My group benefit plan

canada life™

Field Retirees

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 member benefits in Canada, we offer effective benefit solutions for large and small member groups.

Canada Life Online

Visit our website at www.canadalife.com for:

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

My Canada Life at Work

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

With My Canada Life at Work you can:

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

Canada Life's Toll-Free Number

To contact a customer service representative at Canada Life for assistance with your medical and dental coverage, please call 1-888-381-4401.

Customer complaints

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

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

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

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

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 180114 and 180302 and Plan Document No. 52484 sponsored by the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail to the extent permitted by law.

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

The Plan is administered by

and administered by

Bilsland Griffith Benefits Administrators

This booklet was prepared on: August 24, 2023

Access to Documents

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

Legal Actions

Insured benefits

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits

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

Appeals

Insured benefits

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

Non-insured benefits

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

Benefit Limitation for Overpayment

Insured benefits

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

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund'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.

Group Policyholder: The Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund Role

For insured benefits, the Group Policyholder's role is limited to providing members with information and not advice.

Benefits Administrator: Bisland Griffiths Benefits Role

Is your Third Party Administrator who is appointed by the plan sponsor to manage enrollment and eligibility of the plan only.

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

The Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund has an agreement with Canada Life in which the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund has financial responsibility for some or all of the benefits in the plan and we process claims on the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund'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

The Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund 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 the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund 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 the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund'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 the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund from the requirements under the Financial Institutions Act (British Columbia).

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

TABLE OF CONTENTS

	Page
Benefit Summary	1
Commencement and Termination of Coverage	6
Dependent Coverage	7
Beneficiary Designation	7
Member Life Insurance	8
Healthcare	9
Dentalcare	29
Coordination of Benefits	37

Benefit Summary

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

Member Life Insurance	$10,000
Healthcare	
Covered expenses will not exceed customary charges	
Deductible	Nil
Reimbursement Levels	
Out-of-Country Care Expenses	
- Non-Emergency Care	50%
- Emergency Care	100%
Medical Travel Expenses	50%
All Other Expenses	100%
Basic Expense Maximums	
Hospital	Semi-private
Nursing Home	$100 every 12 months
Home Nursing Care	$10,000 each calendar year, personal support workers are included in this maximum up to $100 each month
Medical Travel in Canada	$500 lifetime

In-Canada Prescription Drugs	Included
Drugs Used To Treat Erectile Dysfunction	$1,800 each calendar year or as otherwise required by law
Viscosupplementation Therapy	$1,000 each calendar year or as otherwise required by law
Smoking Cessation Products	$300 lifetime or as otherwise required by law
Hearing Aids	$2,500 every 5 calendar years
Incontinence Supplies	$1,000 each calendar year
Custom-fitted Orthopedic Shoes	$250 each calendar year
Custom-made Foot Orthotics	$200 every 2 calendar years
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of $2,000
Canes, Walkers, Crutches and Wheelchairs (including repairs and accessories)	$1,000 lifetime combined
Blood-glucose Monitoring Machines	1 every 4 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each calendar year
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500
Custom-made Compression Hose	2 pairs each calendar year
Wigs for Cancer Patients	$200 lifetime
Prostate Specific Antigen Tests (PSA Tests)	1 each calendar year

Paramedical Expense Maximums

Acupuncturists	$200 each calendar year
Chiropractors	$750 each calendar year, plus $50 for x-rays each calendar year
Massage Therapists	$750 each calendar year
Naturopaths	$200 each calendar year
Physiotherapists	$750 each calendar year
Podiatrists	$500 each calendar year, plus $50 for x-rays each calendar year
Psychologists/Social Workers/ Registered Clinical Counsellors	$1,000 combined each calendar year
Speech Therapists	$200 each calendar year

Visioncare Expense Maximums

Eye Examinations	$110 every 2 calendar years
Glasses and Contact Lenses	$700 combined every 2 calendar years
Laser Eye Surgery	$1,500 lifetime
Contact Lenses for Special Conditions	$200 every 2 calendar years

Out-of-Country Care Maximums

Non-Emergency Expenses	$3,000 every 3 calendar years
Emergency Expenses	
- for members under age 65	$5,000,000 lifetime
- for members age 65 and over	100,000 lifetime

Overall Healthcare Maximum	
- for members under age 65	$1,000,000 lifetime
- for members age 65 and over	$100,000 lifetime

The overall Healthcare maximum does not apply to Global Medical Assistance and Out-of-Country Care expenses

If you live in Quebec, this maximum does not apply to in-Canada prescription drug expenses if the drug is listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase.

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The British Columbia Dental Association Fee Guide in effect on the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	70%
Plan Maximum	
Basic and Major Treatment	$4,000 combined each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your retirement begins.

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

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

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

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

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 2 years or until they no longer qualify, whichever happens first, provided the applicable premium payments are continued.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

  For spousal changes due to a life event please see your benefits administrator.

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

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

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

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

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under the Trustees of the Boilermakers Lodge 359 Health and Welfare Trust Fund 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 plan administrator.

MEMBER LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your benefits administrator will explain the claim requirements to your beneficiary.

- Your life insurance terminates when you are no longer eligible as determined by your benefits administrator

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

HEALTHCARE

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

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

Covered Expenses

- Ambulance transportation, including air or rail, to the nearest centre where adequate treatment is available

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

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

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

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

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

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

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

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

Limitation

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

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

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

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

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

  - 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.

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

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

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

- Custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician or podiatrist

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician. Replacement batteries are also covered

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

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

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

- Treatment of injury to sound natural teeth.

  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:

  - accidental damage to dentures

  - dental treatment completed more than 12 months after the accident

  - injuries due to biting and chewing

  - orthodontic diagnostic services or treatment

- Out-of-hospital services of a qualified acupuncturist

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

- Out-of-hospital services of a qualified massage therapist

- Out-of-hospital services of a licensed naturopath

- 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 treatment by a registered clinical counsellor, registered psychologist or qualified social worker. Treatment by a registered clinical counsellor is only eligible if provided in British Columbia.

- Out-of-hospital treatment of speech impairments by a qualified speech therapist

Visioncare

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

- Glasses, 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

- Contact lenses when the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses

Medical Travel In Canada

The plan will pay for the following expenses if you are referred away from home by your physician for treatment by another physician within your own province or elsewhere in Canada and the round trip distance is 1,000 kilometres or more.

- Travelling expenses for the person requiring the treatment and one companion if recommended by the attending physician. Benefits are limited to either round trip economy class travel or automobile fuel expenses.

  Limitations

  Taxicab, car rental charges and automobile repair charges are not covered.

- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred.

  Limitations

  Telephone expenses are not covered.

Transportation and lodging expenses associated with in-Canada medical travel are limited to a lifetime maximum of $500.

Global Medical Assistance Program

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

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

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

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

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

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

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

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

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

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

  Limitation

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

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

Limitation

Meal expenses are not covered.

Out-Of-Country Care

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

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

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

  Limitations

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

  - the amount payable under this plan for continued treatment outside Canada, and

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

  No benefits are paid for:

  - any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency

  - any subsequent and related episodes during the same absence from Canada

- expenses related to pregnancy and delivery, including infant care:

  - after the 34th week of pregnancy, or
  - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

- expenses incurred more than 180 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 180-day period, benefits will be extended to the end of the confinement

- **Non-emergency care** outside Canada is covered for you and your dependents if:

  - it is required as a result of a referral from your usual Canadian physician

  - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties

  - you are covered by the government health plan in your home province for a portion of the cost, and

  - a pre-authorization of benefits is approved by Canada Life before you leave Canada for treatment.

Limitations

No benefits will be paid for:

- investigational or experimental treatment

- transportation or accommodation charges.

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

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

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 the plan administrator determines.

General 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 members

- 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, intrauterine devices (IUDs), diaphragms 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 the plan administrator to be a covered service or supply

- Extra medical supplies that are spares or alternates

- Services or supplies received outside Canada except as listed under Out-of-Country Care and Global Medical Assistance

- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and 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

- 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

- Anti-obesity 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 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Non-injectable allergy extracts

- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

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

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

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

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

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

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

Prior Authorization

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

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

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

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

Health Case Management

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

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

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

Health Case Management Limitation

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

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

Health Case Management Expense Benefit

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

Designated Provider Limitation

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

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

Patient Assistance Program

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

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

How to Make a Claim

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

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

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

  Be sure to keep original receipts for your own records.

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

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

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

- **All Other Healthcare Claims**

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

  Submit online claims to Canada Life as soon as possible, but no later than 12 months after you incur the expense.

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

  Paper claims: To submit paper claims, access www.mycanadalifeatwork.com to obtain a personalized claim form, or obtain form M635D from your plan 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 as soon as possible, but no later than 12 months after you incur the expense.

- **Drug claims**

  The plan will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

DENTALCARE

A deductible may be applied before you are reimbursed. All expenses incurred in Canada and outside Canada on a non-emergency basis will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

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

- denturist fee guides are applicable when services are provided by a denturist.
- dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.
- specialist fee guides are applicable when specialists provide services within their speciality.

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

Treatment Plan

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

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
    - one complete oral examination every 36 months
    - limited oral examinations twice 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 each calendar year
    - scaling, limited to a maximum combined with periodontal root planing of 12 time units each calendar year

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
    - oral hygiene instruction once in a person's lifetime
    - pit and fissure sealants on bicuspids and permanent molars every 60 months
    - space maintainers including appliances for the control of harmful habits
    - finishing restorations

- interproximal disking
- recontouring of teeth
- unmounted diagnostic casts

- 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, including isolation of teeth. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 12 time units each calendar year
  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - desensitization
- Appliance maintenance, including:
  - denture relines for dentures at least 6 months old, once every 36 months

- denture rebases for dentures
- resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
- denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
- denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- removal and recementation of crowns, inlays, onlays and bridgework

- Oral surgery
- Alveoloplasty
- Adjunctive services, including a consultation with a member of the profession

Major Coverage

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays and inlays. Coverage for tooth-coloured onlays or inlays on molars is limited to the cost of metal

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

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when 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

- Appliance maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 months

  - tissue conditioning

  - repairs to covered bridgework

General Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling

- The following endodontic services - root canal therapy for primary teeth, enlargement of pulp chambers and endosseous intra coronal implants

- The following periodontal services - topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations

- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor gingivoplasty and stomatoplasty) and gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

- Crowns or onlays if the tooth could have been restored using other procedures. If crowns or onlays are provided, benefits will be based on coverage for fillings

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

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

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

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

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

- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare

- Orthodontic treatment

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

- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

- Congenital defects or developmental malformations in people 19 years of age or over

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your plan 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 the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after the dental treatment.

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

- **For all other Dentalcare claims**, access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your plan administrator. 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 12 months after the dental treatment.

COORDINATION OF BENEFITS

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

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

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

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

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