CUPE 2424 Active Employees

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

To contact a customer service representative at Canada Life for assistance with your medical and dental coverage, please call 1-800-957-9777.

Customer complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 153180 and 153181 and Plan Document No. 51801 issued by Canada Life and Policy No. 50813-G issued by Sun Life of Canada. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies 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

and

Sun Life of Canada

This booklet was prepared on February 27, 2023 and reflects the plan design as of February 1, 2023

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.

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

Your employer has an agreement with Canada Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

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 Financial Institutions Act (British Columbia).

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

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Benefit Summary

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

Employee Basic Life Insurance Benefit (Underwritten by Sun Life of Canada)	See description
Optional Life Insurance	
Employee	Available in $10,000 units to a maximum of $500,000
Spouse	Available in $10,000 units to a maximum of $350,000 If you do not retire on your normal retirement date, all amounts of insurance reduce by 50%, to a maximum of $100,000 If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum See the Optional Life Insurance section of this booklet for evidence requirements

Long Term Disability Income Benefits

Waiting Period	130 working days
Amount	65% of your monthly earnings to a maximum benefit of $20,000

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 $450
Myoelectric Arms	Limited to the cost of an artificial arm
External Breast Prosthesis	1 every 5 calendar years

Item	Limit
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	2 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	$500 each calendar year
Naturopaths	Included
Osteopaths	Included
Physiotherapists	Included
Podiatrists/Chiropodists	Included
Psychologists/Social Workers/ Psychotherapists/ Clinical Counsellors	Included
Speech Therapists	$200 each calendar year

Visioncare Expense Maximums

Eye Examinations	Once every 24 months
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery	$500 combined every 24 months
Visual Motor Therapy	$10 every half hour

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 on 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 on 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	50%

Plan Maximums

Basic Coverage	Unlimited
Major Coverage	$2,000 each calendar year
Orthodontic Coverage	$2,500 lifetime

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible for Long Term Disability Income benefits:

- immediately if you are a full-time employee,

- immediately if you are a part-time employee who holds an appointment of 12 months or more with a workload equal to 50% or more of full-time workload, or

- on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 12 months which is extended beyond 12 months.

You are eligible for Dentalcare benefits:

- immediately if you are a full-time employee,

- immediately if you are a part-time employee who holds an appointment of 4 months or more with a workload equal to 50% or more of full-time workload, or

- on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 4 months which is extended beyond 4 months

- after 3 months of continuous employment if you are a temporary employee with a workload equal to 50% or more of full-time workload. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

You are eligible for all other benefits:

- immediately if you are a full-time employee,

- immediately if you are a part-time employee who holds an appointment of 4 months or more with a workload equal to 50% or more of full-time workload, or

- on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 4 months which is extended beyond 4 months.

In addition, to qualify for coverage for all benefits you and your dependents must reside in Canada, and to qualify for coverage for Healthcare and Dentalcare benefits you and your dependents must be covered under the government health plan in your province of residence.

- 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.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- Temporary employees are eligible for Dentalcare benefits only.

- Seasonal employees may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the plan terminates, whichever is earliest.

- 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 as follows:

- for non-retired employees who are past the normal retirement age, and active employees who would be eligible to retire, 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.

- for all other non-retired employees, for 3 months or until they no longer qualify, whichever happens first.

Normal Retirement Date

Your normal retirement date is:

- The first day of September coinciding with or next following the date you reach age 65 if you joined the plan before July 1, 1957

- The first day of July closest to the date you reach age 65 if you joined the plan on or after July 1, 1957

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.

EMPLOYEE BASIC LIFE INSURANCE BENEFIT

(Underwritten by: Sun Life of Canada)
Contract Number: 50813
Effective: August 1, 2005 (version 4)

Benefit Details

INSURANCE BENEFITS FOR YOU

LIFE INSURANCE

Amount	200% of your annual Basic Earnings, the result adjusted to the next higher $1,000 (if not already a multiple of $1,000), up to a maximum benefit of $1,000,000
Reduction of Amount of Insurance	The Amount of Insurance shown above is reduced to the lesser of 100% of annual earnings or $25,000 on the date you attain your normal retirement date

This benefit ends on the date you retire or reach age 70, whichever is earlier.

CHANGES IN AMOUNTS

Your insurance may change if your status affecting the insurance changes. Such change is made on the day your status changes.

If you are not Actively At Work (i) on the date an increase would otherwise take effect,or (ii) on the date the group policy is amended to provide additional or increased benefits, any increase will only take effect on the first day you are Actively At Work.

DEFINITIONS

The group policy contains a number of definitions not listed here. The following definitions will be of greatest interest to you.

Note: All terms which are defined in the group policy are capitalized throughout the text of this booklet.

Deemed Date of Retirement – If you become Totally Disabled, your date of retirement is deemed to be the first day of July of the year you reach age 65.

Employee – a person classified by the Employer as a permanent full-time employee scheduled to work at least 24 hours a week, **excluding** anyone who is a temporary employee, replacement non-faculty employee and visiting scholar.

Illness - bodily injury, disease, mental infirmity, Pregnancy or sickness.

Normal Retirement Date – the first day of July of the year you reach age 65.

Totally Disabled – you are Totally Disabled if you are prevented by Illness from performing the regular duties of your own job.

Waiting Period – you are considered to have satisfied the Waiting Period by the date of your Employment.

General Information

The information in this document is important to you. It provides a summary of the benefits made available to you through your Employer's group policy with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies. You should keep this document in a safe place. Your Employer can provide you with full details of the group policy.

In the event of any discrepancy between the information in this document and the group policy, the terms and provisions of the group policy apply.

<u>Accessing Your Records</u>

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the group policy.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

Insurance Coverage Begins

Your insurance begins on the day following your completion of the Waiting Period (see theBenefit Details) provided you enrol without delay. Otherwise evidence of insurability may be required before you can join the plan. Sun Life will issue to you a Certificate showing your insured benefits and effective date of cover.

If you are not Actively At Work on the effective date indicated on the Certificate, your coverage is delayed until the day you are Actively At Work.

Insurance Coverage Ends

Your insurance ends on the earliest of:

- the date your Termination Of Employment occurs,
- the end of the period for which premium is paid for your insurance,
- the date the group policy is no longer in force.

Making a Claim

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your Employer to get the proper form to make a claim.

There are time limits for making claims. These limits are shown under each benefit. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal Actions

Limitation period for Ontario:

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 *Limitations Act, 2002*.

Limitation period for any other province:

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 of your province or territory.

Life Insurance

The amount of your Life insurance can be determined from the Benefit Details. If you die while insured, Sun Life will pay the amount of your Life insurance to the last nominated beneficiary as filed. In the absence of a beneficiary nomination, payment will be made to your estate.

You may name the beneficiary of your choice or your estate. Any nominations you make are revocable, unless you stipulate otherwise or the law provides otherwise.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Disability Benefit

If you become Totally Disabled while insured, and before your normal retirement date or earlier retirement, and your Total Disability continues for an uninterrupted period of 6 months, your Life insurance will remain in force during your continued Total Disability without payment of premium. Any amount of insurance continued is subject to the terms of the group policy.

Conversion

If your insurance ends, you are entitled, during the 31 day conversion period, to purchase an individual life insurance policy from Sun Life under the terms of the Conversion contained in the group policy. No medical examination is required.

Making a Claim

If you die, a claim should be made as soon as reasonably possible.

If you become Totally Disabled, a claim must be made not later than 12 months after you stopped being Actively At Work. Each year Sun Life may require proof of your continued Total Disability.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance, you must provide proof of your insurability for any amount in excess of 100% of your annual earnings to a maximum of $150,000, and for all amounts applied for more than 31 days from the date you first become eligible, and your application must be approved by Canada Life. When your spouse applies for optional life insurance, proof of insurability must be provided and the application must be approved by Canada Life.

Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If your spouse dies you will be paid the amount for which your spouse was insured.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your optional life insurance, and your spouse's, continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Canada Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for a claim form.

- Your and your spouse’s optional life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your and your spouse’s optional life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

- If your or your spouse's optional life insurance terminates before your normal retirement date, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your employer for details.

- Your optional life insurance will not continue past the end of the day before the date you reach age 71. Your spouse's coverage will not continue past the end of the day before the date your coverage ends or your spouse reaches age 65, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or:

- if you joined the employer's retirement plan before July 1, 1957, the first day of September coinciding with or next following the date you reach age 65 or;

- if you joined the employer's retirement plan on or after July 1, 1957, the first day of July closest to the date you reach age 65,

whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as they are accumulated within a period of 12 consecutive months and the disabilities arise from the same disease or injury. If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the short term disability or sick leave benefit period, but not later than one year after your disability started.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular job.

- After 24 months, LTD benefits will continue only if your disability prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications.

- After the waiting period, separate periods of disability are considered to be one period of disability if they arise from:
    - the same disease or injury and start within 6 months after the previous disability ends, or within 24 months after the end of an approved comprehensive rehabilitation program. Rehabilitation plans are not considered under this 24-month provision.
    - an unrelated disease or injury and start within 1 month after the previous disability ends.
- Because your employer contributes to the cost of LTD coverage, benefits are taxable.
- Your LTD insurance will not continue past the end of the day before the date you reach age 65.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Other income includes:

- benefits under any Workers' Compensation Act or similar law
- 50% of income from an approved rehabilitation program

The balance of earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- Any period during which you are residing outside Canada for more than 90 days unless:

  - you are receiving regular and continuous treatment from a physician;

  - you provide evidence within 30 days of departure that you are receiving such regular and continuous treatment; and

  - you are available to be examined by a doctor provided and paid for by Canada Life, if required.

- Any period of confinement in a prison or similar institution.

- Disability arising from war, insurrection, or voluntary participation in a riot.

How to Make a Claim

- To submit claims online, go to www.canadalife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions.

  You can get this form from your employer, or online from the Canada Life corporate website. To access the form online, go to www.canadalife.com.

Please ensure that your claim is submitted to Canada Life as soon as possible, but no later than 6 months after proof of your claim has been requested.

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 confinement or home nursing care if it represents acute or convalescent.

  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.

- The plan covers preferred accommodation in a hospital, excluding chronic care, long term care and palliative care, when provided in Canada.

  For hospital accommodation, for a visiting scholar, the plan covers the hospital’s semi-private rate in Ontario. For all other employees, the plan covers the difference between the hospital’s semi-private and standard ward rates.

  For out-of-province hospital accommodation, for a visiting scholar, the plan covers the hospital’s semi-private rate in Ontario. For any other employee, the plan covers any difference between the hospital's semi-private rate and the government authorized allowance in your home province.

  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 your 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.

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

  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

- 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, a qualified social worker, a registered clinical counsellor or a qualified psychotherapist 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

- 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

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.

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

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this plan as set out below.

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 Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic 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 claims (including those for Global Medical Assistance expenses)** should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access My Canada Life at Work to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Canada Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government's share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Canada Life's Out-of-Country Claims Department at 1-800-957-9777.

- **You may submit all Healthcare claims online**. To use this 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 12 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.

- **We also accept paper claims for all Healthcare expenses.** Access My Canada Life at Work 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.

- **For 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 when specialists provide services within their speciality.

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

- 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

  Alternative benefits will be provided for the services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants, limited to the cost of a bridge if a bridge is considered a reasonable treatment.

- Appliance maintenance including:
    - repairs to covered bridgework
    - removal and recementation of bridgework

Orthodontic Coverage

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

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 12 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.

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