Carleton University

CUASA
Retirees

canada life™

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

My Canada Life at Work

As a Canada Life plan member, you can register for My Canada Life at Work™ at www.mycanadalifeatwork.com. Make sure to have your plan and ID numbers available when registering.

With My Canada Life at Work you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

Canada Life's Toll-Free Number

- For assistance with your medical and dental coverage, please call 1-800-957-9777
- For all other inquiries, please call 1-888-252-1847

Process to make a complaint

If you have any concerns regarding these products or Canada Life's services, please let us know. You can call:

Toll-free: 1-888-252-1847

You can also contact Canada Life on our website by visiting www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy No. 153180 and Plan Document No. 51801. If there are variations between the information in the booklet and the provisions of the policy or plan document, the policy or plan document will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is administered by

This booklet was prepared on March 5, 2026 and reflects the plan design as of May 16, 2025

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions

Insured benefits

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* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

For insured benefits, the employer's role is limited to providing employees with information and not advice.

Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your online account or by submitting a request through our privacy centre at www.canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit www.canadalife.com/privacy.

Notice of Liability for Benefits

Your employer has entered into an agreement with The Canada Life Assurance Company whereby the Healthcare (except Global Medical Assistance) and Dentalcare benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the Healthcare (except Global Medical Assistance) and Dentalcare benefits are:

- an unsecured financial obligation and are payable from your employer's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts your employer from the requirements under the *British Columbia Financial Institutions Act*.

If Quebec law applies, any uninsured benefit is not under the supervision and control of the Autorité des marchés financiers.

TABLE OF CONTENTS

Benefit Summary

This summary must be read together with the benefits described in this booklet.

Healthcare

Covered expenses will not exceed customary charges

Deductibles

Individual	$25 each calendar year
Family	$50 each calendar year

The individual and family deductibles do not apply to In-Canada Hospital, Out of-Country Emergency Care, Global Medical Assistance and Visioncare Expenses

Reimbursement Levels

In-Canada Hospital, Global Medical Assistance and Out-of-Country Emergency Care Expenses	100%
In-Canada Prescription Drug Expenses	
- covered dispense fee portion of the drug charge	100%
- remaining portion of the drug charge	80%
All Other Expenses	80%

Out-of-Pocket Maximum for Quebec Residents

An out-of-pocket maximum is applied to in-province expenses for drugs listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows:

1. reimbursement will be made at 100%
2. no further out-of-pocket amounts will apply

The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	Included
In-Canada Prescription Drugs	Included
Zyban Smoking Cessation Products	3-month supply each calendar year or as otherwise required by law
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $8. This does not apply if you live in Quebec.
Custom-fitted Orthopedic Shoes Or Boots	1 pair each calendar year or the actual cost of modifications and adjustments to stock item footwear
Custom-made Foot Orthotics	2 pairs every 12 months to a maximum of $700
Myoelectric Arms	Limited to the cost of an artificial arm
External Breast Prosthesis	1 every 5 calendar years
Surgical Brassieres	2 pairs each calendar year
Blood-glucose Monitoring Machines	1 every 4 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each calendar year
Transcutaneous Nerve Stimulators	Up to 6 months of rental
Custom-made Compression Hose	3 pairs each calendar year
Elastic Stockings	6 pairs each calendar year
Wigs for Cancer Patients	$200 lifetime
Eyeglasses or Contact Lenses Following Cataract Surgery	$50 per eye per lifetime

Automatically-adjusting Positive Airway Pressure Machines (APAP), Positive Airway Pressure Machines (BiPAP and VPAP) and Continuous Positive Airway Pressure Machines (CPAP)	Combined one device every 5 years
Supplies for CPAP, APAP, BiPAP and VPAP Machines	
- Mask	1 every 12 months
- Head Gear	1 every 12 months
- Hose	1 every 12 months
- Filters (Package of 5)	3 packages every 12 months

Paramedical Expense Maximums

Chiropractors	$200 each calendar year $25 for x-rays each calendar year
Christian Science Practitioners	Included
Massage Therapists	$600 each calendar year
Naturopaths	Included
Osteopaths	Included
Physiotherapists	Included
Podiatrists/Chiropodists	Included
Psychologists/Social Workers/ Psychotherapists/Therapists/ Counsellors	Included
Speech Therapists	$200 each calendar year

Visioncare Expense Maximums	
Eye Examinations	1 every 24 months
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery	$800 combined every 24 months
Visual Motor Therapy	$10 every half hour
Gender Affirmation Procedures Expense Maximum	$15,000 lifetime
Out-of-Country Emergency Care Expense Maximum	$1,000,000 lifetime
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis

- for treatment rendered inside Canada	The dental fee guide in effect one year prior to the date treatment is rendered for the province in which treatment is rendered
- for treatment rendered outside Canada	The dental fee guide in effect in your province of residence one year prior to the date treatment is rendered

Specialist fee guides are applicable only when a specialist performs periodontal, surgical and endodontic examinations.

Deductible	Nil

Reimbursement Levels

Basic Coverage	100%
Major Coverage	80%
Orthodontic Coverage	80%

Plan Maximums

Basic Treatment	Unlimited
Major Treatment	
- Dental Implants	$2,500 lifetime
- All Other Major Treatment	$1,000 combined each calendar year
Orthodontic Treatment	$2,500 lifetime

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your retirement begins providing you are at least age 55 and you were covered under your employer's regular group health plan on the day immediately preceding your retirement.

- You and your dependents will be covered as soon as you become eligible.

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Canada Life, you and your dependents may be required to provide evidence of good health acceptable to Canada Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

Your coverage terminates when you are no longer eligible or the plan terminates, whichever is earlier.

- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your employer for details.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. See your employer for details.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued until the end of the month in which they cease to be qualified dependents, or the due date of the first payment to which they have not made a required contribution for survivor coverage, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

- Your unmarried natural, adopted, foster or step-child, including any natural child of an unmarried minor dependent and any other unmarried child for whom you have been appointed legal guardian for all purposes by a court of competent jurisdiction, under age 21, or under age 25 if they are full-time students.

  Note: If you are a Quebec resident, full-time students are covered for prescription drug benefits until age 26.

  Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

HEALTHCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Covered Expenses

- Ambulance, including air ambulance when provided by a licensed ambulance company. Transportation to the nearest centre where adequate treatment is available, from one treatment centre to another on the recommendation of the attending physician, or from a treatment centre to the patient's residence on the recommendation of the attending physician

  If the services of a registered nurse are required during an air ambulance flight, nursing services and return air fare for the registered nurse are also covered.

- Hospital or home nursing care if it represents acute or convalescent care.

  Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.

- Preferred accommodation in a hospital, excluding chronic care, long term care and pallative care, when provided in Canada.

  For hospital accommodation, the plan covers the difference between the hospital's semi-private and standard ward rates.

  For out-of-province hospital accommodation, any difference between the hospital's semi-private rate and the government authorized allowance in the person's home province is also covered.

  The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person’s home province.

  Limitation

  Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- The plan covers home nursing services of a registered nurse, a registered practical nurse if the person is a resident of Ontario or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada.

  Nursing care is care that requires the skills and training of a professional nurse, and is provided by a professional nurse who is not a member of the patient's family.

  You should apply for a pre-care assessment before home nursing begins.

- Drugs and drug supplies described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses provided outside Canada are payable only as provided under the out-of-country emergency care provision.

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives

  - Injectable drugs including vitamins, insulins and allergy extracts. Radium and drugs used for radioactive isotope treatment are covered. Syringes for self-administered injections are also covered.

  - Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, alcohol swabs and sensors for flash glucose monitoring machines

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Fertility drugs

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

  For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician including but not limited to:

  - continuous positive airway pressure machines (CPAP), automatically-adjusting positive airway pressure machines (APAP), bilevel positive airway pressure machines (BiPAP) and variable positive airway pressure machines (VPAP) combined to one device every 5 years. A patient must first go through a study done by a sleeping clinic. The following supplies are also covered:
    (a) mask, one every 12 months
    (b) head gear, one every 12 months
    (c) hose, one every 12 months
    (d) filters, a maximum of 3 packages every 12 months. Each package contains 5 filters

  - visual services or supplies due to cataract surgery
    (a) eyeglasses or contact lenses following cataract surgery, limited to the amount listed in the Benefit Summary
    (b) replacement of unbroken visual aids in lieu of cataract surgery
    (c) replacement for glasses and contact lenses as a result of natural growth of a dependent child under age 18

  - visual services or supplies due to an accidental injury
    (a) eyeglasses including prescribed safety glasses
    (b) contact lenses where vision in the better eye cannot be corrected to the 20/70 level by glasses
    (c) repairs due to breakage from the accidental injury
    (d) replacement for glasses and contact lenses as a result of natural growth of a dependent child under age 18

- Custom-made foot orthotics when prescribed by a physician, podiatrist or chiropodist

- Custom-fitted orthopedic boots or shoes, when prescribed by a physician

- Hearing aids, including initial batteries, tubing and ear molds provided at the time of purchase, when prescribed by an audiologist, otolaryngologist, otologist or a physician. Repair charges are also covered. Ear examinations and tests are excluded

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

- Continuous glucose monitoring machines prescribed by a physician, including sensors and transmitters

- Radium therapy, radioactive isotopes and diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

- Treatment of injury to sound natural teeth. Treatment must start within 90 days after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

  If an alternate dental procedure or material will restore the tooth (teeth) or dental arch(es) satisfactorily, then payment for the lesser procedure or material will be made toward a more elaborate or precision appliance/procedure that the patient and his or her dentist may choose.

Limitations

No benefits are paid for:

- accidental damage to dentures
- dental treatment completed more than 36 months after the accident
- orthodontic diagnostic services or treatment

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a Christian Science Practitioner who is listed in the current Christian Science Journal
- Out-of-hospital services of a qualified massage therapist when prescribed by a physician, a nurse practitioner or a midwife
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist when recommended by a physician, a nurse practitioner or a midwife. Referrals are required every 12 months for ongoing treatment. The physiotherapist must not be a participant in the Ontario Health Insurance Plan (OHIP), except that the initial assessment performed by a physiotherapist who is an OHIP participated will be covered
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist or chiropodist

- Out-of-hospital treatment by a registered psychologist, qualified social worker, qualified psychotherapist, qualified therapist, or qualified counsellor when recommended by a physician or by a nurse practitioner. Referrals are required every 12 months for ongoing treatment.

- Out-of-hospital treatment of speech impairments by a qualified speech therapist when recommended by a physician. A new referral is required if the ongoing treatment has been interrupted by a period of 12 months or longer

Visioncare

- Eye examinations, including refractions, once every 24 months, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

- Visual motor therapy performed by a licensed ophthalmologist or optometrist.

Gender Affirmation Procedures

Procedures for gender affirmation are covered if the person meets the following conditions:

- The person has a diagnosis of gender dysphoria

- The person has been assessed and recommended for surgical or other procedures by a healthcare provider

- The person is 18 years old or older

- The person has received prior approval from Canada Life. You or your dependent and the healthcare provider must complete an application form for each procedure. Contact Canada Life to obtain this form.

  Submit the form to Canada Life.

  Canada Life will assess all procedures based on the terms of this plan. Canada Life reserves the right to request details of the procedures performed.

Covered Procedures

Covered gender affirmation procedures include but are not limited to:

- Top procedures

  - breast augmentation (breast implants)
  - mastectomy (removal of breasts)
  - chest contouring
  - pectoral implants

- Bottom procedures

  - penectomy (removal of penis)
  - orchiectomy (removal of testicles)
  - scrotectomy (removal of scrotum)
  - vaginoplasty (construction of a vagina)
  - hysterectomy (removal of uterus)
  - salpingo-oophoerectomy (removal of fallopian tubes and ovaries)
  - vaginectomy (removal of vagina)
  - metoidioplasty (construction of male genitals)
  - phalloplasty (construction of a penis), implantation of penile and/or testicular prosthesis
  - scrotoplasty (construction of scrotum)

- Other procedures

    - facial feminization or masculinization procedures (such as forehead, brow, eye/eyelid, nose, jaw, lip, cheek or chin contouring, augmentation or reduction)
    - laryngoplasty (Adam's apple reduction or augmentation)
    - hairline reconstruction; hair removal (electrolysis or laser); hair transplants
    - voice surgery/vocal cord surgery
    - liposuction, lipofilling and other aesthetic procedures

Eligible procedures are subject to change.

Limitations

No benefits are paid for:

- Travel or accommodation expenses
- Sperm preservation or cryopreservation of fertilized embryos
- Procedures related to medical fertility problems
- Procedures that are not considered medically necessary by the healthcare provider
- Procedures performed outside of Canada

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Canada Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation

  Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Limitation

Meal expenses are not covered.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes and it is required during the first 180 days starting with the person's departure from Canada. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

    - treatment by a physician
    - diagnostic x-ray and laboratory services
    - hospital accommodation in a standard or intensive care unit, if the confinement begins while you or your dependent is covered
    - medical supplies provided during a covered hospital confinement
    - paramedical services provided during a covered hospital confinement
    - hospital out-patient services and supplies
    - medical supplies provided out-of-hospital if they would have been covered in Canada
    - drugs
    - out-of-hospital services of a professional nurse
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada

Limitations

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

No benefits will be paid for:

- expenses for the regular treatment of an injury or disease that existed before the departure; and

- expenses incurred on a non-emergency or referral basis.

You or your dependent must return to his or her province of residence for at least 30 consecutive days before becoming eligible for another 180 days of coverage.

Limitations

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private benefit plans are not permitted to cover by law

- Services or supplies for which a charge is made only because you have coverage

- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan

- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - contraception, other than oral contraceptives
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute
- Expenses incurred due to intentionally self-inflicted injuries, while sane or insane
- Expenses for services and products rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage

- Out-of-province expenses for elective (non-emergency) medical treatment or surgery

- Brain or body scanners, or in connection with cosmetic or plastic surgery, unless for restorative purposes to repair tissue damaged by disease or bodily injury

- Eyeglasses or hearing aids, except otherwise provided in this plan, rest cures, travel for health reasons, periodic health check-ups or examinations, or examinations for insurance purposes

- Services provided in a health spa, chronic care or psychiatric hospital or chronic care unit of a general hospital, except as otherwise provided in this plan, or for services or supplies provided while confined in a nursing home or home for the aged

- Any care, services or supplies which are not medically necessary

- Bodily injury sustained while committing or attempting to commit a criminal offense

- Replacement of any supply, appliance or prosthetic device covered under this plan, except where the replacement is normal because the item is no longer serviceable due to general usage, or as a result of the natural growth of a child

- Chronic care

- Visioncare services and supplies required by an employer as a condition of employment

- Non-prescription sunglasses and safety glasses

- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid

In addition under the prescription drug coverage, no benefits are paid for:

- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Anti-obesity drugs
- Protein supplements
- Experimental drugs

- Smoking cessation products, other than Zyban
- Drugs used to treat erectile dysfunction
- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

Special Measures For Quebec Residents Age 65 And Over For Prescription Drug Coverage

If you reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage on the date you reach age 65. At that time, you automatically become covered under the basic prescription drug plan provided by the *Régie de l'assurance-maladie du Québec*. You must pay the applicable premiums under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan. If your dependents are not eligible for private coverage on their own, you must register them under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.

If you are still eligible, you will remain covered for prescription drugs under this plan, but on a supplemental basis. This means that this plan may cover deductible and co-payment amounts you are required to pay under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.

However, you can instead choose to remain covered as you are now for prescription drugs under this plan. This would provide you with drug coverage that is at least as good as the coverage offered by *Régie de l'assurance-maladie du Québec*. If you do this:

- You must contact *Régie de l'assurance-maladie du Québec* to opt out of the public prescription drug insurance plan.
- Your premiums under this plan may remain the same or they may increase. **It's important you verify this information with your employer before opting out of the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.**

A one-time election may be made to be covered under this plan. You must make this election and communicate it to your employer by the end of the 60-day period immediately following:

- The date you reach age 65; or
- The date you become a resident of Quebec, within the meaning of the *Quebec Health Insurance Act,* if you are age 65 or over.

Otherwise, we will assume that you have decided to:

- Remain enrolled in the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan; and
- Maintain your prescription drug coverage offered under this plan on a supplementary basis.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic prescription drug plan provided by the *Régie de l'assurance-maladie du Québec*.

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

How to Make a Claim

- **Out-of-Country Emergency Care and Global Medical Assistance Claims**

  Access www.canadalife.com to obtain an Out-of-Country/Travel Assistance claim form and the provincial authorization form for your home province or territory.

  Complete all applicable forms, including all required information. Forward the claim forms, along with copies of your receipts, as directed on the claim form.

  Be sure to keep original receipts for your own records.

  This plan will pay all eligible claims including your provincial or territorial medical plan portion. Your provincial or territorial medical plan will then reimburse this plan for the government's share of the expenses.

  If your provincial or territorial medical plan refuses payment, you may be asked to reimburse this plan for any amount it already paid on behalf of the provincial or territorial medical plan.

  Submit all claims as soon as possible to meet provincial submission timelines.

- **All Other Healthcare Claims**

  Online claims: To submit online claims, register at www.mycanadalifeatwork.com. To use this service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Submit online claims to Canada Life as soon as possible, but no later than 15 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

  Paper claims: To submit paper claims, access www.mycanadalifeatwork.com to obtain a personalized claim form, or obtain form M635D from your employer. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 18 months after you incur the expense.

- **Drug claims**

  Your employer will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

  Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

DENTALCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level for a general practitioner shown in the **Benefit Summary**, except that:

- denturist fee guides are applicable when services are provided by a denturist.
- dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.
- specialist fee guides are applicable only when a specialist performs periodontal, surgical and endodontic examinations.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist’s supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
    - one complete oral examination every 36 months
    - periodontal, surgical and endodontic examinations
    - limited oral examinations once every 5 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
    - limited periodontal examinations once every 5 months
    - specific oral and emergency oral examinations once every 12 months
    - complete series of intra-oral x-rays once every 24 months
    - intra-oral x-rays:
        - periapical x-rays
        - bite-wing x-rays once every 5 months
    - panoramic x-ray every 24 months
    - histological and pulp vitality tests
    - consultation with patient

- Preventive services:
  - polishing once every 5 months
  - scaling, limited to a maximum combined with periodontal root planing of 16 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - topical application of fluoride once every 5 months
  - oral hygiene instruction once every 5 months
  - pit and fissure sealants on bicuspids and permanent molars every 60 months for dependent children only
  - interproximal disking for dependent children under age 12
  - recontouring of teeth for functional reasons
- Minor restorative services:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns
  - natural tooth preparation
  - acrylic or composite resin (white fillings) restoration on permanent molars without the limitation of amalgam equivalent

- Endodontic services:
  - treatment of the pulp chamber
  - root canal therapy
  - apexification
  - periapical services. Apicoectomies are covered for permanent teeth only
  - isolation of teeth
  - bleaching
  - emergency procedures
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 16 time units every 12 months
  - periodontal surgery
  - occlusal adjustment and equilibration, limited to a combined maximum of 8 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - periodontal appliances, once every 5 years including adjustments, relines and repairs
  - temporomandibular joint appliances including adjustments, relines and repairs
  - post surgical treatment
  - desensitization

- periodontal re-evaluations
- temporomandibular joint x-rays
- surgical excision of benign cysts and granulomas
- denture-related surgical services for remodelling and recontouring oral tissues
- dislocation management of temporomandibular joint

- Denture maintenance, including:
  - denture relines for dentures
  - denture rebases for dentures
  - denture repairs and additions and resetting of denture teeth
  - tissue conditioning
- Oral surgery
- Adjunctive services

Major Coverage

- Prosthodontic examinations
- Interpretation of x-rays or models from another source
- Diagnostic casts
- Maxillofacial prosthesis
- Master cast techniques
- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns

- Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays

- Inlays. Coverage for tooth-coloured inlays on molars is limited to the cost of metal inlays

  Replacement crowns, onlays and inlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Implant retained appliances, bridgework when required to replace one or more teeth extracted while the person is covered. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Bridgework is also covered when:

  - it replaces a covered temporary appliance

  - it replaces a bridge that is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered for major coverage as a result of the placement of an initial opposing appliance or the extraction of additional teeth while covered.

  The following bridgework related items are also covered:

  - recontouring of retainers/pontics

  - fixed prosthetics

- Appliance maintenance including:

  - repairs to covered bridgework

  - removal and recementation of bridgework

  - removal and reinsertion of implant-retained appliances for repair

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

General Limitations

If you do not apply for dentalcare coverage within one month after you become eligible, benefits are limited to $250 during the first 12 months of your coverage, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect.

No benefits are paid for:

- Duplicate x-rays, occlusal x-rays, custom fluoride appliances, group or audio-visual oral hygiene instruction and nutritional counselling
- Removal of an amalgam restoration and its replacement with a composite restoration, unless there is evidence of recurrent decay or significant breakdown
- The following endodontic services – endosseous intra coronal implants, intentional removal of tooth apical filling and replantation, removal of root filling materials or foreign bodies and mummification
- The following periodontal services - topical application of antimicrobial agents, subgingival periodontal irrigation and dental floss ligation
- Resilient liner in relined or rebased dentures

- The following oral surgery services:

  - implantology
  - surgical movement of teeth other than surgical repositioning
  - remodeling of bone
  - extraoral surgical incision and drainage, and surgical incision for removal of foreign bodies
  - surgical excision of malignant tumors
  - cheiloplasty
  - augmentations of the jaw
  - sequestrectomy
  - mandibulectomy
  - maxillectomy
  - treatment of fractures
  - treatment of maxillofacial deformities other than frenectomy or frenoplasty
  - treatment of muscular disorders
  - treatment of salivary glands
  - treatment of neurological disturbances
  - antral surgery for oro-antral fistula closure – gold plate
  - surgical grafts
  - emergency office procedures

- The following adjunctive services:

  - hypnosis or acupuncture
  - emergency services not specified in Guide
  - local anaesthesia
  - provision of general anaesthetic facilities, equipment and supplies by a separate anaesthetist
  - laboratory procedures

- Veneers, staining porcelain and copings related to covered crowns

- Expenses covered under another group plan's extension of benefits provision

- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare
- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only other than bleaching
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Temporomandibular joint disorders. This limitation does not apply to temporomadibular joint radiographs and appliances, management of a temporomandibular joint dislocation and occlusal equilibration.
- Vertical dimension correction except occlusal equilibration
- Myofacial pain
- Services or supplies rendered for the correction of any congenital or developmental malformation which is not a Class I, Class II or Class III malocclusion
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Lost, stolen or mislaid appliances
- Failure to keep a scheduled appointment with the dentist
- A duplicate device or appliance

- Expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute

- Expenses incurred due to intentionally self-inflicted injuries

- Expenses for services performed by a person who is ordinarily a resident in the patient's home or who is closely related to the patient by blood or marriage

- Treatments or services by any person other than a denture therapist or dentist, except that scaling and cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision and guidance of the dentist

- Services rendered through a medical department, clinic or similar facility provided or maintained by your or your dependent's employer

- Services or supplies which do not meet accepted standards of dental practice, including charges for services which are experimental in nature

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 15 months after the dental treatment.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

- **For all other Dentalcare claims**, access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 18 months after the dental treatment.

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.