GROUP BENEFITS PLAN

TRUSTEES OF THE IUBAC
LOCAL UNION NO. 7
HEALTH AND WELFARE PLAN

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. To register, click “Sign in”. From there, click “GroupNet for plan members”, then follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

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.

Customer complaints

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

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

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

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

The information provided in the booklet is intended to summarize the provisions of Group Policy No. 31702. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail to the extent permitted by law.

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

The Plan is underwritten by

and arranged by

Lee-Power & Associates
616 Cooper Street
Ottawa, Ontario K1R 5J2
Phone: (613) 236-9007

This booklet was prepared on: June 25, 2021

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

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.

Appeals

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.

Benefit Limitation for Overpayment

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.

Quebec Time Limit for the Payment of Benefits

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

- for death benefits, 30 days following receipt of the required proof of claim.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

The employer's role is limited to providing employees with information and not advice.

Protecting Your Personal Information

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

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

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

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 or 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.

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SCHEDULE OF BENEFITS

FOR

GROUP POLICY NO. 31702

MEMBERS AND DEPENDENTS

Life Insurance

Active Members	$30,000
Retired Members	$15,000
Spouse	$5,000
Child	$2,000

Accidental Death, Dismemberment and Specific Loss (Principal Sum)

Active Members	$40,000
Retired Members	Nil

Prescription Drugs

Deductible	Nil
Reimbursement Level	
- Active Members	90%
- Retired Members	80%
Drugs Used To Treat Erectile Dysfunction	$500 each calendar year
Maximum	Unlimited

Healthcare

Co-insurance Percentages	
- Active Members	90%
- Retired Members	80%
Out-of-hospital Nursing Maximum	$7,500 each calendar year
Insulin Pump Supplies	$1,000 every 12 months
Paramedical Maximums (Active and Retired Members)	
- Psychologists	$50 per visit 10 visits each calendar year
- All Others	$40 per visit 20 visits each calendar year

Please Note: No benefits will be paid under this plan for treatment by a paramedical practitioner for which the provincial medical plan of your home province covers a portion of the charge until after the provincial health plan has paid out its maximum benefit.

Extracare Covered Expenses	
Orthotic Appliances	$400 every 12 months
Hearing Aid Maximum	$2,000 in any 5 year period
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each calendar year
Lifetime Maximum	Unlimited

Dentalcare

Co-insurance Percentages	
Routine Treatment	
- Active Members	100%
- Retired Members	80%
Major Treatment	50%
Orthodontic Treatment	50%
Routine Maximum	$2,500 each calendar year
Major Maximum	$2,500 each calendar year
Orthodontic Maximum (for each course of treatment)	$2,000

Visioncare

Co-insurance Percentage	100%
Eyeglass, Contact Lens and Laser Eye Surgery Maximum	$500 every 18 months
Contact Lenses for Special Conditions	
- Active Members	$250 lifetime
- Retired Members	$200 lifetime
Eye Examination Maximum (when not covered by Medicare)	$100 every 18 months
Visual Training and Remedial Therapy	
- Active Members	$250 lifetime
- Retired Members	$200 lifetime

An Active Member is one who is employed and is having contributions remitted on his behalf.

A Retired Member is one who is receiving a pension from Local 7's retirement plan.

CHANGES IN INSURANCE BENEFITS

If your insurance 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 REQUIREMENTS

When You and Your Dependents Become Eligible for Coverage

You and your dependents become eligible for coverage under the plan on the first day of the month after you have accumulated 360 hour-bank credits. Hour-Bank credits represent the total number of hours you have worked.

In addition to having the necessary hour-bank credits, you must be at work on the date you first become eligible or available for work. If not, coverage will begin on the first day following the date you return to work or once again become available and able to work and have the necessary bank credits.

Hour-bank System

Once you accumulate 360 hours and become a member of the Benefit Plan, your hour-bank is charged with 120 hours each month in order to maintain benefit coverage. Any hours over and above those required to maintain your regular monthly coverage are accumulated in your hour-bank up to a maximum of 1440 hours (or 12 months' coverage). The excess hours you accumulate above the 1440 hours will be transferred to the General Fund in that month.

Termination of Coverage

All coverage for you and your dependents terminates on the earliest of the following dates:

(1) the date of termination of this policy, or

(2) the first day of the month following the date your hour-bank has less than 120 hours, or

(3) the date you are no longer a Union Member, or

(4) the date your Administrator ceases to be a party to the Collective Agreement.

When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your Administrator will provide you with details.

Pay Direct Participation

If you are unemployed and your hour-bank has dropped below the minimum of 120 hours, you may continue to pay your premiums directly to the Fund. Benefits can be continued on this basis for a maximum of 12 months.

Reinstatement of Coverage

If your coverage terminated because you have less than 120 hours to your credit in the hour-bank and have not maintained coverage on a pay direct basis, you may be reinstated for coverage when you have accumulated 360 hours in any consecutive 12-month period. In this case coverage becomes effective on the first day of the month next following the date your hour-bank total reaches 360 hours provided you are at work or available to work on the date you become eligible.

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.

Please Note:

For health insurance only, dependent will also mean your unmarried children or your spouse's unmarried children 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.

Dependent Life Insurance will cover a dependent from 15 days.

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.

The plan does not cover children who are working more than 30 hours a week, unless they are full-time students.

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 become disabled and your disability continues without interruption for at least six months, your life insurance will remain in force without further premium payment. After you have been totally disabled for six months, you should submit the appropriate claim forms to Canada Life. 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 earlier of the following:

  (1) the date your insurance is terminated by Administrator, or

  (2) the date your insurance would normally terminate under the Termination of Insurance section.

- If any or all of your insurance terminates, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details.

LIFE INSURANCE FOR YOUR DEPENDENTS

- If your dependent dies, Canada Life will pay you the amount for which he or she was insured. (See the **Schedule of Benefits** at the front of this booklet for the amount.)

- If your spouse's insurance terminates on or before their 65th birthday, your spouse may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your plan administrator for details.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

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. Your employer 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
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

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 enrols 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 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
- 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

PRESCRIPTION DRUGS

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

- 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.

    - 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 your plan administrator before incurring the expense.

The plan will also pay for preventative immunization vaccines and toxoids.

Unless medical evidence is provided to Canada Life that indicates why a drug is not to be substituted, Canada Life can limit the covered expense 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.

Other Services and Supplies

Canada Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Limitations

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

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

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid under the prescription drug portion of the plan for the following:

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan

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

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

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:

  - treatment performed only for cosmetic purposes

  - recreation or sports rather than with other daily living activities

  - the diagnosis or treatment of infertility

  - 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 out-of-province in Canada unless you are covered by the government health plan in your home province and Canada Life would have paid benefits for the same services or supplies if they had been received in your home province

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

- Services or supplies that Canada Life has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Canada Life may take any factor into consideration including, but not limited to, the following:

  - clinical practice guidelines;
  - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
  - information provided by a manufacturer or provider of the service or supply; and
  - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

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

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

  - Canada Life determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or

  - Canada Life determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- 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
- Ontario Drug Benefit Program (ODB) deductibles and co-payments

Prior Authorization

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

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

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

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

Health Case Management

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

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

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

Health Case Management Limitation

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

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

Health Case Management Expense Benefit

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

Designated Provider Limitation

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

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

Patient Assistance Program

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

If you or your dependents are eligible for a patient assistance program, Canada Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Canada Life requires participation 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.

HEALTHCARE

Healthcare benefits provide protection against the cost of those medically necessary services and supplies for which there is only partial or no reimbursement from the provincial health plans. Healthcare benefits cover only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

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 injury or illness.

Services and supplies described under Healthcare are subject to the following provisions described under Prescription Drugs:

- Prior Authorization
- Health Case Management
- Designated Provider Limitation
- Patient Assistance Program
- Other Services or Supplies
- Lower Cost Alternative Limitation
- Approved Provider Limitation

Co-insurance Percentage

- Canada Life pays 90% of all covered expenses for Active Members and 80% of all covered expenses for Retired Members.

Covered Expenses

The following services and supplies are covered by your Healthcare benefits **where permitted by law and to the extent they are not covered under your Provincial Medicare Plan**:

- Doctors' services for treatment provided outside your province of residence
- Physiotherapists' services other than by members of your family
- Radio-active materials
- Oxygen
- Blood transfusions
- Ambulance transportation to the nearest centre where adequate treatment is available (including licensed air ambulance)
- Injectable drugs when administered by a doctor for which no non-injectable alternative is available
- Out-of-hospital treatment of accidental injury to natural teeth completed within 6 months after the accident
- Rental or, at Canada Life's discretion, purchase of the following supplies, appliances and prosthetic devices prescribed by a doctor:
    - standard wheelchairs (excluding electric wheelchairs except for quadriplegics)
    - standard hospital beds (excluding electric hospital beds), bed rails and trapeze bars
    - splints (excluding dental splints), canes, walkers, crutches and casts

- orthotic appliances which are specifically designed and constructed for the patient, up to a maximum of $400 in any 12-month period

- Jobst sleeves for lymphoedema following mastectomy, Jobst burn garments and Jobst support hose

- braces with rigid supports (excluding lumbar supports)

- orthopedic shoes, if an integral part of a brace

- stump socks, shoulder harnesses, head halters, traction apparatus and cervical collars

- colostomy apparatus, ileostomy apparatus and catheters

- enuretic devices

- PUVA therapy for psoriasis, when administered by a dermatologist

- intermittent positive pressure breathing machine

- aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma

- apnea monitors for respiratory disrhythmias

- iron lung

- artificial eyes, including repairs

- one pair of eyeglasses or contact lenses following cataract surgery

- artificial limbs (including repairs and replacement but excluding myoelectrical limbs)

- external breast prostheses, once per calendar year, post-mastectomy
- transcutaneous nerve stimulator for up to 6 months
- non-union bone stimulators
- pacemakers
- insulin, insulin syringe and testing supplies for diabetics
- insulin pump supplies, up to a maximum of $1,000 in any 12-month period

- Out-of-hospital services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province. Benefits are limited to $7,500 for all services in any calendar year.

  Limitations

  No benefits are paid for services provided by a member of your family **or** for services which do not require the specific skills of a registered or practical nurse.

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

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

  - Preferred accommodation in a hospital or accommodation in a nursing home is covered when provided in Canada.

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

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

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

    Limitation

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

- Services of a psychologist up to a maximum of $50 for each visit. Benefits are limited to 10 visits to any one type of practitioner in any calendar year.

- Services of a chiropractor, osteopath, chiropodist/podiatrist, naturopath, massage therapist or acupuncturist up to a maximum of $40 for each visit. Benefits are limited to 20 visits to any one type of practitioner in any calendar year.

- Hearing aids (excluding batteries and repairs) prescribed by an Ear, Nose and Throat Specialist. Benefits for these expenses are limited to $2,000 in any 5 year period.

- Flash glucose monitoring machines.

- Continuous glucose monitoring machines, including sensors and transmitters. Benefits for these expenses are limited to $4,000 in any calendar year.

Limitations

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply

- Delivery and transportation charges

- Services and supplies which are required for recreation or sports but which are not medically necessary for regular activities

- Services and supplies received during a period of hospital confinement which began before your insurance became effective

- Hearings Tests

- Lung Tests

DENTALCARE

Dentalcare benefits provide protection against the cost of dental services which are often significant and unexpected. To be considered a covered expense, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred and will be limited to the maximum fee level of The Ontario Dental Association Fee Guide in effect on the date treatment is rendered.

Dentalcare benefits cover necessary dental treatment by a dentist or physician or by other qualified personnel under the direct supervision of the dental or medical profession (e.g. dental assistants and dental hygienists) and will also cover services rendered by dental specialists, denturologists, denturists, dental hygienists and denture therapists where they are permitted by law to deal directly with the public. If there is no fee schedule for these practitioners in your province, payment will be based on the appropriate General Practitioners' schedule.

Co-insurance Percentage

- Canada Life pays 100% of Routine Treatment covered expenses for Active Members and 80% of Routine covered expenses for Retired Members and 50% of Major and Orthodontic Treatment covered expenses.

Maximum Benefit

- Benefits are limited to $2,500 for all Routine Treatment and $2,500 for all Major Treatment covered expenses for any one family member in any calendar year.

  These maximums are reduced to $1,250 during the first year a family member is insured if the person’s coverage starts on or after July 1 of any calendar year.

- Benefits are limited to $2,000 for each complete course of Orthodontic Treatment.

Treatment Plan

- Upon request, your dental service provider will prepare a treatment plan before your course of treatment begins. A treatment plan is a written report describing your dental service provider's recommendations as to necessary treatment and cost.

- It is suggested you submit a treatment plan to Canada Life before treatment starts for any Routine Treatment expected to cost more than $200 and for all Orthodontic Treatment.

- A pre-determination of the benefits payable for the proposed treatment will then be calculated so you know in advance the portion of the cost you will have to pay. Any pre-determination of benefits is only valid for 90 days from its date of issue.

Covered Expenses

The following items are considered covered expenses under this Dentalcare Benefit:

Routine Treatment

- oral examinations, polishing of teeth, topical application of fluoride solutions, oral hygiene instructions and bite-wing x-rays, twice in any calendar year but not more than once in any 5-month period

- scaling of teeth

- full mouth series of x-rays once every 24 months

- extractions and alveolectomy at the time of tooth extraction

- amalgam, silicate, acrylic and composite fillings

- dental surgery

- general anaesthesia and diagnostic x-ray and laboratory procedures required in relation to dental surgery

- endodontics (root canal therapy)
- periodontal treatment
- necessary treatment for relief of dental pain
- cost of medication and its administration when provided by injection in the dentist's office
- space maintainers for missing primary teeth and habit-breaking appliances
- consultations required by the attending dentist
- adjustments, repairs, relines and rebases to existing dentures
- stainless steel crowns

Major Treatment

- crowns
- installation of an initial appliance (bridgework or dentures) if such appliance is required because at least one additional natural tooth was necessarily extracted after the effective date of coverage for the individual
- replacement of existing dentures or bridgework if

  (a) they are required because of the extraction of one or more natural teeth after the effective date of coverage for the individual and the existing bridgework or dentures cannot be made serviceable.

  If the existing bridgework or dentures can be made serviceable, only the expense of the portion of the replacement bridgework or dentures that replaces the extracted teeth is considered a covered expense.

(b) the existing bridgework or denture is at least 5 years old and cannot be made serviceable

(c) the existing bridgework or denture was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance

(d) the replacement bridgework or denture is made necessary as the result of an initial placement of an opposing denture while insured

(e) the replacement denture or bridgework is made necessary as the result of an accidental bodily injury while insured

- adjustments to bridgework or dentures after the 3-month post-insertion care period

- treatment involving the use of gold when such treatment cannot be rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice

Orthodontic Treatment

- orthodontic treatment (the correction of malposed teeth) for dependent children who are at least 6 but not more than 18 at the time treatment commences

Limitations

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- cosmetic treatment, experimental treatment, dietary planning, congenital or developmental malformation
- expense of dentures which have been lost, mislaid or stolen
- charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used
- charges made by a dentist for broken appointments or for completion of claim forms required by Canada Life
- services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction
- covered expenses for treatment of accidental injury to natural teeth completed more than 12 months after the accident

VISIONCARE

Visioncare benefits provide protection against the cost of vision services and supplies rendered or prescribed by an ophthalmologist or an optometrist. Visioncare benefits cover only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Services and supplies described under Visioncare are subject to the following provisions described under Prescription Drugs:

- Prior Authorization
- Health Case Management
- Designated Provider Limitation
- Patient Assistance Program
- Other Services or Supplies
- Lower Cost Alternative Limitation
- Approved Provider Limitation

Covered Expenses

Canada Life pays 100% of the following covered expenses:

- Visual training or remedial therapy to correct faulty visual skills **but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part**. Benefits for these expenses are limited to a lifetime maximum of $250.

- Eye examinations (including refractions) **but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part**. Benefits for these expenses are limited to $100 in any 18-month period.

- Eyeglass frames and lenses (or contact lenses selected in place of lenses and frames) and laser eye surgery when required to correct vision. Benefits for these expenses are limited to $500 in any 18-month period which includes scratch resistant coating, hardening and shatterproofing or any other type of safety coating on prescription lenses.

- Contact lenses which are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least the 20/40 level in the better eye with ordinary eyeglasses. Benefits for these expenses are limited to a lifetime maximum of $250.

Limitations

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- eye tests or examinations required by an employer, school or government for screening purposes

- artificial eyes, sunglasses or safety glasses

COORDINATION OF BENEFITS

If you or one of your dependents is entitled to benefits for the same expenses

(1) from this plan and some other group insurance plan, or

(2) from this plan and any government insurance plan, or

(3) from this plan and any automobile insurance plan, or

(4) 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 the expenses actually incurred.

GENERAL LIMITATIONS

Your health insurance does not cover services and supplies in the following situations:

- illness or injury for which you or your dependents are covered under Workers' Compensation or similar program
- services received for confinement which is primarily for chronic or custodial care
- services received in a government hospital unless you are required to pay for such services
- services to which there would be no charge if there were no insurance
- 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 portion thereof provided under any government sponsored hospital or medical care program
- aesthetic surgery (cosmetic surgery for beautification purposes)
- services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits
- services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group

- services or supplies that Canada Life has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Canada Life may take any factor into consideration including, but not limited to, the following:

    - clinical practice guidelines;
    - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
    - information provided by a manufacturer or provider of the service or supply; and
    - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

- service, including part-time or temporary service, in the armed forces of any country

- services required due to war (declared or undeclared), insurrection, or participation in a riot

- services required due to any intentional self-inflicted injury or disease, regardless of the person's state of mind and whether or not he or she was able to understand the nature and consequences of his or her actions

Extended Benefits After Termination

Healthcare - If your insurance terminates while you or one of your dependents is totally disabled, your benefit payments for that disability will be continued until the earliest of the following:

- the date the disability ends,
- 90 days from the date the group policy terminates,
- the date you have received benefits for a period equal in length to the period for which you were insured,
- the end of the calendar year next following the calendar year in which your or your dependent's insurance terminates.

If your Healthcare benefits terminate due to termination of the Healthcare benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the Healthcare benefit was still in force.

Dentalcare - If your insurance terminates due to termination of the Dentalcare benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the Dentalcare benefit was still in force.

If Canada Life has started making payments for Orthodontic Treatment and the insurance for the person receiving the treatment terminates, orthodontic benefits will be continued during the 3-month period immediately following termination of insurance.

CONTINUATION OF HEALTHCARE, DENTALCARE AND VISIONCARE BENEFITS FOR DEPENDENTS

If you die, the Healthcare, Dentalcare and Visioncare 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 insurance under this continuation terminates, insurance payments for that dependent will be continued until the earlier of the following:

  - the date the disability ends,

  - 90 days from the date the insurance terminated.

HOW TO MAKE YOUR CLAIMS

Life Insurance

- If you die, your administrator will contact your beneficiary to explain what is required before payment of the insurance money can be made.

- For disability waiver of premium benefits, contact your administrator for claim forms and procedures.

AD&D Insurance

- To claim benefits for yourself, ask your administrator for a claim form. Complete it and return it to your administrator.

- If you die accidentally, your administrator 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.

Prescription Drugs

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

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

Healthcare

- Claims for paramedical services 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.

  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 Healthcare claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your administrator. 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.

Dentalcare

- For dental claims submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your administrator 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 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.

  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 dental claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your administrator. Have your dental service provider complete this form and send it to the Canada Life Benefit Payment Office.

Visioncare

- Claims for vision 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.

  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 vision claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your administrator. Have your doctor or optometrist complete this form and send it to the Canada Life Benefit Payment Office.

Please Note

- No benefits are payable for health expenses submitted on paper more than 15 months after the expense is incurred.

- No benefits are payable for health expenses submitted electronically more than 12 months after the expense is incurred.

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.

- 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.

- 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.

Limitations

- 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.

- Expenses incurred for travel and treatment are not covered by these services.

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.