members Only username or password, click "Register" in the "New to this?" section. If you need further assistance please visit **pages.johnson.ca/myinsurance**.

Real-Time Data

The information you will see is the most up-to-date data on your group benefit plan that we have available.

Complete Information

Each benefit listed in your online benefit statement is linked to a full benefit description, including rates and premium.

"One-Stop" Access

Through your online benefit summary, you will be able to view ALL your individual insurance information.

Unprecedented Convenience

Incorporates your coverages in one easily accessible source. Furthermore, it is available to you 24-hours-a-day, every day.

E-mail Communications

You can easily and instantly submit any questions, comments, or concerns you may have to your personally assigned Service Supervisor.

3

PROCEDURES FOR HANDLING PROBLEMS, CONCERNS OR SUGGESTIONS

Medical and Dental, Life, AD&D or Long Term Disability Plans

All options of the NSTU Group Insurance Plan are monitored, reviewed, amended and overseen by the NSTU Group Insurance Trustees.

All inquiries are first handled by the Consultant/Administrator, Johnson Inc. If the inquiry involves something outside the contract with the insurance company, it may be referred to the Trustees by the Administrator. If an insured client wishes to register a concern or complaint, it may be done by contacting the NSTU Group Insurance Trustees. The Trustees must receive complete details in order to review any such request.

If the inquiry has to do with policy on insurance coverage, it is to be referred to the NSTU Insurance Trustees.

It is pertinent to note that the Trustees will review any inquiry or problem associated with any insurance plan or option to ensure members are receiving fair treatment in accordance with the applicable Master Policies.

Home and Car Insurance

The NSTU Group Insurance Trustees make available home and auto insurance through Johnson Inc., to the membership. The plans are available on a voluntary basis, with the option of paying your insurance premium through payroll deduction with no interest or service charges.

The Trustees cannot set policy regarding home or auto insurance. However, Johnson Inc. or an insured member may refer a situation to the Group Insurance Trustees for review. The Trustees will examine all pertinent information, including the policy and/or the claim file with Johnson Inc. to verify the matter was handled in accordance with the terms and conditions of the policy. If required, Johnson Inc. will notify the insured member of the outcome of the review.

For additional information on Home and Auto Insurance contact Johnson Inc. at: 1-877-738-7189

(mention Group Code 62) or **www.nstu.johnson.ca**