Plan Booklet

Canadian Union of Public Employees
Syndicat Canadien de la Fonction Publique

Local 3906

Policy #97528

Classes A and B

Equitable Life of Canada®

Canadian Union of Public Employees
Syndicat Canadien de la Fonction Publique

Policy #97528

Classes A and B

Through **EQUITABLE LIFE OF CANADA®**, your Employer is providing you with the Group Benefits Plan outlined in this booklet.

We know how important financial security is to you and your family. With this in mind your Group Benefits Plan is designed to help meet some of your financial needs in the event of sickness or death.

We encourage you to read and understand the benefits that your Employer is providing for you. If you have any questions, please contact the person in your company who administers your Group Benefits Plan.

Where provincial legislation permits, you may obtain copies of the application, evidence of insurability, policy and booklets.

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

Group Department

How to contact Equitable Life:
For services in English or French, call toll-free: 1-800-265-4556

IMPORTANT

This booklet is meant to provide information about your Group Insurance Plan. It is not a legal contract. The Master Policy itself determines the benefits, amounts and effective dates that apply to you.

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PROTECTING YOUR PRIVACY

At Equitable Life of Canada, we are committed to protecting the confidentiality and security of your personal information. We follow the privacy principles established by the *Canadian Standards Association Model Code for the Protection of Personal Information*.

To protect and safeguard your personal information, we have set up files in which we maintain your personal information that is needed to administer, service, underwrite, adjudicate and process all aspects of the Group Policy, including the payment of claims.

Your personal information may be accessed by, or exchanged with, authorized employees of Equitable Life and of relevant third parties. These third parties include service providers retained by us, reinsurers, other insurance companies, investigative organizations, health care providers (such as pharmacies, physicians and dentists) and any other person or party whom you authorize.

You have the right to access your personal information held in our files, subject to any legal or business restrictions. If applicable, you can have your personal information corrected.

For more information regarding our privacy policies, please refer to "*Our Commitment to Protecting Your Privacy*" which you can find on our website at **www.equitable.ca** under "Privacy".

You may contact us with any questions, concerns or suggestions with respect to our management of your personal information at the address below:

Chief Privacy Officer
One Westmount Road North
P. O. Box 1603, Station Waterloo
Waterloo, On
N2J 4C7

Telephone 1-800-265-4556
Facsimile (519) 883-7425
Email: privacyofficer@equitable.ca

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THIS GROUP INSURANCE PLAN HAS BEEN ARRANGED BY

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Equitable Life Group Benefits

Department Contact List

Group Benefits Administration *General Policy Inquiries, Personal Information Changes & Web Support* Hours of Operation: 8:15AM – 8:00PM EST 6:15AM – 6:00PM MST 5:15AM – 5:00PM PST	Email: groupbenefitsadmin@equitable.ca Phone: 1 (800) 265-4556 x 283 Toll Free Fax: 1 (888) 878-7747
Dental Claims *Dental Claim Inquiries* Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	Email: group-dental-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373
Equitable Life of Canada Fraud Hotline *(Anonymous Call)*	Phone: 1 (800) 265-8899

EquitableHealth.ca

Health and wellness solutions that matter™

A standard feature of all Equitable Life Group Benefit plans is the easy to access, reliable Canadian health and wellness resources available through EquitableHealth.ca®. This website connects you with Canadian health and wellness resources through the Equitable HealthConnector® platform and LifeWorks® Online.

HealthConnector – Supporting your Health:
Whether you need help knowing what questions to ask your doctor, are dealing with a family or personal medical issue, or are looking for available health resources where you live, the Equitable HealthConnector is there to support you. Go online or phone your personal HealthConnector Information Specialist at 1-888-344-5658 and connect with the support and information you need to navigate the Canadian healthcare system and make more informed health decisions.

The first time you visit EquitableHealth.ca, take a moment to click on *My Services* to see all the health and wellness resources available to you through HealthConnector – it will be time well spent.

LifeWorks Online – Balance and Understanding:
An important part of being truly healthy is recognizing and understanding the non-medical factors that can impact your daily life. LifeWorks allows you to browse articles and other resources that can help you better cope with everyday issues ranging from work-life balance and parenting concerns, financial and legal issues to dealing with aging loved ones. You can also download relevant printed and recorded information and tools directly to your computer that can help you lead a balanced, productive life.

Innovations Plan Member Web Services through EquitableHealth.ca

Innovations is the fast, convenient online way to access information about your Group Benefits whenever you need to. Innovations will help you understand and manage your Group Benefits more effectively and saves valuable time and effort by allowing you to:

- Get real time coverage information, claim status and claims history;
- Access claims and administration forms;
- View and confirm the details of your coverage, including information on your eligible dependents;
- Update personal information, including your address and banking information; and
- Sign up for Electronic Explanation of Benefits (E-EOB) and Direct Deposit payment E-Solutions that will allow you to get your claim payments faster.

Get your claim payments faster with Electronic EOB and Direct Deposit payment E-Solutions through EquitableHealth.ca

These E-Solutions reduce the amount of paper we produce when paying claims and give you access to your benefit information in a secure, online environment.

Electronic EOB will send an automatically generated email notification telling you that your most recent claim has been processed and that you can go to EquitableHealth.ca to view the details of your claim.

Direct Deposit Payment allows you to add or update personal banking information which enables us to deposit the claim payment directly to your bank account, meaning you get your money faster.

Links and instructions for these E-Solutions are available at the top of your Innovations Plan Member Web Services Welcome Page.

If you require any assistance in signing up for or accessing EquitableHealth.ca, please contact Group Administration at: 1-800-265-4556 ext. 283 or by email at groupbenefitsadmin@equitable.ca.

SCHEDULE OF BENEFITS

This booklet was printed on July 31, 2012.

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

IMPORTANT NOTE

The information in the Schedule of Benefits and Summary of Dental Benefit Maximums in this booklet is only a brief summary of your Group Plan. These pages outline the benefits, schedules, deductibles, reimbursement percentages and most of the maximums that apply to your Plan.

See the descriptive pages following the Summary for more information you need to know, such as eligible expenses, exclusions, specific requirements (such as written prescriptions/referrals from your Physician), definitions of Practitioners (qualifications they must have), and other maximums that may apply.

Protecting You From Fraud

Fraudulent claims can result in additional insurance costs for you and your Employer. Equitable Life wants to protect you from the negative results of such criminal activity. To do this, we focus on all means necessary to support the detection, investigation and prosecution of false, incomplete or misleading information. Such criminal actions will result in the claim being denied and coverage being removed.
If you believe someone is involved in fraudulent claims, you can call our anonymous HOTLINE at 1-800-265-8899.

CLASSIFICATION(S)

Class A: All Eligible Regular Full-Time Teaching Assistants of CUPE 3906 without Dependents
Class B: All Eligible Regular Full-Time Teaching Assistants of CUPE 3906 with Dependents (Family)

GENERAL INFORMATION

Class B only
Maximum Age for Dependent Children
Maximum age for dependent children who are not in school full-time: under age 21
Maximum age for dependent children who are in full-time attendance at school: under age 25
(See the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents, including the requirements for continuing coverage for disabled children.)

Class B only
Co-Habitation Requirement for Partners *(see the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents)***:**
24 consecutive months

Maximum Age for Coverage *(also refer to 5. "When Does Your Insurance Terminate" in the General Provisions)***:**
Dental benefit terminates at the earlier of your retirement or on your 70th birthday.

Minimum Number of Hours Per Week employees must work to be eligible for coverage:
130 hours per school year between September 1 and August 31.

Waiting Period: *(see the General Provisions in this booklet for more important information)*
none

SCHEDULE OF BENEFITS

EMPLOYEE AND DEPENDENT DENTAL BENEFITS

Deductible Amount per calendar year:
nil

Type A - Basic Services.
Recall Examination Period:
once in any period of 9 months (Note: This is 9 months from the last paid checkup.)

This Dental Plan includes the following Basic Services Options:
Space Maintainers
Major Surgical Services
Periodontal Services
Maximum units for periodontal scaling and root planing combined: 8 units per calendar year.
Endodontic Services
Denture Repair Services

Reimbursement Percentage:
Type A: 100%

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

Maximum Amount for Class B:
Annual calendar year maximum for Type A: $2,000 per insured person subject to a maximum of $2,000 per insured family.

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

SURVIVOR BENEFIT

Class B only
For the following benefits only: Dental
Maximum Period for Survivor Benefit: 24 months

NOTE

The following pages are standard descriptive pages. Some sections will tell you to look on the Schedule of Benefits or Summary of Dental Benefit Maximums for the details that apply to your own Group Plan. It is very important that you read these descriptive pages as they provide information you need to know.

GENERAL PROVISIONS

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

All regular, full-time graduate students in the Graduate programme, who are employed as a teaching assistant (or research assistant in lieu thereof), for at least 130 hours between September 1 and August 31.

2. **WHEN AM I ELIGIBLE TO JOIN THE GROUP PLAN - IS THERE A WAITING PERIOD?**

You are eligible to apply for coverage under this Group Plan after you have served the **Waiting Period** shown in the Schedule of Benefits.

3. **HOW DO YOU JOIN?**

* Complete the required application form.
* We must receive your application form **before** (but **not later than 31 days** after) you become eligible to join the Group Plan.

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

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

You'll be given a **wallet card** showing the Effective Date of your entry into the Group Plan.
You are eligible for insurance from September 1 of each year to August 31 of the next year, provided you are contracted for the academic year, to work 130 hours in the period of September 1 of each applicable year to august 31 of the following year.
If you're not actively at work on the date your benefits should take effect, your coverage will become effective on the date you return to active work. You must also be actively at work for any future increases in your coverage to be effective.
You must be insured under this Group Plan to be eligible for any benefits.

Eligibility for benefits is not retroactive and benefits terminate at the end of the paid up period (August 31 of each year).

5. **WHAT CAN I DO WHEN I DISAGREE WITH A CLAIM DECISION?**

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation.

GENERAL PROVISIONS

6. WHEN DOES YOUR INSURANCE TERMINATE?

Your insurance terminates on the earlier of the following dates:

* on the date of your retirement, unless this Group Plan provides any benefits for retirees.
* on the date you are no longer employed by the Employer
* on the date your Employer terminates your coverage
* on the date this Group Policy terminates
* on the date you no longer qualify for coverage
* on the date you reach the **Maximum Age for Coverage** shown in the Schedule of Benefits
* on the date it is proven to the satisfaction of the Company that the employee has engaged in fraudulent activity with respect to claims under this Policy.

7. EVIDENCE OF INSURABILITY

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

GENERAL PROVISIONS FOR DEPENDENTS

1. **WHO ARE ELIGIBLE DEPENDENTS?**

Eligible dependents must not be permanent residents outside Canada and include:

Your **spouse**. This means:
* your legally married husband or wife, or
* your partner (a person of the same or opposite sex who resides with you in a conjugal relationship and who you publicly represent as your partner)

You can only cover one spouse at a time. You must notify us in writing if you want to change your spouse.

Your **child**. This means:
* your **natural child, adopted child, stepchild or child of your spouse**.

To be eligible, the child must not have a spouse or partner, normally live with you or your spouse, be supported by you, and not be working on a full-time basis. Look in the Schedule of Benefits to see the **Maximum Age for Dependent Children**.

Note: If dependent children must be in school full-time to be eligible for coverage, proof of this will be required.

Your **permanently developmentally or physically disabled child**. This means
* Your developmentally or physically disabled natural child, adopted child, stepchild or child of your spouse.

To be eligible, the child must not have a spouse or partner and we must have a Doctor's certificate stating he/she is incapable of self-sustaining employment and chiefly dependent upon you for support. This child must have been insured under this Group Policy before reaching the Maximum Age for Dependent Children in the Schedule of Benefits.

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

If you have any eligible dependents when you complete the required application form:
* Fill in the "Number of your Dependent Children" box.
* Fill in the name of your spouse.
* Check off the box marked "Family" in the Health and/or Dental sections if the Group Plan includes these benefits and you wish to cover your eligible dependents.

If you don't have any eligible dependents when you join the Group Plan, tell your Group Plan Administrator as soon as you do acquire a dependent (when you get married, start living with your partner, or have a child). Complete the required forms so your spouse or child can be included. We must be notified **within 31 days** of the date you acquire a dependent or the dependent will be a "**late applicant**". He/she must then provide **satisfactory evidence of insurability**. Benefits for your dependents will become effective **only** if the evidence is approved by the Company. Some or all of your dependent's benefits could be declined or restricted.

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

To continue coverage for a developmentally or physically disabled child, you must apply to the Company **in the 31-day period before the child's 21st birthday**. If the Group Plan includes Health and/or Dental, a single Health and/or Dental premium may be charged for the disabled dependent child.

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

GENERAL PROVISIONS FOR DEPENDENTS

3. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?**

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

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

4. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?**

* on the **date your own coverage terminates**
* on the **date the dependent no longer qualifies** as an eligible dependent as described in #1 above.
* on the date it is proven to the satisfaction of the Company that the dependent has engaged in fraudulent activity with respect to claims under this Policy.

DENTAL BENEFITS
GENERAL PROVISIONS

1. **DESCRIPTION OF THIS BENEFIT**

If you or your eligible dependents incur expenses described in the following pages while insured under this Group Plan, you'll be reimbursed for those charges.

The amount payable is subject to the **Co-Ordination of Benefits** (see #5 below) and any **Deductible Amount** and **Reimbursement Percentage** (see #3 and #4 below).

2. **WHAT ARE THE ELIGIBLE EXPENSES?**

These are the **reasonable and customary charges** made for required Dental treatment performed by a Dentist or, where allowed under the legislation of the province or territory, by an Independently Licensed Dental Hygienist, provided the **Schedule of Benefits** indicates the charges are included under this Group Plan and they are listed in the applicable Dental Fee Guide.

The maximum payable is the amount shown in the **Dental Fee Guide indicated in the Schedule of Benefits** for a General Practitioner.

3. **WHAT IS THE "DEDUCTIBLE AMOUNT"?**

This is the amount you must pay before any benefits become payable under the Group Plan. The Deductible Amount for your Plan is **shown in the Schedule of Benefits**.

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

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

4. **WHAT IS THE "REIMBURSEMENT PERCENTAGE"?**

This is the percentage (portion) of eligible expenses that is paid by the Company after any Deductible amount has been reached. The Reimbursement Percentage for this Group Plan is **shown in the Schedule of Benefits**.

5. **HOW DOES THE "COORDINATION OF BENEFITS" WORK?**

If **you and your spouse** both have Family coverage under the Group Insurance Plans where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first insurance company.

Claims for **your dependent children** should first be submitted through the Group Plan of the parent with the earlier birthday (month/day) in the calendar year. Any balance is then submitted through the other parent's Group Plan.

For example, if your birthday is October 10 and your spouse's birthday is May 25, claims for your dependent children should be sent to your spouse's insurance company first (because your spouse's birthday is earlier in the year). Any unpaid balance would then be submitted to Equitable Life, along with a copy of what your spouse's insurer paid. **Total reimbursement for any claim cannot be more than 100% of the actual expense.**

DENTAL BENEFITS
GENERAL PROVISIONS

6. **WHAT ARE THE MAXIMUM AMOUNTS?**

The **Annual Calendar Year Maximum Amount** is **shown in the Schedule of Benefits**. This is the total amount payable for each insured person in any calendar year and is automatically reinstated each January 1st.

If there is a **Lifetime Maximum Amount shown in the Schedule of Benefits**, this is the maximum amount payable for each insured person for the entire time they're covered under this Group Plan.

Note: If you and/or any of your dependent(s) are a "late applicant" (see #3 "How Do You Join?" under the General Provisions) and submit satisfactory evidence of insurability, Dental coverage for late applicants (if insured for Dental benefits) will be subject to a maximum of $250 for all Dental expenses during the first 12 consecutive months of coverage under the Dental benefit.

7. **PRE-DETERMINATION OF BENEFITS**

If your Dentist suggests a course of treatment that costs **more than $300**, a Treatment Plan and estimates of the charges should be sent to us **before** treatment begins. We'll then be able to tell you in advance how much will be eligible under the Group Plan.

8. **ALTERNATE TREATMENT**

If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this Group Plan is equal to the cost of the less expensive treatment. If you choose to proceed with the more expensive treatment, then you're responsible for the additional costs.

9. **WHAT IS NOT COVERED?**

Dental Benefits are not payable for expenses that result from the following:

(a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)
(b) active participation in a riot, rebellion or insurrection
(c) war or hostilities of any kind (whether or not war is declared)
(d) committing or attempting to commit a criminal offense
(e) charges for un-kept appointments, telephone time, or to complete forms or reports
(f) examinations for a third party
(g) procedures that aren't approved by the Canadian Dental Association or that are experimental in nature
(h) any condition where you or your dependents are entitled to benefits under any Workers' Compensation Act or law or similar legislation or service, or where benefits are payable under any other insurance policy issued by the Company
(i) services performed by a person who usually lives in the patient's home or is related to the patient by birth or marriage, or related to the patient through the patient's spouse
(j) cosmetic surgery or treatment (unless it's required as the result of accidental injuries and provided the surgery or treatment begins within 90 days of the accident)
(k) any expenses for on-going treatment if it started before your coverage under this Plan became effective
(l) treatment performed or supplies delivered after your coverage under this Group Plan terminates (except for covered prosthetic appliances ordered and fitted before the date of termination and delivered within 31 days after the date of termination)
(m) treatment for the purpose of altering vertical dimension, restoring occlusion, splinting (unless shown in the Schedule of Benefits) or replacing tooth structure lost because of abrasion or attrition (wearing away). Your Dentist should tell you if any of these conditions apply and explain them to you.
(n) treatment for disturbances of the temporomandibular joint (TMJ), unless the Dental section in the Schedule of Benefits shows this is covered. Your Dentist should tell you if this condition applies and explain it to you.
(o) services provided outside Canada, except for emergency treatment for an unexpected and unforeseen event (such as the loss of a filling or crown while outside Canada).

DENTAL BENEFITS
GENERAL PROVISIONS

10. **HOW TO SEND IN CLAIMS**

If your Dentist* uses EDI (electronic Dental submission):
Your Dentist's* office will submit the claim electronically to Equitable Life.

If your Dentist* does not use EDI (electronic Dental submission):
When you go to your Dentist*, take a **Form #520 - Dental Claim Form** with you or get one from your Dentist's* office. The Dentist* fills in **Part 1** showing what was done and how much was charged. You may want to take this booklet with you when you go to the appointment in case the Dentist* wants to check what's covered.

* or, where applicable, Independently Licensed Dental Hygienist

Follow the instructions on the form. Be sure each form is **fully completed**, including:

* the **Group Policy Number**
* your **certificate number**
* the **full birthdate (day/month/year) for your dependent**, if it's a Dental claim for your spouse or dependent child
* **all information on a dependent child**, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.
* **sign in Part 3 - Patient Information** on the back of the form.

If any of this information is missing, we'll have to return the form to you for completion and this will cause a delay in getting your payment.

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

IMPORTANT: If your insurance terminates, or if the Dental Benefits under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Dental Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

DENTAL BENEFITS
TYPE A - BASIC SERVICES

1. **DIAGNOSTIC SERVICES**

Services required to evaluate existing conditions, including:
* consultations and biopsies
* oral examinations **
* bitewing x-rays **
* complete mouth x-rays or panoramic films (once in any 24 months).

2. **PREVENTIVE SERVICES**

Services required to prevent dental disease, including:
* dental cleaning **
* oral hygiene instruction **
* application of fluoride **
* pit and fissure sealants for dependent children under age 18.

3. **ROUTINE RESTORATIVE SERVICES**

Services required for the treatment of dental cavities, including:
* amalgam, acrylic or composite fillings
* prefabricated metal or plastic restorations

4. **ROUTINE SURGICAL SERVICES**

Routine extractions (including wisdom teeth) and the anaesthesia required to do them are eligible.

5. **WHAT IS NOT COVERED UNDER THE BASIC DENTAL SERVICES?**

* protective appliances (such as mouthguards) and space maintainers
* all extensive restorative services
* all major surgical services (other than the routine extractions in #4 above).

** See the **Recall Examination Period** in the Schedule of Benefits for how often a recall examination is eligible.

DENTAL BENEFITS
TYPE A - BASIC SERVICES - OPTIONS

The following Type A Basic Services Options are eligible **only if the Schedule of Benefits indicates they are eligible.**

SPACE MAINTAINERS OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for space maintainers if used as a preventative measure to maintain space. Space regainers used to move teeth or used for orthodontics are **not covered**.

MAJOR SURGICAL SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option covers major surgical services such as:
* major oral surgery (other than routine extractions which are covered under the Routine Surgical Services of the Basic Dental Plan)
* necessary sutures (stitches)
* post-operative treatment and related general anaesthesia
* alveoloplasty, gingivoplasty, osteoplasty and frenectomy (your Dentist should tell you if any of these conditions apply and explain them to you).

Surgical services to prepare for orthodontics or major restorative services (other than fillings) are **not covered** under this Major Surgical Service option.

PERIODONTAL SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for services required to treat the soft tissues and bone that support the teeth, including gingivectomy and osseous surgery. Periodontal scaling is subject to the maximum number of units specified in the Dental section in the Schedule of Insurance.

ENDODONTIC SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

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

DENTURE REPAIR SERVICES OPTION (eligible only if shown in the Schedule of Benefits)

This Option pays for services that are required to:
* rebase and reline removable full or partial dentures
* repair broken dentures.
* add teeth to partial dentures (provided the natural tooth is extracted while the insured person is covered under this Group Plan).

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

SURVIVOR BENEFIT
(PREMIUM WAIVED)

1. **DESCRIPTION OF THIS BENEFIT**

If you and your eligible dependents are insured under this Group Policy on the date of your death for the benefits included under the Survivor Benefit, those benefits will continue for your eligible dependents.

Premiums are "waived" (are not payable) once the Survivor Benefit begins.

2. **WHAT BENEFITS ARE INCLUDED IN THE SURVIVOR BENEFIT?**

The **Schedule of Benefits** in this booklet shows:
* what benefits are included
* the **Maximum Period for Survivor Benefit** (the maximum length of time that the Survivor Benefit could be in effect)

3. **WHEN DO THE SURVIVOR BENEFITS TERMINATE?**

Survivor Benefits and the premium waiver terminate on the earliest of the following dates:
* the date the Maximum Period for Survivor Benefit ends
* the date your spouse or a dependent child becomes eligible for similar coverage somewhere else
* the date a dependent child no longer meets the definition of an eligible dependent (as shown under the General Provisions for Dependents and in the Schedule of Benefits in this booklet)
* the date your spouse remarries or qualifies as the spouse of another person
* the date this Group Plan terminates.