

My group benefit plan



canada *life* TM



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 No. 161890 and Plan Document No. 53346. 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



and arranged by

HUB International Insurance Brokers
1900 - 505 Burrard Street, Box 76
Vancouver, BC V7X 1M6

This booklet was prepared on: June 14, 2024

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 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 Dentalcare benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the 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.

TABLE OF CONTENTS

	Page
Benefit Summary	1
Commencement and Termination of Coverage	5
Dependent Coverage	7
Beneficiary Designation	7
Employee Life Insurance	8
Dependent Life Insurance	9
Healthcare	10
Virtual Health Services	30
Dentalcare	32
Coordination of Benefits	40
Diagnostic and Treatment Support Services (Teladoc Medical Experts)	41

Benefit Summary

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

Employee Life Insurance	100% of annual earnings to a maximum of \$500,000, reducing by 50% at age 65
	Any amount of Employee Life Insurance over \$95,000 is subject to approval of evidence of insurability

Dependent Life Insurance

Spouse	\$5,000
Child	\$2,500

Healthcare

Covered expenses will not exceed customary charges

Deductibles

In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge
All Other Expenses	Nil

Reimbursement Levels

In-Canada Prescription Drug Expenses	90%
All Other Expenses	100%

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	\$5,000 for a maximum of 12 months per condition
In-Canada Prescription Drugs	Included
Hearing Aids	\$700 every 5 years
Speech Aids	\$1,000 lifetime
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	\$300 combined every 12 months
Myoelectric Arms	\$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 every 12 months
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of \$2,000

Blood-glucose Monitoring Machines	1 every 4 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	\$4,000 each calendar year
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of \$1,500
Custom-made Compression Hose	4 pairs each calendar year
Wigs for Cancer Patients	\$200 lifetime

Paramedical Expense Maximums

Acupuncturists	\$350 each calendar year
Chiropractors/ Athletic Therapists/ Massage Therapists/ Occupational Therapists/ Physiotherapists	\$1,000 combined each calendar year
Dieticians	\$350 each calendar year
Naturopaths	\$350 each calendar year
Osteopaths	\$350 each calendar year
Podiatrists/Chiropodists	\$350 combined each calendar year
Psychologists/Social Workers/ Psychotherapists/Therapists/ Counsellors	\$1,000 combined each calendar year
Speech Therapists	\$350 each calendar year

Visioncare Expense Maximums

Eye Examinations	1 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	\$250 combined every 24 months

Gender Affirmation Procedures Expense Maximum	\$15,000 lifetime
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Lifetime Healthcare Maximum	Unlimited
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Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered
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Deductibles

Individual	\$50 each calendar year
Family	\$50 each calendar year

The individual and family deductibles do not apply to Accidental Dental Injury expenses

Reimbursement Levels

Basic Coverage	80%
Major Coverage	50%
Accidental Dental Injury Coverage	100%

Plan Maximums

Accidental Dental Injury Treatment	Unlimited
All Other Treatment	\$1,500 combined each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 3 months of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide evidence of good health for you and your dependents before you can participate.
- 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, part-time and seasonal employees may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, you stop making the required contributions, 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 for a period of 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.
- Your unmarried children under age 21, or under age 25 if they are full-time students.

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 LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits 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 to your beneficiary.

- Your life insurance will not continue past the end of the day before the date you reach age 71.
- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance 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 claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.
- Your 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 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 any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

DEPENDENT LIFE INSURANCE

If one of your dependents dies, Canada Life will pay you the dependent life insurance benefit. Your employer will explain the claim requirements.

- Your dependent life insurance will not continue past the end of the day before the date you reach age 71.
- If you are disabled and the premiums for your employee life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.
- Your dependent 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 and your employee life insurance is continued, your dependent life insurance will be continued on the same basis.
- If your spouse's insurance terminates on or before their 65th birthday, your spouse may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your employer for details.

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 transportation to the nearest centre where adequate treatment is available
- Hospital or nursing home confinement or home nursing care if it represents acute, convalescent, or palliative 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.

Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

- Preferred accommodation in a hospital or accommodation in a nursing home is covered 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 standard ward 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.

For accommodation in a nursing home, the plan covers the government authorized co-payment.

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 person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country care provision.
- The following drugs are covered if they are listed in the Canada Life British Columbia drug formulary, as determined by Canada Life, in effect on the date of purchase:
 - (a) drugs which require a written prescription
 - (b) injectable drugs including vitamins and insulins
 - (c) extemporaneous preparations or compounds if one of the ingredients is a covered drug
 - (d) certain other drugs that do not require a prescription by law may be covered when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense
- The following diabetic supplies are covered:
 - (a) insulin syringes
 - (b) disposable needles for use with non-disposable insulin injection devices
 - (c) lancets, test strips, and sensors for flash glucose monitoring machines

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 Canada Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician
- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible
- 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
- 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 services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

- Out-of-hospital treatment of nutritional disorders by a registered dietitian
- Out-of-hospital services of a qualified massage therapist
- 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, a qualified occupational therapist or a licensed athletic therapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist or a qualified chiroprapist
- Out-of-hospital treatment by a registered psychologist, qualified social worker, qualified psychotherapist, qualified therapist, or qualified counsellor
- Out-of-hospital treatment of speech impairments by a qualified speech therapist

Visioncare

- Eye examinations, including refractions, 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

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)
 - scrotoectomy (removal of scrotum)
 - vaginoplasty (construction of a vagina)

- hysterectomy (removal of uterus)
- salpingo-oophorectomy (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 Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

Limitations

If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

- the amount payable under this plan for continued treatment outside Canada, and
- the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

No benefits are paid for:

- any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency
- any subsequent and related episodes during the same absence from Canada

- expenses related to pregnancy and delivery, including infant care:
 - after the 34th week of pregnancy, or
 - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.
- expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement
- **Non-emergency care** outside Canada is covered for you and your dependents if:
 - it is required as a result of a referral from your usual Canadian physician
 - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties
 - you are covered by the government health plan in your home province for a portion of the cost, and
 - a pre-authorization of benefits is approved by Canada Life before you leave Canada for treatment.

Limitations

No benefits will be paid for:

- investigational or experimental treatment
- transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

- treatment by a physician
- diagnostic x-ray and laboratory services
- hospital accommodation in a standard or semi-private ward 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
- for emergency care only, ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

Other Services or Supplies

Canada Life can, on such terms as it determines, cover services or supplies not otherwise covered under this plan where the service or supply represents reasonable treatment.

General Limitations

Canada Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Canada Life.

Canada Life can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

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

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance 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, except as may be provided under the prescription drug provision
 - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Canada Life to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country 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 Canada Life would have paid benefits 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
- Chronic care

- Services or supplies that Canada Life has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Canada Life may take any factor into consideration including, but not limited to, the following:
 - clinical practice guidelines;
 - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
 - information provided by a manufacturer or provider of the service or supply; and
 - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Drugs or drug supplies that appear on an exclusion list maintained by Canada Life. Canada Life may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. Canada Life may add or remove a drug or drug supply from an exclusion list at any time.

For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

- Canada Life determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or
- Canada Life determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- 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 normally used for contraception
- 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 administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, except where prescribed for the treatment of gender dysphoria
- Preventative immunization vaccines and toxoids
- Smoking cessation products
- Fertility drugs, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Canada Life maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to www.canadalife.com.

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Canada Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Canada Life has recommended or approved health case management, Canada Life can require that a service or supply be purchased from or administered by a provider designated by Canada Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Canada Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Canada Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Canada Life requires participation, Canada Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

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 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.

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 15 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.

VIRTUAL HEALTH SERVICES

Virtual health services are available to you and your dependents (each a “person” for the purposes of these services) by downloading the service provider’s application specified by Canada Life from time to time. These services include the following:

- Unless prohibited by applicable laws, access to an unlimited number of consultations via telephone calls, text messaging and videoconferencing with medical professionals
- Prescriptions and prescription renewals, when medically needed
- Where diagnostic or laboratory tests are medically needed:
 - completion of necessary requisitions
 - results of the diagnostic or laboratory tests provided and accessible through the provider’s application
 - information on the results of diagnostic/laboratory tests via the service provider’s application
- Details of a person’s care plan provided to the person on request of that person
- Access to self-guided internet-based cognitive behavioral therapy (iCBT)
- Access to specialists such as psychologists, dieticians and work and life coaches for an additional fee

The above services will be available 24 hours a day, 7 days a week.

How to Access these Services

- **Visit the Website**

English: <https://consultplus.dialogue.co/>

French: <https://consultplus.dialogue.co/?lng=fr>

- **Download the App**

Download the Consult+ app to any mobile device.

- **Visit the Help & Support Pages**

English: www.canadalife.com/resources/consult-faq.html

French: www.canadalife.com/fr/resources/consult-faq.html

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, 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
 - limited oral examinations twice every 12 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 twice every 12 months
 - complete series of x-rays every 36 months
 - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
 - polishing and topical application of fluoride each twice every 12 months
 - scaling, limited to a maximum combined with periodontal root planing of 14 time units every 12 months

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

 - pit and fissure sealants on bicuspid and permanent molars every 60 months
 - space maintainers including appliances for the control of harmful habits

- finishing restorations
- interproximal diskling
- recontouring of teeth
- Minor restorative services including:
 - caries, trauma, and pain control
 - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
 - retentive pins and prefabricated posts for fillings
 - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
 - root planing, limited to a maximum combined with preventive scaling of 14 time units every 12 months
 - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:
 - denture relines for dentures at least 6 months old, once every 36 months
 - denture rebases for dentures at least 2 years old, once every 36 months
 - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
 - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
 - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- Oral surgery
- Adjunctive services

Major Coverage

- 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

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

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

- the existing appliance is a covered temporary appliance
- the existing appliance 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 and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues
- Appliance maintenance following the 3-month post-insertion period including:
 - denture remakes, once every 36 months
 - tissue conditioning
 - repairs to covered bridgework
 - removal and recementation of bridgework

Accidental Dental Injury Coverage

- Treatment of injury to sound natural teeth. Treatment must start within 60 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

General Limitations

If you do not apply for dentalcare coverage within one month after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic Coverage expenses are limited to \$100 during the first 12 months of your coverage
- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

If overdentures are provided, coverage will be limited to standard complete dentures.

If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided

- Orthodontic treatment
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- 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
- Congenital defects or developmental malformations in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

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 15 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.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (Teladoc Medical Experts)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents, parents and parents in-law (each a “person” for the purpose of this service) can generally access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-2378 toll-free or via teladoc.ca/canadalife/.
- The person accessing the service will be connected with a member advocate who will be dedicated to the person’s case and will provide support through the process. The member advocate will take the necessary medical history and answer the person’s questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the person’s health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes several weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.
- If the person decides to seek treatment by a different physician, a member of the Teladoc Medical Experts team can help identify a specialist qualified to meet the person's specific medical needs either in their geographic area or outside of Canada.
- The member advocate may identify a Teladoc Medical Experts specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

General Limitations

- Expenses incurred for travel and treatment are not covered by this service.
- Access to this service may be restricted to persons for whom their physician has made a diagnosis of a physical or mental illness or condition for which there is objective evidence, or where a physical or mental illness or condition is suspected.

These services are not insured services. Canada Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.



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