

My group benefit plan



canada *life*™



HEALTH AND WELFARE PLAN

March 1, 2020

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

GroupNet for Plan Members

As a Canada Life plan member, you can register for GroupNet™ for Plan Members at www.canadalife.com or on the GroupNet Mobile app. Follow the instructions to register.

Make sure to have the following information ready so we can identify you:

- Plan Numbers (44541 and 58604) and member ID number
- Your date of birth
- The date of birth of one of your dependants
- Your postal code
- Your email address

Follow the registration instructions to choose your own user name and password.

With GroupNet and GroupNet Mobile 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.

The information provided in the booklet is intended to summarize the contract provisions of Group Policy No. 44541 and Plan Document No. 58604. 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.

Group Policy No. 44541: Life Insurance, Accidental Death & Dismemberment, Short Term Disability, Long Term Disability and Global Medical Assistance

Plan Document No. 58604: Health Care, Vision Care and Dental Care

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

UNITED ASSOCIATION LOCAL UNION 516

This booklet was prepared on: March 12, 2020

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statement 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.

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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Member Class Summary

Class 1 – Active Members – Building Trades

Class 2 – Associate Members

Class 10 – All Other Retirees

Class 11 – Current Year Retirees

Class 12 – Active Members – Metal Trades FMO

SCHEDULE OF BENEFITS

FOR

**GROUP POLICY NO. 44541 AND
PLAN DOCUMENT NO. 58604**

MEMBERS

Life Insurance

Classes 1 & 12	\$75,000, reducing by 50% at age 65, terminating at age 70
Classes 2, 10, & 11	\$75,000, terminating at age 65

AD&D Insurance (Principal Sum)

Classes 1 & 12	\$30,000, reducing by 50% at age 65
Class 2	\$30,000, terminating at age 65
Class 10 & 11	Nil

Weekly Income Insurance

Classes 1, 2, & 12	\$600 weekly
Class 10 & 11	Nil

Long Term Disability Insurance

Classes 1, 2, & 12	\$2,500 monthly, terminating at age 65
Class 10 & 11	Nil

MEMBERS AND DEPENDENTS

Healthcare

Covered expenses will not exceed customary charges

Calendar Year Deductible (per family member)	\$25
Calendar Year Deductible (per family)	\$25

The individual and family deductibles do not apply to Global Medical Assistance, Visioncare and In-Canada Prescription Drug expenses

Co-insurance Percentages

- Out-of-Country Emergency treatment covered expenses	100%
- all other covered expenses	80% of the first \$1,000 of benefits and 100% of the remainder

Prescription Drugs	Unless medical evidence is provided to Canada Life that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable drug
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Basic Expense Maximums Per Person

Hospital	Private room
Home Nursing Care	\$50,000 for a maximum of 12 months per condition
In-Canada Prescription Drugs	Included
Hearing Aids	\$700 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	Included
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	\$2,000 lifetime
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	\$4,000 each calendar year
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	4 pairs each calendar year
Wigs for Cancer Patients	\$200 per medical condition

Paramedical Expense Maximums Per Person

Chiropractors, Physiotherapists, Podiatrists, Osteopaths, Naturopaths, Massage Therapists and Acupuncturists	\$1,500 combined maximum each calendar year
Speech Therapists	\$1,500 each calendar year
Psychologists/Social Workers/ Family, Marriage or Registered or Professional Clinical Counsellors	
- For Classes 1, 2, 11 & 12	\$1,500 combined maximum each calendar year
- For Class 10	\$1,500 combined maximum each calendar year

Visioncare Expense Maximums Per Person

Eye Examinations	1 every 24 months from last date of service to a maximum of \$80
Glasses and Contact Lenses, Prescription Sunglasses, Prescription Safety Glasses and Laser Eye Surgery	\$500 combined maximum every 24 months from last date of service

Healthcare Maximums

Classes 1, 2, & 12	Unlimited except where maximums are indicated for specific covered expenses
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Class 10

- Out-of-Country Emergency treatment covered expenses per person	\$500 each calendar year
- all other Healthcare expenses except Global Medical Assistance	\$10,000 lifetime for the retiree and \$10,000 lifetime for the spouse Annual Reinstatement amount is \$2,500

Class 11

- Out-of-Country Emergency treatment covered expenses per person	\$500 each calendar year
- all other covered expenses	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Dental Fee Guide	The dental fee guide in effect in your province of residence on the date treatment is rendered
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Deductible	Nil
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Co-insurance Percentages

Basic Coverage	90%
Major Coverage	75%
Orthodontic Coverage (including adults)	50%
Accidental Dental Injury Coverage	90%

Plan Maximums Per Person

Basic Treatment	Unlimited
Major Treatment	\$3,000 each calendar year
Orthodontic Treatment	\$4,000 lifetime
Accidental Dental Injury Treatment	Unlimited

CHANGES IN BENEFITS

If your benefits change because of an amendment to the plan, or because of a change in your age, class, earnings, dependent status, etc., the new benefits become effective on the date the change affecting your benefits occurred.

When a change results in increased benefits you must be actively at work to be eligible for the new benefits. If you are not at work on the date the new benefits would otherwise become effective, the change will not become effective until you return to work.

ELIGIBILITY FOR MEMBERS

This Plan is an Hour Bank system designed for members of UA LOCAL 516, and was established on June 1, 1971.

The employers remit for each hour worked under the collective agreement. These hours are accumulated in the Hour Bank to provide you with coverage when you meet the eligibility requirements as outlined further along in this booklet.

You are asked to read this booklet carefully so that you will have a clear understanding of how your coverage operates for the benefit of you and your family.

Details of how you cash-pay and the coverage available to you are also included in this booklet.

We welcome your interest and suggestions in the hope that the Plan will always reflect the needs of the majority of the people it represents.

For any additional information or assistance, please follow this procedure:

- (1) For initial claims inquiry, contact Canada Life. The telephone number is 1-800-957-9777.
- (2) When communicating your areas of concern please use your group numbers #44541 and #58604.

To establish coverage

- (1) You must be a member in good standing of the UA LOCAL 516.
- (2) You must be enrolled in the Plan by completing an Application Form listing yourself and dependents. You may not obtain coverage even if you have sufficient hours to qualify, until the Application Form has been completed and forwarded to the Plan Office.
- (3) You must have a minimum of 420 hours worked within a period of 6 consecutive months, reported and paid into the Plan by your employer(s) and completed one bargaining month.

To establish coverage if you are an associate member your employer must remit the first month of premium prior to commencing coverage.

When coverage commences

Union members who have filled out an Application Form will have coverage commencing on the first day of the month following that in which sufficient hours are reported and paid to the Plan by your employer(s).

Example:

Your employer(s) reports that you worked in excess of 420 hours for the last six months. August hours are reported and tabulated in September, hence, your coverage becomes effective on October 1st.

Once coverage starts you will continue to be covered as long as your Hour Bank contains sufficient hours.

Please Note

If you are away from work on the date when your coverage would normally start, Weekly Income Insurance of a member and all coverage for an associate member would not become effective until you return to work.

Hour Bank Accumulation

A union member working more than 140 hours per month may accumulate a bank of hourly contributions that can be drawn on in periods of unemployment. The member may not, however, accumulate more than 700 hours in their hour bank.

Owner and Associate members cannot accumulate hours but shall pay 150 hours per month at the current collective agreement rate.

Cash-Pay Provision

(Applicable to Union Members Only)

If your Hour Bank drops below 140 hours, you will receive a Shortage Notice stating the balance of your current Hour Bank and the amount required to maintain coverage. Refer to the Shortage Notice itself and the note pertaining to your hours. If you make payment of the amount requested by the deadline specified on the Notice, your coverage will be continuous.

Limitations on Self-pay

Members may self-pay for an additional six (6) month period at the self-pay rate required. (The Plan Administrator will consider an extension under special circumstances.) The monetary amounts of self-payments are applied on a month-by-month basis, regardless of when the payment is received. Self-pay rates are subject to change.

Members on self-pay will not have Weekly Income Insurance.

Owner members shall pay at a rate of 150 hours per month and are not eligible for self-pay.

Layoff Coverage

Members on layoff coverage will not be eligible for the basic Weekly Income Insurance; however, all other benefits will remain in full force as long as the members hour bank status is correctly maintained.

Reporting of Hours

Your Agreement requires that employers report, prior to the 15th day of each month, all hours worked by you up to the close of the employer's payroll ending closest to the last day of the preceding month. It is advisable that you keep your pay slips as errors may occur in reporting or tabulating.

Termination of Coverage

Coverage will end either when a member's Hour Bank falls below 140 hours and he/she fails to make a cash contribution to bring the hour bank up to the minimum required for coverage, or cessation of membership in Local 516. Owner members' and associate members' benefits will end when the required contribution of 150 hours per month is not remitted.

Coverage can be maintained for whole months only.

Once coverage has been terminated the Plan does not allow for backdating of coverage.

Reinstatement of Benefits

Members who allow their coverage to lapse will have to requalify by working 280 hours within a 6 month period. This must be reported to the Plan. You may not requalify by self-payment.

Disability Credits

If you become so disabled as to be unable to work, your Hour Bank will be credited with four hours for each calendar day that you are so disabled, or 140 hours for a full calendar month. Such disability credits will count towards maintaining your coverage, but credit will not be granted for more than 500 hours. Should special circumstances arise, they can be extended by the Plan Administrator. In the case of disabilities arising from occupational causes, you will be required to provide the Administrator's Office with such evidence as it requires to determine the nature and duration of your disability, including W.C.B. cheque stubs. WCB slips will only be accepted if received by the Health and Welfare Plan office within 90 days of the date of issuance.

In the case of other disabilities, the Weekly Income Insurance under this Plan will be used to determine entitlement to disability credits.

ASSOCIATE PARTICIPANTS ELIGIBILITY AND MAINTENANCE OF COVERAGE

Who is eligible

Any employer who employs members of the UA LOCAL 516 is eligible as an associate member together with the personnel of such employers.

100% of the office personnel of each employer must elect to participate as associate members in order to qualify. No person who has attained the age of 65 may apply to join the plan as an associate member.

To establish coverage

- (1) Application must be made within 30 days of becoming an employee or employer, by completing the application form listing yourself and dependents.
- (2) Associate members must contribute 150 hours per month at the current health and welfare rates established in the collective agreement.

When coverage commences

Employers of associate members will remit the requisite amount prior to commencement of benefits. (i.e. April hours are forwarded to the union office in May for June benefits.)

Once coverage starts you will continue to be covered as long as you remain employed and the monthly contributions are made.

Termination of coverage

Coverage for an associate member will stop at the end of the last month for which payment has been made.

ELIGIBILITY FOR RETIRED MEMBERS CLASSES 10 & 11

Current Year Retirees are eligible to participate in the plan between January and December of the year you retire. You will be moved into the class All Other Retirees on January 1 of the following year.

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide evidence of insurability for you and your dependents before you can participate.
- Increases in benefits while you or your dependents are in hospital will not become effective until you or your dependents are released from hospital.
- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.

EXTENDED BENEFITS AFTER TERMINATION

Weekly Income Insurance - If your insurance terminates while you are disabled you will continue to receive Weekly Income benefits during that period of disability, up to the maximum noted in the Weekly Income benefit description.

DEFINITION OF DEPENDENT

Dependent means:

- Your spouse (legal or common-law)
- Your unmarried children or your spouse's unmarried children who are
 - under 21 years of age, or
 - 21 or over and in full-time attendance at a university or similar institution, or
 - 21 or over who are incapable of supporting themselves because of mental or physical handicap and who were insured under this plan on the day before they reached age 21.

Unmarried children of your spouse are considered dependents only if

- they are also your children, or
- your spouse is living with you and has custody of the children.

Your grandchildren are considered dependents if

- your child (the parent of the grandchild) meets the requirements of an insurable child, and
- both your child (the parent of the grandchild) and your grandchild reside with you.

The plan does not cover:

- children who are working more than 30 hours a week, unless they are full-time students, or
- spouses or children who are not a resident in Canada or the U.S.

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.

LIFE INSURANCE FOR MEMBERS

- If you die, your named beneficiary will be paid the amount of your group life insurance. 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. (See the **Schedule of Benefits** at the front of this booklet for the amount.)
- If you are an active Class 1 & 12 union member, your life insurance will not continue past the end of the last day of the month before the date you reach age 70. For all other participants, your life will not continue past the end of the day on the last day of the month in which you reach age 65.
- If you become disabled while insured and before reaching age 70 for active union members and before reaching age 65 for all other participants, and your disability continues without interruption for at least 17 weeks, your life insurance will remain in force without further premium payment. After you have been totally disabled for 17 weeks, you should submit the appropriate claim forms to Canada Life. Your premiums will be waived upon satisfactory proof of your disability but only until you reach age 70 for active union members and age 65 for all other participants. Proof of continued disability may be required each year.

If you are not approved for waiver of premium your life insurance will be continued on a premium paying basis until the earliest of the following:

if you are an associate member

- (1) the date your insurance is terminated by your employer,
- (2) the date you begin work for another employer,

if you are a member

- (1) the last day of the month in which, after the deduction for the current months coverage, your Hour Bank falls below 140 hours,
- (2) the date your insurance is terminated by your employer.

- If any or all of your insurance terminates **at or before age 65**, you may be able to apply for an individual conversion policy.

Application for an individual conversion policy must be made within 31 days after termination of insurance. During this period your life insurance under this plan will remain in force free of charge.

Please call Brent Delveaux at TRG Group for assistance with conversion.

**ACCIDENTAL DEATH, DISMEMBERMENT AND
SPECIFIC LOSS (AD&D) INSURANCE
(Not Applicable to Class 10 & 11)**

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Canada Life will pay the Principal Sum 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. The Plan will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	Amount Payable
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use

Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

If you are an associate member, your AD&D insurance will not continue past the end of the day on the last day of the month in which you reach age 65. Otherwise, your AD&D insurance will not continue past the end of the day on the last day of the month in which you reach age 70.

Surgical Reattachment

If you suffer the loss of a limb that is surgically reattached, Canada Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation

If you die as the result of an accident that is at least 150 kilometres away from your home, Canada Life will pay up to \$2,500 for the preparation and transportation of your body to the place of burial or cremation less any amounts paid under this plan's global medical assistance benefit.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Canada Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled:

- as a full-time student at a post-secondary institution at the time of the accident causing your death, or
- as a full-time student at the secondary school level at the time of the accident causing your death and enrolls as a full-time student at a post-secondary institution within 365 days after the accident.

Canada Life will pay up to 5% of the Principal Sum, or \$5,000, whichever is less, for each year of full-time post-secondary school enrolment. Canada Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

Limitations

No benefits will be paid for tuition expenses incurred before the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Canada Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's global medical assistance benefit, up to \$2,000, for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to \$.44 per kilometre travelled.

Limitation

Meal expenses are not covered.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Canada Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Canada Life will pay up to 10% of the Principal Sum, or \$10,000, whichever is less.

Limitations

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Canada Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Canada Life will pay up to \$10,000.

Limitations

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Canada Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Canada Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's healthcare benefit, up to \$10,000 for all home and vehicle modifications combined.

Limitations

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

General Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment, except surgical reattachment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

- To claim benefits for yourself, ask your employer for a claim form. Complete it and return it to your employer.
- If you die accidentally, your employer will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

WEEKLY INCOME INSURANCE
(Not Applicable to Class 10 & 11)

If you are unable to earn your living because of an accident or illness, your Weekly Income Insurance would provide you with a weekly income. (See the Schedule of Benefits at the front of this booklet for the amount.)

- To receive Weekly Income benefits you need not be confined at home, but your disability must be severe enough to prevent you from performing your regular work, and you must be under the continuous care and personal attendance of a physician.
- If you are an associate member, your Weekly Income coverage will not continue past the end of the day on the last day of the month in which you reach age 65. Otherwise, your Weekly Income coverage will not continue past the end of the last day of the month before the date you retire.
- Weekly Income benefits begin with the fourth day of disability due to injury or the sixth day of disability due to illness.

If you have not seen a physician on or before the date benefits would otherwise start, they will not start until after your first visit to the doctor or chiropractor.

- Weekly Income benefits will be paid for a total of not more than 17 weeks for each period of disability.
- Canada Life will not pay for
 - disability due to injury sustained while working for pay or profit other than with this employer.
 - disability due to illness for which you are covered under Workers' Compensation or similar program.
 - disability due to or associated with treatment rendered for aesthetic purposes.

- disability during a period you are confined in a mental institution due to a court order, or
- disability during a period you are serving a prison sentence.
- disability during the scheduled duration of a leave of absence including maternity leave. Maternity leave is considered to begin on the earlier of the date agreed upon by you and your employer or the date of birth.

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

- disability during the scheduled duration of any lay-off unless you become disabled
 - (a) before notice of lay-off is given, or
 - (b) more than 2 months before the date the lay-off is scheduled to begin, whether or not notice of lay-off has been given.
- disability resulting from self-inflicted injury, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions.
- disability resulting from war, or engaging in a riot or insurrection.
- Successive absences from work are considered to be in the same period of disability unless separated by
 - four complete consecutive weeks of active, full-time work, or
 - one full day of work if the disability is due to completely different causes.
- Your Weekly Income benefits will be reduced by any amounts payable under an Automobile Insurance Plan where permitted by law if the amount you receive from your Weekly Income Insurance and the amount from the Automobile Insurance Plan exceeds 100% of your average weekly earnings when last at work.

Weekly Income Insurance

- To submit claims online, go to www.canadalife.com.
- To submit paper claims, obtain an Employee Claim Submission Guide (form M5454) 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 3 months after the end of the waiting period.

From time to time other forms may be forwarded to you. Have your doctor complete these forms and return them to your Health and Welfare Office.

LONG TERM DISABILITY INSURANCE **(Not Applicable to Class 10 & 11)**

Long Term Disability insurance provides you with regular income to replace salary or wages lost because of a lengthy disability due to disease or injury. Because your employer pays all or a portion of the cost of this LTD insurance, the monthly benefit is **taxable** for income tax purposes.

- Your LTD insurance will not continue past the end of the day on the last day of the month in which you reach age 65.

Benefits Entitlement

You are entitled to benefits after you have been continuously disabled for 17 weeks.

If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks 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 to the date the short term disability or sick leave benefits end, but not longer than one year after your disability starts.

After the waiting period, successive disabilities are considered to be in the same disability period if they arise from the same disease or injury and the later disability starts:

- 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.

LTD benefits are payable for the first 24 months following the waiting period if injury or disease prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly take at least 60% of your time at work to complete. Only the duties you regularly performed for the employer before disability started are considered.

After 24 months, LTD benefits continue to be payable only if disease or injury prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 50% of your pre-disability monthly earnings, indexed for inflation. The employment must exist either in the province or territory where you worked when you became disabled or where you now live. Whether or not employment is actually available is not considered in assessing your disability.

You are entitled to LTD benefits as long as your disability continues but only until you reach age 65.

Amount Payable

Your monthly LTD benefit before reduction by other income is \$2,500 per month.

Your monthly LTD benefit may be reduced by other income you are entitled to during disability. Canada Life reduces your LTD benefit if it together with the income listed below exceeds 80% of your pre-disability monthly earnings. This percentage is called the coordination level. In this case, your LTD benefit is reduced by the amount in excess of the coordination level. Under this provision, other income includes:

- benefits under any Workers' Compensation Act or similar law.
- loss of income benefits available through legislation which you and any other members of your family are entitled to on the basis of your disability. Automobile insurance benefits are included where permitted by law.

- disability benefits under a plan of insurance available as a result of your membership in an association of any kind.
- employment income, disability benefits, or retirement benefits related to any employment, except for income from an approved rehabilitation plan or program. Rehabilitative employment income is considered only under the rehabilitation incentive.

Rehabilitation Incentive

Earnings received from an approved rehabilitation plan or program are not used to reduce your monthly LTD benefit unless those earnings, together with your income from this plan and the income used to reduce your LTD benefit under the amount payable section, would exceed 100% of your pre-disability monthly earnings. If they do, your LTD benefit is reduced by the amount in excess of 100%.

Rehabilitation Benefits

The rehabilitation benefit is designed to help you, as a disabled individual, return to gainful employment and therefore a more productive lifestyle.

Rehabilitation involves a training strategy or work-related activity that:

- can be expected to facilitate your return to your own or another job; and
- is recommended or approved by Canada Life.

In considering whether or not a rehabilitation proposal is appropriate, Canada Life assesses such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to employment.

Canada Life recognizes your needs by making a distinction between a comprehensive rehabilitation program and a rehabilitation plan.

To be classified as a comprehensive rehabilitation program, the goal must be to return to work:

- in a different job that requires extensive or prolonged training; or
- in a self-employed capacity.

Training is considered extensive or prolonged if it lasts longer than 12 consecutive months.

To be classified as a rehabilitation plan, the goal must be to return to work:

- in the same job;
- in a modified job with the same employer; or
- in a different job that capitalizes on transferable skills.

If you do not participate or cooperate in a rehabilitation plan or program that has been recommended or approved by Canada Life, you will no longer be entitled to benefits.

When Canada Life recommends or approves a rehabilitation plan or program, careful consideration is given to its duration. The duration must be approved by Canada Life. Once approved, your qualification for benefits is guaranteed for that period as long as you continue to participate and cooperate in the plan or program.

If you are participating in a comprehensive rehabilitation program that involves employment, your qualification for benefits is guaranteed until at least the end of the 24-month "own job" period described under the benefits entitlement section.

If you are participating in a comprehensive rehabilitation program that involves training rather than employment, the benefit period will be extended up to 6 months after training ends. This extension is provided for purposes of job search.

Employment income earned during this extension will be considered under the rehabilitation incentive.

To further help you return to gainful employment, Canada Life will pay for expenses, other than usual employment expenses, associated with a rehabilitation plan or program. The maximum expense benefit during a disability period is 3 times your monthly LTD benefit. Expenses claimed under this benefit must be pre-authorized by Canada Life.

If your insurance terminates at the end of a rehabilitation plan or program that requires you to change employers, you may convert your group coverage to an individual disability income policy without proof of insurability. If you are interested in obtaining an individual policy, ask your employer for further details.

Survivor Benefit

If you die while LTD income benefits are payable, Canada Life will pay a survivor benefit 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. The amount of the survivor benefit will be 3 times your monthly LTD income benefit.

Benefit Limitations

No benefits will be paid for:

- disability periods that begin before your insurance starts or after it ends.
- 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 of disability after you fail to participate or cooperate in a rehabilitation plan or program that has been recommended or approved by Canada Life.

- any period in which you do not participate or cooperate in a reasonable and customary treatment program for your disability.

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

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

- the scheduled duration of any lay-off or leave of absence. A leave of absence is considered to start on the date agreed upon by you and your employer.

This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.

- any 12-month period in which you do not live in Canada for at least 6 of those months.
- a period of confinement in a prison or similar institution.
- disability arising from war, insurrection, or voluntary participation in a riot.

Conversion Privilege

If you change jobs, you may apply for an individual LTD policy (one of the standard conversion policies offered by Canada Life) without proof of your insurability. You must apply during the 31 days after you start your new job and you must start your new job during the 6 months after you leave your present one.

You may also convert to an individual LTD policy without proof of insurability if your insurance under the group plan terminates because you cease to be in an eligible class, as long as that class remains insured. In this case, you must apply during the 31 days after your insurance terminates.

In either case, the group policy must be in force at the time you apply for conversion and your application must be acceptable to Canada Life according to its underwriting rules for individual disability insurance (other than medical evidence rules). If your application is acceptable, the individual LTD policy will take effect on the date Canada Life approves your application as long as the first premium has been paid.

How to Make a Claim

Before the end of the Weekly Income benefit period, Canada Life will ask your Health and Welfare Office to provide information to begin processing your LTD claim. All information must be submitted within 6 months of the request.

HEALTHCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Schedule of Benefits**. Benefits may be subject to plan maximums and frequency limits. Check the **Schedule of Benefits** 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 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 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 contraceptive drugs and products containing a contraceptive drug
 - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered
 - Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, and sensors for flash glucose monitoring machines
 - Extemporaneous preparations or compounds if one of the ingredients is a covered drug
 - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact Canada Life before incurring the expense.

The plan will also pay for vaccines used to prevent disease or illness

Unless medical evidence is provided to Canada Life that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable 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.

Effective May 1, 2003, the B.C. Government made a significant change to the B.C. PharmaCare Program, which will effect how your drug claims are treated. This new program, called **Fair PharmaCare**, will provide each BC resident or family (if applicable) with your own PharmaCare deductible, which is specific to your earnings or your family earnings (if applicable). The computer systems at each pharmacy are linked to PharmaCare so the transaction will be seamless from your point of view. The Pharmacist will confirm the amount you need to pay. You will be required to pay the pharmacist the amount of the prescription and a reimbursement cheque will be mailed to you automatically.

If you do not register with PharmaCare, Canada Life will stop paying claims after they have paid out \$750 on your behalf or your family's behalf (if applicable) and send you a letter asking for your Fair PharmaCare registration number. To ensure your claims will continue to be paid, simply provide the PharmaCare registration number to Canada Life.

You can register in one of the following ways:

- By Internet – register online at www2.gov.bc.ca/gov/content/health
- By phone – call toll-free in B.C. 1-800-387-4977 and provide the required information. The Registration Desk will calculate your temporary deductible based on what you report your income to be. You can also estimate your deductible using the Fair PharmaCare Calculator at the PharmaCare website.

When you are ready to register, you will need to be prepared with the following information:

- B.C. Care Card numbers for yourself, your spouse (if applicable) and your dependent children (if applicable).
- Your net income and your spouse's net income (if applicable) from two years ago. This information can be found on line 236 on your notice of assessment form. For example, if you are registering in 2012, use the net income from 2010.
- Social Insurance Numbers (SIN) for yourself and your spouse (if applicable).
- Birth dates for you, your spouse (if applicable) and your dependent children (if applicable).

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician
- Custom-made orthopedic shoes, off-the-shelf (pre-fabricated) orthopedic shoes, custom-fitted or modified orthopedic shoes, and custom-made foot orthotics are covered where the expense is eligible and provided all required documentation is submitted with the claim.

Claim/Prescription Requirement

The orthopedic shoes and custom-made foot orthotics described above are generally covered when they are considered to be reasonable treatment of disease or injury, and when prescribed by one of the following health care providers: Physician (MD), Chiropractor, Podiatrist or Orthopedic Surgeon.

The prescription must set out the medical diagnosis necessitating the supply prescribed. Prescriptions outlining symptoms rather than a medical diagnosis will not be sufficient.

Further required documentation may be required from the provider.
For example:

Custom-made orthopedic shoes:

- details of the casting technique
- description of the process and material used to fabricate

Custom-fitted or pre-fabricated orthopedic shoes:

- brand name of pre-fabricated orthopedic shoes
- description of each modification made to the shoes
- breakdown of the cost of the shoes and each modification

Custom-made foot orthotic:

- copy of a detailed biomechanical examination or gait analysis
- details of the casting technique used
- detailed description of the type of orthotic provided
- breakdown of the charges for the orthotic

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician
- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-glucose sensors, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs
- 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 treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment by a registered psychologist, qualified social worker, qualified family counsellor, registered clinical counsellor, professional clinical counsellor or qualified marriage counsellor
- Out-of-hospital treatment of speech impairments by a qualified speech therapist
- Out-of-hospital services of a qualified massage 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, prescription safety glasses, prescription sunglasses 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

Global Medical Assistance Program

- If you or a dependent require medical assistance while travelling for business, vacation or to and from an educational facility, this program pays for certain emergency services provided through a worldwide communications network. These services are covered in addition to those hospital and medical expenses described earlier in this booklet. Each family member will be issued an identification card listing the network's worldwide emergency telephone numbers.
 - Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from your or your dependent's home.
 - The program provides you and your dependents with 24-hour a day telephone access to the worldwide communications network. Program personnel will direct you to the nearest doctor or medical outlet equipped to provide the treatment needed.
 - The program provides on-site hospital payment when required for admission, to a maximum of \$1,000.

The following services are covered, subject to Canada Life's prior approval:

- If you or a dependent is critically ill or injured and suitable local care is not available, the program covers the cost of medical evacuation, including transportation and medical care en route to the nearest suitable hospital while travelling in Canada. If you or a dependent is travelling outside Canada, the program covers transportation 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

- If you or a dependent is alone and confined to a hospital for more than 7 days while travelling, the program will pay for one round trip economy class ticket for one family member to join the patient. Benefits will also be paid for moderate quality lodgings for the family member up to \$1,500.
- If you or a dependent is hospitalized while travelling with a companion, the program will pay the extra costs for moderate quality lodgings incurred when the return trip is delayed due to the medical condition of yourself or dependent. Benefit will be paid up to a maximum of \$1,500.
- The program covers the cost of comparable return transportation home if you or a dependent and a travelling companion miss prearranged, prepaid return transportation because hospital confinement. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.
- If you or a dependent dies, the program also pays for the preparation and transportation of the deceased home.

- If you or a dependent is hospitalized or dies, leaving unaccompanied minor children who travelled with you or a dependent, the program will pay return transportation home for the children and an escort when considered necessary.
- If you or a dependent is unable to drive due to sickness or injury, the program will pay the costs of returning the vehicle, either private or rental, home or to the nearest rental agency. Benefits will be paid up 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.

Points to Note

Neither the communications network nor Canada Life is responsible for the availability, quantity, quality or results of any medical treatment received by you or a dependent or for unsuccessful attempts by you or a dependent to obtain medical services.

When your insurance terminates, you must return your identification cards to your employer.

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. To qualify for benefits, you must be covered by the government health plan in your home province.

Retired Members are strongly recommended to purchase additional travel insurance on an individual basis.

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 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
 - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

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.

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as Canada Life determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited 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 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
 - 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 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
- Chronic care
- Blood glucose monitoring machines
- Visioncare services and supplies required by an employer as a condition of employment

- Services or supplies that the plan administrator 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, the plan administrator 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 the plan administrator. The plan administrator 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. The plan administrator 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:

- the plan administrator 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
- the plan administrator 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
- Smoking cessation products
- Fertility drugs
- 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 100 days
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, 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:

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

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 in, 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 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your Health and Welfare Office. 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.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members 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 6 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.

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your Health and Welfare Office. 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.

- **For drug claims**, the Plan will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription. You will be required to pay the pharmacist the full price of the prescription and a reimbursement cheque will be mailed to you automatically.

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.

When your coverage ends, return your direct pay drug identification card to your employer.

DENTALCARE

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

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Schedule of Benefits**. 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.

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
 - limited oral examinations twice each calendar year, except that only one limited oral examination is covered in any calendar year that a complete oral examination is also performed
 - limited periodontal examinations twice each calendar year
 - 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 calendar year
 - scaling, limited to a maximum combined with periodontal root planing of 16 time units every calendar year

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:
 - scaling and root planing, limited to a maximum of 16 time units each calendar year
 - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units each calendar year

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 3 calendar years
 - denture rebases for dentures at least 2 years old, once every 3 calendar years
 - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 3 calendar years
- Oral surgery
- Adjunctive services

Major Coverage

- Crowns, including metal, plastic, porcelain and ceramic. 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.

- Implants.

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or implant-retained appliances. Bridgework 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 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 including implantology.
- Appliance maintenance following the 3-month post-insertion period including:
 - denture remakes, once every 36 months
 - denture adjustments, once every 12 months
 - denture repairs and additions, tissue conditioning and resetting of denture teeth
 - repairs to covered bridgework
 - removal and recementation of bridgework.

Orthodontic Coverage

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

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.

Limitations

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 - 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 implantology, remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns, onlays or surgical implants 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 and partial overdentures are provided

- 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your Health and Welfare Office 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 GroupNet for Plan Members 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 6 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your Health and Welfare Office. 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.

CONTINUATION OF HEALTH BENEFITS FOR DEPENDENTS

If you die, the health and dental benefits for your dependents will be continued for a period of 2 years.

- If your surviving children cease to qualify as eligible dependents (as defined earlier in this booklet), the health benefits being continued after your death will terminate on the date they no longer qualify.
- If a dependent is disabled on the date coverage under this continuation terminates, his benefit payments will be continued until the earliest of the following:
 - the date the disability ends,
 - the date your dependent has received maximum benefits,
 - 90 days from the date the coverage terminated.

Please Note: If your dependent is in the hospital on the last day of this 90-day period, payments for that dependent will be continued until the hospital confinement ends or until maximum benefits have been paid.

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 (BEST DOCTORS[®] SERVICE)

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 serious physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- 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 6 to 8 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, the member advocate can help identify a specialist qualified to meet the person's specific medical needs.

Limitation

Expenses incurred for travel and treatment are not covered by this service.

- If the person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process.

Limitation

Expenses incurred for travel and treatment are not covered by this service.

- The member advocate may identify a Best Doctors 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.

Access to this service may be restricted to persons for whom their physician has made a diagnosis of a serious physical or mental illness or condition for which there is objective evidence, or where a serious 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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