My group benefit plan

canada life™

THE CHRISTIAN REFORMED CHURCH IN NORTH AMERICA

All Eligible Ordained Employees of the Christian Reformed Church (CRC), Eligible CRC Endorsed Chaplains and Eligible Employees of a CRC Congregation residing in Quebec

January 1, 2022

We are pleased to offer you our services. As we adhere to principles of inclusion, the words he, she, his and her refer to all genders.

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, select Sign in from the menu. Then select the GroupNet for plan members tile and 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.

Employer Role

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

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

GEM Benefits Inc.
42 Riddell Street
Woodstock, ON N4S 6M1
1-800-435-9077
www.gembenefits.ca

This booklet was prepared on: January 20, 2022

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.

GROUP BENEFIT PLAN

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YOU SHOULD KNOW

Effective Date of Plan - **January 1, 2020**

Covered Classes - **All eligible ordained employees of the Christian Reformed Church (CRC), eligible CRC Endorsed Chaplains and eligible employees of a CRC Congregation residing in Quebec**

IMPORTANT

The coverages described in this group benefit plan are insured under Group Policy No. 328970 issued to the Contractholder by Canada Life. They are available to you if you are included in the covered classes shown above. Only those coverages for which you become covered will apply to you. The billing no. for the Optional Life Coverage is 328971.

The Diagnostic and Treatment Support Services (Teladoc Medical Experts) described in this group benefit plan is not insured but is administered under Group Contract No. 328970GMRSC, issued to the Contractholder by Canada Life. Because this contract is not insured, it is not protected by Assuris.

The Virtual Health Services described in this group benefit plan is not insured but is administered under Group Contract No. 328970GVHS, issued to the Contractholder by Canada Life. Because this contract is not insured, it is not protected by Assuris.

This booklet is a description of the group benefits at the date shown on the front cover.

Conformity with law

If any provision of this group benefit plan conflicts with any law which applies to individuals shown in the covered classes, the plan will be amended to conform to that law.

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.

Cost

The employer pays the entire cost of the coverage except that you pay for the optional life coverage when you enroll for it.

Waiting period

You are eligible for coverage on the **first day on the month** coinciding with or next following your date of employment on a full-time basis.

Mandatory enrollment

In order to be in conformity with law, you and you qualified dependents may be required to enroll for some or all coverages under this group benefit plan.

The coverages are described in the Summary of Coverages and the coverage description pages. Be sure to read these pages carefully. They show when benefits are or are not payable, and outline the conditions, limitations and exclusions that apply to the coverages.

SUMMARY OF COVERAGES

COVERAGE FOR YOU

LIFE COVERAGE

Basic amount: $25,000.

Termination: Your basic amount terminates at the end of the month coinciding with or next following your attainment of age 70 or your retirement, if earlier.

Optional amount: You may **choose** units of $10,000, up to a maximum of $500,000.

To become covered for an optional amount, you will be required to submit **evidence of insurability** satisfactory to Canada Life if:

(1) you enroll for the first time for an optional amount; or

(2) you wish to change to a higher number of units.

Termination: Your optional amount terminates at your attainment of age 65 or your retirement, if earlier.

COVERAGE FOR YOUR SPOUSE

Optional coverage for your spouse who is younger than age 65: You may **choose** units of $10,000 for your spouse, up to a maximum of $500,000.

To become covered for optional coverage, your spouse will be required to submit **evidence of insurability** satisfactory to Canada Life if:

(1) you enroll your spouse for the first time for optional coverage; or

(2) you wish to change your spouse's coverage to a higher number of units.

Termination: The optional coverage for your spouse terminates at your spouse's attainment of age 65 or, if earlier, at your retirement.

COVERAGES FOR YOU AND YOUR QUALIFIED DEPENDENTS

PAY-DIRECT PRESCRIPTION DRUG PLAN

The drug plan is described in detail on later pages.

Covered percentage, as follows:

(1) **for the following in-Canada drug expenses:**

(a) **drugs purchased in Quebec** - 80% of the total amount payable for the prescription or refill, including dispensing fee.

(b) **drugs purchased outside Quebec:**

(i) 90% of the total amount payable for the prescription or refill, including dispensing fee for drugs purchased from Costco Wholesale Canada Ltd., one of its affiliates, or Alliance Pharmacy Group using the prescription drug card.

(ii) 90% of the total amount payable for the prescription or refill, including dispensing fee for drugs subject to Prior Authorization or Health Case Management and purchased from the provider designated by Canada Life (whether or not the person used the prescription drug card).

(iii) 80% of the total amount payable for the prescription or refill, including dispensing fee for drugs purchased from any other source or drugs purchased without using the prescription drug card.

(2) **for all other drug expenses** - 80% of the total amount payable for the prescription or refill, including dispensing fee.

However, the covered percentage applicable to:

(1) **your eligible charges** will become 100% for the remainder of the calendar year once you have paid the highest maximum contribution* established by the Quebec basic prescription drug insurance plan.

(2) **your spouse's eligible charges** will become 100% for the remainder of the calendar year once he or she has separately paid the highest maximum contribution* established by the Quebec basic prescription drug insurance plan.

(3) **Eligible charges incurred by your dependent children** will be equal to the covered percentage applicable to your own eligible charges at all times.

* Eligible charges used to satisfy the highest maximum contribution applicable to an individual are any portion of the expenses related to eligible drugs and medicines which are not reimbursed by Canada Life. Any amounts paid on behalf of your dependent children will be applied toward satisfaction of your maximum contribution.

Termination: The end of the month coinciding with or next following your retirement.

EXTENDED HEALTH CARE COVERAGE

Covered percentage, as follows:

(1) 100% of eligible charges for expenses incurred while out of province;

(2) 50% for continuous glucose monitors and all associated supplies and equipment; and

(3) 80% of all other eligible charges.

Overall lifetime maximum: Unlimited.

Termination: The end of the month coinciding with or next following your attainment of age 70 or your retirement, if earlier.

Benefits provided (The complete list is shown on later pages.)	**Maximum amount payable** (per covered person)
Semi-private room and board in a hospital outside the province of residence but within Canada	(Not subject to the deductible).
Semi-private room and board in a convalescent or rehabilitation hospital in Canada (not in a public general hospital)	100 days for any one disability.
Expenses incurred while out of Canada, as follows:	
Treatment of a medical emergency	A lifetime maximum of $1,000,000.
Specialized treatment not available in Canada	A lifetime maximum of $50,000.
Psychologist (including Christian therapist and psychotherapist), registered social worker, or social worker with a Master of Social Work (M.S.W.) degree	An overall maximum of $1,000 in a calendar year.
Chiropractor, naturopath, osteopath, podiatrist, chiropodist, massage therapist, physiotherapist, occupational therapist, or speech therapist	$500 per practitioner in a calendar year.
Private duty nursing in the home	$10,000 in a calendar year.
Custom-made orthopedic shoes	$200 in a calendar year.
Hearing aids	$250 every 24 months.
Lenses required as a result of cataract surgery	$200 per surgery.
Vision care	$100 every 24 months for eye examinations, laser eye surgery, eyeglass frames and lenses, and contact lenses.
Heidelberg Retinal Tomography (HRT), where allowed by provincial legislation	Reasonable and customary charges.
Continuous glucose monitors and all associated supplies and equipment	$2,000 in a calendar year.

GLOBAL MEDICAL ASSISTANCE COVERAGE

This coverage is described in detail on later pages.

Termination: The end of the month coinciding with or next following your attainment of age 70 or your retirement, if earlier.

DENTAL CARE COVERAGE

BASIC AND MAJOR SERVICES are shown in the List of Dental Services.

Covered percentage: Basic services - 80% of eligible charges.
Major services - 50% of eligible charges.

Deductible: $50 per covered person or $100 per covered family (maximum of $50 per covered person). However, when the deductible described under the orthodontic services has been satisfied, no further deductibles will be required during that calendar year.

Fee guide: The dental association fee guide for general practitioners, in the covered person's province of residence, the guide in effect on the date the service is rendered.

Combined maximum for basic and major services: $1,500 per covered person in a calendar year.

Termination: The end of the month coinciding with or next following your attainment of age 70 or your retirement, if earlier.

ORTHODONTIC SERVICES

Each dependent child who is younger than age 20 on the date the orthodontic procedure commences will be eligible.

Covered percentage: 50% of eligible charges.

Deductible: $50 per covered person or $100 per covered family (maximum of $50 per covered person). However, when the deductible described under the basic and major services has been satisfied, no further deductibles will be required during that calendar year.

Lifetime maximum: $2,000 per covered person.

Termination: The end of the month coinciding with or next following your attainment of age 70 or your retirement, if earlier.

DEFINITIONS

The following definitions apply throughout this group benefit plan unless a term is defined differently within a specific coverage for the purpose of that coverage.

ACTIVELY AT WORK means you are working at your usual place of employment and performing all of the usual and customary duties of your occupation on a regular full-time basis.

BENEFITS means any amounts which become payable under a coverage.

CALENDAR YEAR means January 1 through December 31.

CANADA LIFE means The Canada Life Assurance Company.

CONTRACT means **Group Insurance Policy No. 328970.**

CONTRACTHOLDER means The Christian Reformed Church in North America in its capacity as the **Policyholder** of Group Insurance Policy No. 328970.

COVERED PERCENTAGE is the percentage of eligible charges shown in the Summary of Coverages, which will be reimbursed under a coverage after satisfaction of the deductible.

COVERED PERSON is an individual who is covered for employee coverage under a coverage, or a qualified dependent with respect to whom an employee is covered for dependents coverage under a coverage.

DEDUCTIBLE is the amount of eligible charges shown in the Summary of Coverages, which must be paid by or on behalf of a covered person in any calendar year before reimbursement will be made under a coverage.

DEPENDENT CHILD means either:

(1) an unmarried person who is your natural child or your adopted child; or

(2) an unmarried step-child, foster child, or a child of a common-law spouse, who resides with you and is dependent on you for support;

and who is:

(1) younger than 22 years of age; or

(2) 22 years but younger than 26 years of age, in full-time attendance at an accredited institute of learning, and dependent on you for support.

The coverage of a dependent child who is incapable of self-sustaining employment due to a mental or physical handicap will be continued under the contract after he or she would no longer be eligible for coverage as described above, provided the child remains incapacitated, unmarried, and dependent on you for support. To continue a child's coverage under this provision, proof that incapacity existed while covered as a dependent child should be provided to Canada Life within one year after coverage would otherwise terminate. Additional proof will be required from time to time.

EARNINGS means your regular earnings from the employer, excluding shift premium, overtime pay, dividends, bonuses or any other special compensation unless specifically stated otherwise.

EMPLOYER means The Christian Reformed Church in North America.

FULL-TIME BASIS means you regularly work at least 20 hours per week for the employer.

HE or SHE and HIS or HER refers to all genders.

PHYSICIAN means a duly licensed doctor of medicine (M.D.).

PROVINCE or **PROVINCIAL** refers to any province or territory of Canada.

QUALIFIED DEPENDENT means your spouse and dependent children.

SICKNESS means any disorder of the body or mind, including one caused by pregnancy.

SPOUSE means either:

(1) an individual to whom you are legally married; or

(2) your common-law spouse who is an individual with whom you cohabit and whom you publicly represent as your spouse.

You must state the name of the person to be considered your spouse for the purposes of the contract. Only one spouse will be considered at any time as being covered under the contract.

YOU refers to the employee of the employer as shown in the covered classes on the You Should Know page.

WHO IS ELIGIBLE TO BECOME COVERED

FOR EMPLOYEE COVERAGE

You are eligible for employee coverage when you:

(1) are within the covered classes shown on the You Should Know page;

(2) are working on a full-time basis; and

(3) have completed the waiting period shown on the You Should Know page.

If your coverage ends because of leave of absence, layoff or disability and you are re-employed within 6 months of the date of termination, you will be eligible for coverage on the first day you are actively at work.

FOR DEPENDENTS COVERAGE

You are eligible for dependents coverage while you are eligible for employee coverage and you have a qualified dependent.

FOR EMPLOYEE AND DEPENDENTS COVERAGE

Any individual residing outside of Canada will not be eligible to be covered, unless an exception is requested by the employer and approved in writing by Canada Life.

If you and your spouse are employed by the employer, each of you may be eligible for and apply for employee coverage.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE COVERAGE

The effective date of your coverage will be determined as follows:

(1) When you are required to contribute toward the cost of coverage, on the later of the following dates:

   (a) the date you become eligible for employee coverage;

   (b) the date your completed written application is received by the employer, provided application is made within 31 days of your date of eligibility. However, if you apply later than 31 days after your date of eligibility or if you apply for any optional life coverage, you must provide evidence of insurability and the effective date of your coverage will be the date Canada Life approves the evidence. If, in accordance with law, the evidence of insurability you provide cannot be used to refuse you eligibility for certain coverage, such coverage will be effective on the date your written application is received by the employer.

(2) When you are not required to contribute toward the cost of coverage, your coverage will commence on your date of eligibility.

If you are covered under your spouse's health and/or dental care plan, you may choose not to become covered for the pay-direct prescription drug plan, extended health care coverage and dental care coverage under this group benefit plan. However, if coverage under your spouse's plan should terminate, you may apply for the pay-direct prescription drug plan, extended health care coverage and dental care coverage under this group benefit plan within 31 days.

Should you apply after the 31-day period, the following will apply, except when it is prohibited by law:

(1) For the dental care coverage: Coverage will become effective the date you apply. However, benefits will be limited to $100 per covered person during the first 12 months of coverage.

(2) For the pay-direct prescription drug plan and extended health care coverage: You must provide evidence of insurability and the effective date of your coverage will be the date Canada Life approves the evidence.

Evidence of insurability may be required to be submitted at your expense.

In any event, if you are not actively at work on the date your coverage is to be effective, it will become effective when you return to active work.

DEPENDENTS COVERAGE

The effective date of a dependent's coverage will be the latest of the following dates:

(1) If you already have a qualified dependent at the time you become eligible for employee coverage, that dependent's coverage will be effective on the date the employee coverage is effective. However, if you applied later than 31 days after the effective date of your own coverage, evidence of insurability must also be submitted for each of your dependents and their coverage will be effective on the date Canada Life approves the evidence. If, in accordance with law, the evidence of insurability submitted for your dependents cannot be used to refuse them eligibility for certain coverage, such coverage will be effective on the date the employee coverage becomes effective.

(2) If you have dependents coverage on a dependent on the date you acquire another qualified dependent, this dependent's coverage will be effective immediately.

(3) If you have no qualified dependents at the time you become eligible for employee coverage and later acquire a qualified dependent, this dependent's coverage will be effective on the date you apply for dependents coverage, provided application is made within 31 days of the date you are first eligible for dependents coverage, otherwise the dependent's coverage will be effective on the date Canada Life approves the evidence of insurability submitted for the dependents. However, any optional dependents life coverage for your spouse will only become effective on the date Canada Life approves the required evidence of insurability. If, in accordance with law, the evidence of insurability submitted for your dependent cannot be used to refuse that person eligibility for certain coverage, such coverage will be effective on the date your written application for dependent's coverage is received by the employer.

(4) A dependent's coverage will be effective on the date the dependent is discharged from the hospital if the dependent, other than a newborn child, is confined in a hospital on the date his or her coverage would otherwise have commenced. This does not apply (a) to the Dental Care Coverage or (b) when it is prohibited by law.

Evidence of a dependent's insurability may be required to be submitted at your expense.

CHANGE IN COVERAGE

If your coverage changes due to a change in earnings or classification, or as a result of a plan change, your coverage will not be adjusted until the first day, on or after the date of the change, on which you are actively at work and the appropriate contribution is being made.

If your dependents coverage changes due to a change in your classification, or as a result of a plan change, and a dependent (other than a newborn child) is confined in a hospital on the effective date of the change, the coverage will not be adjusted until the dependent is discharged from the hospital. This does not apply (a) to the Dental Care Coverage or (b) when it is prohibited by law.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE

Your coverage will terminate on the earliest of the following dates:

(1) the end of the month coinciding with or next following the date you cease to be a member of any eligible class because of termination of employment (described below) with the employer or for any other reason;

(2) the date your class is terminated;

(3) the date you enter service in the armed forces of any country;

(4) the date the employer ceases to make contributions for you;

(5) the end of the month coinciding with or next following the date you attain the termination age shown in the Summary of Coverages; and

(6) the date the contract terminates.

Termination of employment

For the purposes of the contract, your employment will be considered to terminate when you are no longer actively at work for the employer. However, if you are absent from work for any of the reasons described in the Continuation of Coverage During Absence From Work section below, the employer may, without discrimination among persons in like circumstance, consider you as not having terminated employment for the purposes of the contract and as continuing to be a member of any eligible class, and coverage will then be continued as outlined in the section below.

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

Your coverage will be continued while you are absent from work due to:

(1) **sickness or injury,**

(a) for life coverage, with payment of premium,

(i) and you are younger than age 65 and do not qualify for waiver of premium, until the date which is the earliest of:

1. the date the employer stops paying premiums or otherwise determines that coverage has terminated, and

2. your attainment of age 65.

(ii) and you are age 65 or over, until the date which is the earliest of:

1. the date the employer stops paying premiums or otherwise determines that insurance has terminated, and

2. the end of the sixth month following the date you ceased to be actively at work due to disease or injury,

(b) for all other coverage, until the earliest of the dates specified in the above Employee Coverage section.

(2) **temporary layoff,** until the end of the month in which you were laid off.

(3) **approved leave of absence,** the pay-direct prescription drug plan, extended health care coverage and dental care coverage will be continued until the end of the 24th month following the date your leave commenced. Your life coverage will be continued for a maximum of 3 months following the date the leave of absence began.

(4) **strike, lockout or other work stoppage.** If the law requires that certain coverage be continued for a specific period of time during a strike, lockout or other work stoppage, such coverage will continue during that period but not past the earliest of the dates specified in the above Employee Coverage section. Any required contributions may have to be paid by you.

If the employer has terminated your employment and is required to extend benefits to you during a prescribed notice of termination in accordance with any federal or provincial employment standards legislation, you may continue to be covered under the contract for that period. The employer must ask for the continuation in writing and in no event will it extend past the date on which the contract terminates.

DEPENDENTS COVERAGE

A dependent's coverage will terminate on the earliest of the following dates:

(1) the date your own coverage terminates;

(2) the date the dependent ceases to be a qualified dependent;

(3) the date Canada Life receives a request to terminate the dependent's coverage; and

(4) the date the employer ceases to make contributions for dependents coverage.

WHEN YOU HAVE A CLAIM

LIFE COVERAGE

Employee life coverage

Your beneficiary must send proof of death to the employer. The employer will provide the proper claim forms for completion.

Spousal life coverage

You must provide the employer with proof of death. The employer will provide the proper claim forms for completion.

SUBMISSION OF HEALTH AND DENTAL CLAIMS

To make a health claim

Out-of-country claims (including those for global medical assistance expenses) should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

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

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

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

For all other health claims, access GroupNet for plan members to obtain a personalized claim form or obtain the health claim form from the employer and send the completed form directly to Canada Life.

(1) Keep a separate running record of the covered expenses for each covered person.

(2) Save all bills; in most instances they will serve as proof of claim.

(3) Submit claims when a reasonable number of bills and receipts have been accumulated.

(4) Avoid frequent submission of small claims, but large claims should be submitted promptly.

(5) Each claim, other than for drugs, should include:

(a) patient's full name,

(b) date or dates the service was rendered or purchase was made,

(c) nature of the sickness or injury,

(d) type of service or supply furnished,

(e) itemized charges, and

(f) attending physician's written referral or prescription. (This is not required when the service or supply is furnished by a physician. Physician is as defined in the Extended Health Care Coverage.)

(6) Each drug bill must show:

(a) patient's full name,

(b) prescription number and name of medication, and

(c) date of purchase and the charge for each item.

Also refer to the procedures for using the Pay-Direct Prescription Drug Plan as described on later pages in this group benefit plan.

If you prefer, claims for expenses incurred in Canada for prescription drugs, paramedical services and visioncare may be submitted online.

(1) 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.

(2) For online claim submissions, your Explanation of Benefits will only be available online.

(3) Online claims must be submitted to Canada Life as soon as possible, but no later than 6 months after you incur the expense.

(4) 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.

Submit only original bills and receipts; photocopies or carbon copies are not acceptable.

To make a dental claim

Access GroupNet for plan members to obtain a personalized claim form or obtain the dental claim form from the employer, complete the claimant's portion and have the dental service provider complete the provider's statement. The form should then be sent directly to Canada Life.

If you prefer, you can submit the claim online (for expenses incurred in Canada) by entering the information on the completed claim form. To use this online service you will need to be registered for GroupNet for plan members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online. Online claims must be submitted to Canada Life as soon as possible, but no later than 6 months after you incur the expense. You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

GENERAL INFORMATION

ASSIGNMENT RULES

Death benefits are not assignable, meaning that ownership of death benefits cannot be transferred to any person or organization.

BENEFICIARY RULES

"Beneficiary" means the person you designate in writing to receive the benefits.

Benefits becoming payable under the contract on account of your death will be paid to your named beneficiary. Any benefit amount for which you have not named a beneficiary or there is no surviving beneficiary at your death will be paid to your estate.

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.

If there is more than one beneficiary and the form does not specify their shares, the beneficiaries will share equally.

If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries unless the designation form states otherwise.

CLAIM RULES

Proof of loss

The time limits for submitting proof of loss under a coverage are described in the applicable coverage description page.

Failure to furnish any such proof within the time required will not invalidate or reduce any such claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Quebec time limit for the payment of benefits

Where Quebec law applies, Canada Life will pay benefits in accordance with the terms set out in this policy within the following time period:

Death benefits – 30 days following receipt of the required proof of loss.

All other benefits – 60 days following receipt of the required proof of loss.

Physical examination and autopsy

Canada Life, at its own expense, will have the right and opportunity to have any covered person, whose injury, sickness or treatment is the basis of a claim, examined by a physician or dentist designated by Canada Life when and as often as it may reasonably require during the period of a claim under the contract and, in a case of death, to have an autopsy performed where it is not forbidden by law.

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.

Legal action

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.

OVERPAYMENT OF BENEFITS

Nothing in this group benefit plan will prevent Canada Life from recovering any overpayment of benefits from the person or organization to whom such payment has been made, irrespective of the cause of such 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 fulfill 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.

COORDINATING COVERAGE GUIDELINES FOR OUT-OF-COUNTRY/PROVINCE HEALTH CARE EXPENSES

If a person who is covered under the contract for global medical assistance coverage or for expenses resulting from emergency or referral health care provided outside Canada or outside the province of residence under the extended health care coverage is also covered under another plan or plans* which provides similar coverage, any claim will be coordinated with the other plan(s) in accordance with the coordinating coverage guidelines for out-of-country/province health care expenses as outlined by the Canadian Life and Health Insurance Association Inc.

* The "other plans" may include employment-related group contracts, individual or group travel or health policies, credit card coverages or any other private insurance source.

COORDINATION OF BENEFITS

If a person who is covered under the contract for the pay-direct prescription drug plan, extended health care coverage or dental care coverage is also covered under another plan* which provides similar coverage, any claim will be coordinated and/or reduced so that benefits payable from all plans will not exceed 100% of the eligible charges incurred.

* The "other plan" is defined as group insurance or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any prepayment coverage or capitation plan, as long as the group is not formed solely for the purpose of obtaining insurance. This definition of other plan does not include school insurance or individual travel insurance.

If a person is eligible to receive benefits under this plan and the same, or similar benefits under another plan, payment will be determined as follows:

(1) The plan which does not contain a coordination of benefits provision will pay before the plan which does.

(2) If the other plan(s) contains a coordination of benefits provision, priority will be given to the plan(s) in the following order:

(a) The plan where the person is covered as a member. However, if a person is a member of 2 or more plans, priority will be given as follows:

(i) the plan where the member is covered as an active full-time employee,

(ii) the plan where the member is covered as an active part-time employee,

(iii) the plan where the member is covered as a retiree.

(b) The plan where the person is covered as a dependent spouse.

(c) The plan where the person is covered as a dependent child. However, if a person is covered as a dependent child under 2 or more plans, priority will be given as follows:

(i) the plan of the parent with the earlier date of birth (month/day) in the calendar year,

(ii) the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same date of birth.

An exception to this rule occurs if the parents are separated/divorced, in which case priority will be given as follows:

(i) the plan of the parent with custody of the child,

(ii) the plan of the spouse of the parent with custody of the child,

(iii) the plan of the parent not having custody of the child,

(iv) the plan of the spouse of the parent in (iii) above.

(d) Health plans with dental accident coverage will determine benefits before dental plans, where a person may be able to claim under both plans.

(e) If priority cannot be established using the above priorities, the benefits will be prorated in proportion to the amounts that would have been paid under each plan had there been coverage under just that plan.

If payments which should have been made under the contract by the terms of this coordination of benefits provision have been made under any other plan, Canada Life will have the right to pay to any company or organization the amount necessary to satisfy the intent of this coordination of benefits provision. The amounts paid in this manner will be considered benefits paid under the contract and Canada Life will be fully discharged from liability to the extent of the payments made.

If payments have been made by Canada Life under the contract which are in excess of the maximum amount of payment necessary to satisfy the intent of this coordination of benefits clause, Canada Life will have the right to recover any such excess from any company or organization or person to or for whom such payments were made.

TO WHOM PAYABLE

Benefits under a coverage will be payable to you unless otherwise specified within the coverage.

EMPLOYEE LIFE COVERAGE

FOR YOU

PART I. DEATH BENEFITS

DEFINITION

Where used in this coverage, "total disability" or "totally disabled" means:

(1) you are not working for wage or profit; and

(2) due to bodily injury or disease, you are not able to engage in any and every gainful occupation for which you are reasonably fitted by education, training or experience.

A. DEATH BENEFIT

If you die while covered under this coverage, the amount of your life coverage (shown in the Summary of Coverages) that is in effect on the date of your death will be paid when Canada Life receives due written proof of death.

B. EXTENDED DEATH BENEFIT DURING TOTAL DISABILITY

If you become totally disabled while covered under this coverage and are younger than age 65, Canada Life will, upon receipt of satisfactory proof of total disability, continue the coverage **without payment of premiums** while you are totally disabled, subject to the remainder of this section B.

Notice that total disability exists and has continued without interruption for at least 6 months must be given to Canada Life within one year after commencement of total disability. Satisfactory proof of total disability must be given to Canada Life within 3 months of the date of notice and thereafter when and as required by Canada Life once each year.

The amount of coverage continued is the amount for which you were covered at the date of commencement of total disability. However, if the coverage would normally reduce when you attain a certain age or for any other reason, the amount of coverage continued under this section B. will reduce accordingly.

Upon your death the amount of coverage will be paid provided satisfactory proof is submitted that such total disability continued to the date of death.

If you die before age 65 and within a year after the date of commencement of total disability and before any proof has been given, then notice that total disability continued to the date of death must be given to Canada Life within one year after death. Satisfactory proof must be given to Canada Life within 3 months of the date the notice is received by Canada Life.

If an individual policy of life insurance has been issued in accordance with section D. Conversion Privilege, payment will be made only if the individual policy is surrendered without claim.

This extension protection will immediately terminate if you:

(1) cease to be totally disabled;

(2) reach age 65;

(3) retire;

(4) fail to furnish any required proof that the total disability continues; or

(5) fail to submit to a medical exam by physicians named by Canada Life when and as often as Canada Life requires.

If the extension protection ends after you have given proof of total disability and you have not returned to active work with the employer, you have the same rights and benefits under section D. Conversion Privilege as if you ceased to be covered under this coverage.

C. EXTENSION OF BENEFIT

A death benefit is payable if you die within 31 days after ceasing to be covered under this coverage. The amount of the benefit is equal to the amount of life coverage you were entitled to convert under section D. Conversion Privilege.

D. CONVERSION PRIVILEGE

If you cease to be covered under this coverage on or before your attainment of age 65, your coverage may be converted to an individual life insurance policy without evidence of insurability. The policy will be issued in accordance with the applicable laws or guidelines in effect in your province of residence. The amount converted must be at least equal to the minimum amount for which Canada Life will issue an individual policy for the plan of insurance chosen.

The premium for the individual policy will be based on Canada Life's premium rate as of the effective date of the individual policy, according to the plan of insurance chosen, the amount of insurance converted and your attained age.

You must apply for the individual policy and pay the first premium within 31 days after ceasing to be covered under this coverage. The individual policy will be effective 31 days after this coverage is terminated.

If you convert all or part of your life coverage under the terms of this section D., you will not be eligible for further coverage under this coverage, unless the individual policy is cancelled.

E. SELF-DESTRUCTION LIMITATION ON OPTIONAL COVERAGE

Benefits will not be payable for optional coverage if you die as a result of suicide or intentionally self-inflicted injury, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions, within 2 years of the date you first became covered for the optional coverage. Any increase in your optional coverage will also be subject to this 2-year self-destruction limitation.

Canada Life will refund the amount of premiums paid with respect to the optional coverage which is subject to this limitation.

F. TO WHOM PAYABLE

Any benefits payable on account of your death will be paid to your beneficiary determined under the beneficiary rules shown on the General Information page.

G. PROOF OF CLAIM

Written proof of a claim must be given to Canada Life in accordance with the following:

Death claim - not later than 5 years after the date of death.

Disability claim - written notice must be given not later than one year after the date of commencement of total disability. Written proof must be given not later than 3 months after the date the notice is received by Canada Life.

PART II. LIVING BENEFITS

DEFINITIONS

Where used in this coverage, the following phrases have the meanings set forth below:

(1) "Living benefits" means the amount of life coverage that you may elect to place under this option. The living benefits is a one-time lump sum payment which is equal to 50% of your total amount of life coverage (shown in the Summary of Coverages) in effect on the date Canada Life receives proof that you are terminally sick, to a maximum of $50,000. However, the living benefits may be reduced if, within 6 months after the date Canada Life receives such proof, a reduction on account of age would have applied to your amount of life coverage. In that case, the amount of living benefits will be 50% of your amount of life coverage after applying the reduction, subject to the living benefits maximum.

(2) "Terminally sick" means your life expectancy is 12 months or less.

A. OPTION

If you become terminally sick while covered under this coverage or while your coverage is being continued under the Extended Death Benefit During Total Disability section of this coverage, you may elect to have the living benefits option. Such election is subject to the provisions set forth below.

B. PAYMENT OF LIVING BENEFITS

If you elect this option, Canada Life will pay the living benefits in one sum when it receives proof that you are terminally sick.

C. TO WHOM PAYABLE

The benefit under this option is payable to you.

D. AMOUNT PAYABLE ON YOUR DEATH

Canada Life will pay to your beneficiary as determined under the beneficiary rules shown on the General Information page, in one sum, the amount of the life coverage proceeds, LESS the total of (1) the amount of the living benefits option you received, and (2) an amount representing interest calculated from the date of the living benefits payment to the date of your death, using an effective annual interest rate as notified by Canada Life when applying for living benefits.

E. CONDITIONS

Your right to be paid under this option is subject to these terms:

(1) You must choose this option in writing in a form satisfactory to Canada Life.

(2) You must furnish satisfactory proof to Canada Life that your life expectancy is 12 months or less, including certification by a physician.

(3) Living benefits will be made available to you on a voluntary basis only.

Therefore:

(a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this option.

(b) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this option.

The deduction of the living benefits and its accrued interest take priority over any other demand or claim for benefits payable on your death.

F. EFFECT ON COVERAGE

When you elect this option, the total amount of life coverage payable on your death, including any amount under the Extended Death Benefit During Total Disability section of this coverage, will be reduced by the living benefits. Also, any amount you could otherwise have converted to an individual policy will be reduced by the living benefits.

SPOUSAL LIFE COVERAGE

FOR YOUR SPOUSE

A. DEATH BENEFIT

If your spouse dies while covered under this coverage, the amount of life coverage (shown in the Summary of Coverages) that is in effect on the date of death will be paid when Canada Life receives due written proof of death.

B. EXTENDED DEATH BENEFIT DURING TOTAL DISABILITY

During any period of total disability for which you are entitled to a waiver of premium benefit under this contract's employee life coverage, Canada Life will waive the premium on the life coverage for your spouse.

C. EXTENSION OF BENEFIT

A death benefit is payable if your spouse dies within 31 days after ceasing to be covered under this coverage. The amount of the benefit is equal to the amount your spouse was entitled to convert.

D. CONVERSION PRIVILEGE

If you cease to be covered under this coverage because of termination of employment, the coverage on the life of your spouse may be converted to an individual life insurance policy provided your spouse is younger than age 65. Evidence of insurability is not required. The amount converted cannot exceed your spouse's amount of coverage when his or her coverage ends. This amount must be at least equal to the minimum amount for which Canada Life will issue an individual policy for the plan chosen.

The premium for the individual policy will be based on Canada Life's premium rate as of the effective date of the individual policy, according to the plan of insurance chosen, the amount of insurance converted and the spouse's attained age.

Your spouse must apply for the individual policy and pay the first premium within 31 days after ceasing to be covered under this coverage. The individual policy will be effective 31 days after this coverage is terminated.

E. SELF-DESTRUCTION LIMITATION ON OPTIONAL COVERAGE

Benefits will not be payable for optional coverage if your spouse dies as a result of suicide or intentionally self-inflicted injury, regardless of their state of mind and whether or not they were able to understand the nature and consequences of their actions, within 2 years of the date your spouse first became covered for the optional coverage. Any increase in your spouse's optional coverage will also be subject to this 2-year self-destruction limitation.

Canada Life will refund the amount of premiums paid with respect to the optional coverage which is subject to this limitation.

F. TO WHOM PAYABLE

Any benefit becoming payable will be paid to you. If you predecease your spouse, the death benefit will be paid to the estate of your spouse or, at Canada Life's option, to a surviving relative of your spouse.

G. PROOF OF CLAIM

Written proof of a claim must be given to Canada Life not later than 5 years after the date of death.

PAY-DIRECT PRESCRIPTION DRUG PLAN

FOR YOU AND YOUR QUALIFIED DEPENDENTS

Your Pay-Direct Prescription Drug Plan covers the eligible charges for drugs, medicines and certain supplies that represent reasonable treatment of a disease or injury, when prescribed by a physician or other person entitled by law to prescribe them, and dispensed by a licensed pharmacist or other person entitled by law to dispense them.

Treatment is considered reasonable if it is:

(1) accepted by the Canadian medical profession;

(2) proven to be effective; and

(3) of a form, intensity, frequency, and duration essential to diagnosis or management of the disease or injury.

Before incurring large drug expenses, you may want to confirm your coverage by contacting Canada Life with both the name and drug identification number (DIN) of the drug prescribed. You can obtain this information from your pharmacist.

Canada Life can limit the eligible charge for any drug to that of a lower cost interchangeable drug determined in accordance with Canada Life's adjudication practices at the time of claim.

An interchangeable drug includes but is not limited to:

(1) a generic equivalent of the brand name drug deemed to be interchangeable by law where the drug is dispensed; or

(2) a subsequent entry biologic drug.

The right to limit the eligible charge does not apply if medical evidence has been provided that indicates a contraindication to the interchangeable drug.

To have a prescription filled for yourself or a qualified dependent, take the prescription to a participating pharmacy and present it, along with your prescription drug card, to the pharmacist. Pay the required amount and the prescription will be filled.

Do not lend your prescription drug card to anyone outside your immediate family and do not leave it at the pharmacy.

If your employment ends, you are no longer eligible for this coverage.

A. SERVICES PROVIDED

The services described in this coverage are provided by the pharmacy benefits manager appointed by Canada Life and are subject to the agreement between Canada Life and the pharmacy benefits manager, as may be amended from time to time.

B. PAYMENT OF BENEFITS

After paying the required amount, a benefit will be paid if a covered person incurs eligible charges for drugs, medicines and supplies described in section C. while covered for this coverage. A charge is considered to be incurred on the date of the purchase for which the charge is made. The covered percentage is shown in the Summary of Coverages. Benefits for drug claims submitted through the pharmacy benefits manager's electronic claims system will be issued to the pharmacy benefits manager.

Covered charges for drugs eligible under any government drug plan are limited to any amounts the employee is required to pay for himself or his family under the government plan.

C. ELIGIBLE CHARGES

Eligible charges are the charges actually made to the covered person for the following drugs, medicines and supplies, subject to the assessment provisions described in section D.

Canada Life can limit the eligible charge for a drug or drug supply to that of a lower cost alternative drug or drug supply that represents reasonable treatment.

(1) drugs, including contraceptive drugs and products containing a contraceptive drug, that require a prescription according to:

  (a) the Food and Drugs Act, Canada; or

  (b) provincial legislation in effect where the drug is dispensed.

(2) drugs and medicines which must be covered according to the law establishing the Quebec basic prescription drug insurance plan.

(3) drugs that must be injected, including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered.

(4) disposable needles for use with non-disposable insulin injection devices, lancets, test strips and sensors for flash glucose monitoring machines.

(5) extemporaneous preparations or compounds if one of the ingredients is a covered drug.

(6) vaccines used to prevent disease.

(7) drugs that do not require a prescription by law if:

  (a) they are listed in the current Compendium of Pharmaceuticals and Specialties; and

  (b) they are categorized as:

- antimalarials
- fibrinolytics
- nitroglycerin
- potassium replacements
- single entity fluorides
- single entity iron salts
- thyroid agents
- topical enzymatic debriding agents

The following non-prescription items are not covered:

(a) atomizers, appliances, prosthetic devices, or colostomy supplies.

(b) first aid or diagnostic supplies or testing equipment.

(c) non-disposable insulin delivery devices or spring loaded devices used to hold blood letting supplies.

(d) delivery or extension devices for inhaled medications.

(e) oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas, or injectable total parenteral nutrition solutions, whether or not prescribed for a medical reason, except where federal or provincial law requires a prescription for their sale.

(f) diaphragms, condoms, contraceptive jellies, foams, sponges, or suppositories, contraceptive implants, or appliances normally used for contraception, whether or not prescribed for a medical reason.

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

D. ASSESSMENT PROVISIONS

Eligible charges are subject to the following assessment provisions.

(1) **Prior authorization**

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

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

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

(2) **Health case management**

Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

(a) consultation with the covered person and his or her regularly attending physician to gain understanding of the treatment plan recommended by the attending physician;

(b) comparison with the covered person’s regularly attending physician of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;

(c) identification to the covered person’s regularly attending physician of opportunities for education and support; and

(d) monitoring the covered person's adherence to the treatment plan recommended by his or her regularly attending physician.

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

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

(a) Canada Life has implemented health case management and the person does not participate or cooperate; or

(b) the person has not adhered to the treatment plan recommended by his or her regularly attending physician with respect to the use of the drug or drug supply.

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.

(3) **Designated provider limitation**

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

(a) **limit** the eligible charge for a drug or drug supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the drug or drug supply had it been purchased from or administered by the provider designated by Canada Life; or

(b) **decline** a claim for a drug or drug supply that was not purchased from or administered by a provider designated by Canada Life.

(4) **Patient assistance program**

A patient assistance program means a program that provides assistance to persons with respect to the purchase of drugs or drug supplies.

Canada Life can require a covered person to apply to and participate in any patient assistance program to which the person may be entitled. Further, Canada Life can **reduce** the amount of an eligible charge for a drug or drug supply by an amount up to the amount of financial assistance the person is entitled to receive for that drug or drug supply under a patient assistance program.

E. EXCLUSIONS

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

The following exclusions apply provided that they do not act to exclude a drug or medicine for which coverage is required by law.

No benefits will be paid for:

(1) any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada.

(2) any single purchase of a drug that would not reasonably be consumed or used within 34 days, except for the following maintenance drugs when dispensed in quantities that would reasonably be consumed or used within 100 days:

- antiasthmatics
- antibiotics for acne
- anticoagulants
- anticonvulsants
- antihypertensive agents
- antiparkinson
- antituberculosis
- cardiac agents
- estrogens
- glaucoma
- hypoglycemic agents
- oral contraceptives
- potassium replacements
- thyroid preparations.

(3) drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.

(4) non-injectable allergy extracts.

(5) drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.

(6) smoking cessation products.

(7) fertility drugs, whether or not prescribed for a medical reason.

(8) expenses that private insurers are not permitted to cover by law.

(9) drugs, medicines or supplies for which a charge is made only because the person has insurance coverage.

(10) any portion of drugs, medicines or supplies which the person is entitled to receive, or for which the person is 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 exclusion, government plan does not include a group plan for government employees.

(11) drugs, medicines or supplies that do not represent reasonable treatment.

(12) drugs, medicines or supplies associated with the items described in section C, unless specifically listed as an eligible charge or determined by Canada Life to be an eligible charge.

(13) drugs, medicines or supplies associated with:

(a) treatment performed for cosmetic purposes only;

(b) recreation or sports rather than with other regular daily living activities.

(14) drugs, medicines or supplies received out of province unless:

(a) the person is covered by the government health plan in his home province; and

(b) Canada Life would have paid benefits for the same services or supplies if they had been received in the person's home province.

(15) drugs used to treat erectile dysfunction.

(16) expenses arising from war, insurrection, or voluntary participation in a riot.

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:

(1) the date you reach age 65; or

(2) 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*.

F. CONCURRENT DRUG UTILIZATION REVIEW

In Canada claims for covered drugs submitted electronically to the pharmacy benefits manager are subject to concurrent drug utilization review at point-of-sale to determine if:

(1) drug interactions between prescribed drug and another drug already being taken by the patient may occur;

(2) a prescribed drug may be harmful to a patient;

(3) the frequency of refills is reasonable; or

(4) the duration and dosage of the therapy is within recommended limits.

Based on the outcome of the review, a pharmacist may refuse to dispense the drug as prescribed.

Neither Canada Life nor the pharmacy benefits manager makes any guarantees about the accuracy of the patient information provided for the concurrent drug utilization review or about the review results, nor are they responsible for any decision made by a pharmacist as a result of the review process.

G. EXTENSION OF COVERAGE ON YOUR DEATH

If your dependents are covered under this coverage on the date of your death, their coverage will continue **on a noncontributory basis** until the earliest of:

(1) 24 months from the date of your death;

(2) the date your spouse remarries;

(3) the date the dependent is no longer a qualified dependent;

(4) the date that similar coverage is obtained elsewhere;

(5) the date this coverage is cancelled; and

(6) the date the contract is cancelled.

H. PROOF OF CLAIM

Satisfactory proof of the loss on which a claim may be based must be given to Canada Life within 15 months of the date the expense was incurred.

EXTENDED HEALTH CARE COVERAGE

FOR YOU AND YOUR QUALIFIED DEPENDENTS

DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) "Convalescent or rehabilitation hospital" means an institution, other than a public general hospital, that is legally operated, is supervised by a staff of physicians, has registered nurses (R.N.) in attendance 24 hours a day, provides room and board and skilled nursing care of sick or injured persons during the convalescent stage of a sickness or injury, and which is not, other than incidentally, a nursing home or a facility for rest or for the aged. Additionally, it must be approved for resident inpatient care under a provincial hospital services program and eligible to receive payments under, and in accordance with, the provincial hospital services plan.

(2) "Eligible charges" means the reasonable and customary charges actually made to the covered person for the medical services and supplies described in section B., provided the services and supplies are medically necessary for the care and treatment of a covered person's sickness, injury or condition and are ordered by a physician unless otherwise stated, and the charges:

   (a) exceed the amount payable under any government medical, health or hospital services plan or, if the person is not covered under such a plan, exceed the amount that would have been payable by the plan of the province in which the covered person resides;

   (b) exceed the amount payable under any other coverage of the contract, any Workers' Compensation Act or similar law, or any other source, other than an individual policy issued by another company; and

   (c) are those for which Canada Life is not prohibited by law from providing.

(3) "Hospital" means an institution that is legally operated, is supervised by a staff of physicians, has registered nurses (R.N.) in attendance 24 hours a day, provides a broad range of 24-hours-a-day medical and surgical services for sick and injured persons, and which is not, other than incidentally, a nursing home or a facility for rest or for the aged.

(4) "Medical emergency" means an unforeseen event occurring while a covered person is travelling which causes that person sickness or injury requiring immediate hospital or medical treatment. Such travel must be for the purpose of business or pleasure and not in any way for the purpose of obtaining hospital or medical treatment.

(5) "Medically necessary" means the service or supply is ordered by a physician and is commonly and customarily recognized throughout the physician's profession as appropriate and required in the treatment of the patient's diagnosed sickness, injury or condition. The service or supply must not be educational, experimental or investigational in nature, nor provided primarily for the purpose of medical or other research.

In the case of a hospital confinement, the duration and the services and supplies will be considered necessary only to the extent Canada Life determines them to be:

(a) related to the treatment of the sickness, injury or condition; and

(b) not allocable to the scholastic education or vocational training of the patient.

(6) "Physician" means a duly licensed doctor of medicine (M.D.). "Physician" also means a duly licensed dentist, podiatrist, chiropodist, chiropractor, osteopath, naturopath, optometrist, ophthalmologist, psychologist or psychotherapist, practising within the scope of his or her profession. In addition, for the purposes of the coverage, the term “psychologist” will include reference to a registered social worker and a social worker with a Master of Social Work (M.S.W.) degree. ("Duly licensed" means licensed, certified or registered by the jurisdiction in which he or she is practising.)

(7) "Reasonable and customary charge" means the usual charge of the provider for the service or supply, in the absence of coverage, but not more than the prevailing charge in the area for a like service or supply. A like service or supply is one of the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience.

(8) "Reasonable treatment" means treatment that is:

(a) accepted by the Canadian medical profession;

(b) proven to be effective; and

(c) of a form, intensity, frequency, and duration essential to diagnosis or management of the disease or injury.

A. PAYMENT OF BENEFITS

After satisfaction of the deductible (shown in the Summary of Coverages), a benefit will be paid if a covered person incurs eligible charges in connection with the services and supplies described in section B. while covered under this coverage. A charge is considered to be incurred on the date of the service or purchase for which the charge is made.

For all eligible charges, benefits will be equal to the covered percentage (shown in the Summary of Coverages) once the deductible has been satisfied each calendar year.

B. ELIGIBLE CHARGES

Eligible charges are the reasonable and customary charges actually made to the covered person for the following medically necessary services and supplies, subject to the assessment provisions described in section C.

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

(1) **Hospital**

Charges for semi-private room and board in a hospital while the covered person is **travelling outside the province of residence but within Canada**.

(2) **Convalescent or rehabilitation hospital**

Charges for semi-private room and board in a convalescent or rehabilitation hospital in Canada, up to the maximum amount payable shown in the Summary of Coverages.

The confinement must be ordered by a physician as necessary for recuperative care or rehabilitative treatment and the covered person must be admitted within 14 days following a period as an inpatient in a hospital.

Exclusions

(a) Charges for convalescent or rehabilitation care in a public general hospital.

(b) Charges which are primarily for custodial care such as chronic care facilities and nursing homes.

(3) Services of a duly licensed **doctor of medicine (M.D.)** for treatment of a medical emergency while the covered person is **travelling outside the province of residence but within Canada**.

(4) **Expenses incurred while out of Canada**

Charges for expenses incurred while out of Canada will be eligible provided the expense is recommended by a physician on account of:

(a) **treatment of a medical emergency while travelling outside Canada;** or

(b) **specialized treatment not available in Canada** when the covered person is referred outside Canada by his or her regularly attending physician.

Benefits will be reduced by any charges covered under any government plan and will be subject to the maximum amount payable shown in the Summary of Coverages.

Eligible expenses include:

(a) public ward accommodation and other services and supplies furnished by the hospital;

(b) services of a physician;

(c) emergency outpatient services;

(d) drugs and medicines which **by law** may only be dispensed upon the prescription of a doctor of medicine (M.D.) or other person entitled by law to prescribe them; and

(e) any other medically necessary services and supplies not specifically listed in this item which would otherwise be covered under this coverage.

(5) **Ambulance service** to and from the nearest medical facility equipped to provide adequate treatment.

(6) Services of a dentist for **dental treatment** of injuries to sound, vital, natural teeth when caused by a direct **accidental** blow to the mouth occurring while a covered person (but not when caused by an object wittingly or unwittingly placed in the mouth).

Exclusion

Benefits will not be payable for charges incurred more than 12 months after the accident.

(7) Services of a **psychologist, psychotherapist, Christian therapist, registered social worker,** or **social worker with a Master of Social Work (M.S.W.) degree** in connection with the diagnosis and treatment of mental, nervous or emotional disorders, up to the maximum amount payable shown in the Summary of Coverages.

Coverage includes treatment done by all Christian Providers at all Clinics working with religious beliefs including counsellors where the service being provided is deemed as Christian faith clinic for religious healing and beliefs.

(8) Services of a **chiropractor**, **naturopath**, **osteopath**, **podiatrist**, or **chiropodist**, including one X-ray examination per specialty, up to the maximum amount payable shown in the Summary of Coverages. (The amount payable will be limited to one specialty per practitioner per day.)

(9) Treatment by a registered **massage therapist** practising within the scope of his or her profession, when the person is referred by a duly licensed doctor of medicine (M.D.), up to the maximum amount payable shown in the Summary of Coverages.

(10) **Private duty professional nursing services in the home** by a registered nurse, a registered practical nurse (if the covered person is a resident of Ontario), a licensed practical nurse (if the covered person is a resident of any other province or territory), or similarly licensed person, other than a close relative, provided (a) the service is prescribed by a duly licensed doctor of medicine (M.D.), and (b) intensive care nursing is required in the treatment of an acute sickness; up to the maximum amount payable shown in the Summary of Coverages.

Exclusions

Benefits will not be payable when the services actually furnished:

(a) are mainly custodial;

(b) are mainly to assist the covered person with the functions of daily living or to dispense oral medication; or

(c) could be furnished properly by someone who does not have the professional qualifications stated above.

(11) Treatment by a **physiotherapist**, **occupational therapist**, or **speech therapist** practising within the scope of his or her profession, up to the maximum amount payable shown in the Summary of Coverages.

(12) **Custom-made orthopedic shoes** and modifications to such shoes, up to the maximum amount payable shown in the Summary of Coverages.

(13) Purchase, repair or replacement of **hearing aids**, up to the maximum amount payable shown in the Summary of Coverages.

(14) **Lenses required as a result of cataract surgery**, up to the maximum amount payable shown in the Summary of Coverages.

(15) **Vision care:** eye examinations by an optometrist or ophthalmologist, laser eye surgery when performed by a licensed ophthalmologist, eyeglass frames and lenses, and contact lenses, up to the maximum amount payable shown in the Summary of Coverages.

Exclusions

(a) Safety glasses; tinted lenses provided for aesthetic or cosmetic purposes; non-corrective sunglasses.

(b) Services or supplies not reasonably necessary for the vision care of the covered person.

(16) **Heidelberg Retinal Tomography (HRT)**, where allowed by provincial legislation, up to the maximum amount payable shown in the Summary of Coverages.

(17) **Intra-uterine devices**

The requirement that the service or supply is necessary on account of sickness of a covered person does not apply to this item.

(18) **Other services and supplies when obtained from a licensed medical technician or authorized medical supplies vendor:**

X-ray examinations and therapy and diagnostic laboratory procedures.
Colostomy and ileostomy supplies.
Diabetic supplies: rubbing alcohol, cotton swabs and flash glucose monitoring machines.
Blood and blood plasma not replaced by or for the patient.
Oxygen and rental of equipment for its administration.
Artificial limbs, larynx and eyes.
Electronic heart pacemaker.
Casts, splints, trusses, braces, crutches, surgical dressings.
Orthotics.
Rental of a wheelchair, hospital bed or iron lung.
Continuous glucose monitors and all associated supplies and equipment, up to the maximum amount payable shown in the Summary of Coverages.

(19) **Other services or supplies**

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

C. ASSESSMENT PROVISIONS

Eligible charges are subject to the following assessment provisions.

(1) **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.

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

If the use of a lower cost alternative service or supply represents reasonable treatment, Canada Life may require a covered person 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.

(2) **Health case management**

Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

(a) consultation with the covered person and his or her regularly attending physician to gain understanding of the treatment plan recommended by the attending physician;

(b) comparison with the covered person's regularly attending physician of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;

(c) identification to the covered person's regularly attending physician of opportunities for education and support; and

(d) monitoring the covered person's adherence to the treatment plan recommended by his or her regularly attending physician.

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

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

(a) Canada Life has implemented health case management and the person does not participate or cooperate; or

(b) the person has not adhered to the treatment plan recommended by his or her regularly attending physician with respect to the use of the service or supply.

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.

(3) **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 the service or supply be purchased from or administered by a provider designated by Canada Life, and:

(a) **limit** the eligible charge 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

(b) **decline** a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

(4) **Patient assistance program**

A patient assistance program means a program that provides assistance to persons with respect to the purchase of services or supplies.

Canada Life can require a covered person to apply to and participate in any patient assistance program to which the person may be entitled. Further, Canada Life can **reduce** the amount of an eligible charge for a service or supply by an amount up to the amount of financial assistance the person is entitled to receive for that service or supply under a patient assistance program.

D. OVERALL LIFETIME MAXIMUM

Benefits payable are subject to the overall lifetime maximum (shown in the Summary of Coverages) per covered person.

E. EXCLUSIONS

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

The following exclusions apply provided that they do not act to exclude a drug or medicine for which coverage is required by law.

(1) Any charges incurred in connection with:

(a) Commission of, or attempt to commit, any criminal offence but not when injuries are sustained as a result of driving a vehicle when the covered person's blood contained more than 80 milligrams of alcohol in 100 millilitres of blood (.08).

(b) Sickness due to war or any act of war, civil commotion, insurrection or hostilities of any kind.

(c) Rest cures, travel for health reasons, periodic checkups and examinations, or pregnancy tests.

(d) Telephone consultations made by a physician with respect to a person's sickness or injury.

(2) Any charges incurred for:

(a) Services or supplies dispensed by a person who normally resides with the covered person or who is related to the covered person by blood or marriage.

(b) Physicians' services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of temporomandibular joint dysfunctions (TMJD) or malocclusion involving joints or muscles by methods, including, but not limited to, crowning, wiring or repositioning teeth. This does not apply to a charge made for dental treatment described in section B.

(c) Services or supplies to the extent that they are available under any government medical, health or hospital services plan or where such a plan prohibits payment.

(d) Services or supplies for which the covered person is not required to make payment, or where payment is received as a result of legal action or settlement.

(e) Services or supplies to the extent that they are payable or would have been payable under any Workers' Compensation Act or similar law, had timely pursuit been made.

(f) Services or supplies to the extent that such services or benefits for such services are available under any plan or program established pursuant to the laws or regulations of any government, including any motor vehicle no fault coverage required by statute.

F. EXTENSION OF BENEFITS

If the coverage of a covered person terminates for any reason and if the covered person is totally disabled on the date of termination, benefit payments for the expenses incurred as a result of that sickness will continue during the total disability as if such coverage had continued. Benefits will continue for a period of 90 days or, if earlier, to the date the individual becomes covered under any other group plan, whether issued by Canada Life or another company.

"Totally disabled" and "total disability" means that the covered person, if an employee, is prevented solely because of sickness from engaging in any work for compensation or profit, or, if a dependent, is prevented solely because of sickness from engaging in all of the normal activities of a person of like age and sex, and who is in good health.

G. EXTENSION OF COVERAGE ON YOUR DEATH

If your dependents are covered under this coverage on the date of your death, their coverage will continue **on a noncontributory basis** until the earliest of:

(1) 24 months from the date of your death;

(2) the date your spouse remarries;

(3) the date the dependent is no longer a qualified dependent;

(4) the date that similar coverage is obtained elsewhere;

(5) the date this coverage is cancelled; and

(6) the date the contract is cancelled.

H. PROOF OF CLAIM

Written proof of the loss on which a claim may be based must be given to Canada Life within 15 months of the date the expense was incurred.

GLOBAL MEDICAL ASSISTANCE COVERAGE

FOR YOU AND YOUR QUALIFIED DEPENDENTS

COVERAGE

Global medical assistance is covered if:

(1) it is required as a result of a medical emergency arising while the covered person is travelling outside Canada for vacation, business, or education; and

(2) the covered person is covered by the government health plan in that person's home province.

Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from the covered person's home.

Assistance is provided through a worldwide communications network that operates 24 hours a day. The network assists in locating medical care and obtaining Canada Life's prior approval of covered services. The network can also approve on-site hospital payment when required for admission, to a maximum of $1,000.

A. COVERED SERVICES

Covered services are subject to the assessment provisions described under this plan's extended health care coverage.

Canada Life can limit the eligible charge for a service to that of a lower cost alternative service that represents reasonable treatment.

Reasonable treatment is as defined in the extended health care coverage.

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

(1) **Medical evacuation**

Medical evacuation is covered if suitable local care is not available. If the covered person is travelling within Canada, coverage is provided for transportation to the nearest hospital where treatment is available. If the covered person is travelling outside Canada, coverage is provided for transportation to:

(a) the nearest hospital outside Canada where treatment is available; or,

(b) a hospital in Canada.

When services are covered under this coverage they are not covered under other coverages in this plan.

(2) **Family assistance**

Round trip economy class transportation and lodging are covered for one family member joining a covered person who will be hospitalized for more than 7 days while travelling provided that there was no family member travelling with the covered person.

(3) **Travelling companion**

Extra lodging costs are covered for one travelling companion when the return trip for the covered person and travelling companion is delayed because the covered person is hospitalized.

Exclusion

No benefits are payable for extra lodging costs for a travelling companion if family assistance benefits are claimed under (2) for the same period of confinement.

(4) **Transportation reimbursement**

The cost of comparable return transportation home for a covered person and one travelling companion is covered if prearranged, prepaid return transportation is missed because the covered person is hospitalized. A rental vehicle is not considered prearranged, prepaid return transportation.

Exclusion

Any amount for which other compensation is available is not covered.

(5) **Death**

In case of death, preparation of the covered person's body and its return transportation home are covered.

(6) **Unaccompanied minor children**

Return transportation home is covered for minor children who had travelled with the covered person and who are left unaccompanied because of the covered person's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary.

(7) **Vehicle return**

The cost of returning a covered person's vehicle, whether private or rental, home or to the nearest appropriate vehicle rental agency is covered when sickness or injury prevents the covered person from driving. The maximum amount payable is $1,000.

Exclusion

No benefits will be paid for vehicle return if transportation reimbursement benefits are claimed under (4) for the same period of confinement.

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

B. REFUND OF ON-SITE HOSPITAL PAYMENTS

Where on-site hospital payments exceed Canada Life's liability for that confinement under this group benefit plan, the covered person must refund the excess to Canada Life. If the hospital confinement is not covered in this group benefit plan, Canada Life is entitled to a full refund of the amount advanced.

C. LODGING LIMITATION

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses as well as taxicab and car rental charges are included. The maximum amount payable for lodging expenses is $1,500 per confinement.

Exclusion

Meal expenses are not covered.

D. DISCLAIMER

Neither the communication network nor Canada Life is responsible for:

(1) the availability, quantity, quality, or results of any medical treatment a person receives; or

(2) any unsuccessful attempts by a person to obtain medical services.

E. IDENTIFICATION CARDS

If a covered person's coverage terminates for any reason, the employer is responsible for immediate recall of the global medical assistance identification cards.

F. LIMITATIONS

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

No benefits will be paid for:

(1) expenses that private insurers are not permitted to cover by law.

(2) services the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.

(3) expenses arising from war, insurrection, or voluntary participation in a riot.

G. EXTENSION OF BENEFITS

If the coverage of a covered person terminates for any reason and if the covered person is totally disabled on the date of termination, benefit payments for the expenses incurred as a result of that sickness will continue during the total disability as if such coverage had continued. Benefits will continue for a period of 90 days or, if earlier, to the date the individual becomes covered under any other group plan, whether issued by Canada Life or another company.

"Totally disabled" and "total disability" means that the covered person, if an employee, is prevented solely because of sickness from engaging in any work for compensation or profit, or, if a dependent, is prevented solely because of sickness from engaging in all of the normal activities of a person of like age and sex, and who is in good health.

H. EXTENSION OF COVERAGE ON YOUR DEATH

If your dependents are covered under this coverage on the date of your death, their coverage will continue **on a noncontributory basis** until the earliest of:

(1) 24 months from the date of your death;

(2) the date your spouse remarries;

(3) the date the dependent is no longer a qualified dependent;

(4) the date that similar coverage is obtained elsewhere;

(5) the date this coverage is cancelled; and

(6) the date the contract is cancelled.

I. PROOF OF CLAIM

Written proof of the loss on which a claim may be based must be given to Canada Life within 15 months of the date the expense was incurred.

DENTAL CARE COVERAGE

FOR YOU AND YOUR QUALIFIED DEPENDENTS

DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) "Dentist" means a duly licensed dentist practising within the scope of his or her profession and any other licensed, certified and/or registered dental auxiliary personnel.

(2) "Eligible charges" means the charges actually made to the covered person for services which are included for payment in the List of Dental Services described in the following pages, and which are reasonable, necessary and customary for good dental care and are performed or recommended by a dentist, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist; to the extent that the charges:

(a) do not exceed the amount specified in the fee guide shown in the Summary of Coverages;

(b) are not provided by any law or governmental program under which the individual is or could be covered; and

(c) exceed the amount payable under any other coverage of the contract, any Workers' Compensation Act or similar law, or any other source.

When 2 or more covered dental procedures are separately suitable for the dental care of a specific condition, and both are consistent with good dental care, the contract will provide benefits for the least expensive service.

When a charge is made for an unlisted service furnished for the dental care of a specific condition and the list contains one or more services which, under standard practices, are separately suitable for the dental care of that condition, the contract will provide benefits for the least expensive service.

Where a covered dental expense does not appear in the prevailing fee guide, the amount of the eligible charge for such procedure will be determined by Canada Life on a reasonable and customary basis.

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.

(3) "Orthodontic procedure" means the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

(4) "Orthodontic treatment plan" means a dentist's report, on a form satisfactory to Canada Life, which:

(a) describes the recommended treatment for orthodontic procedures;

(b) estimates the duration over which treatment will be completed;

(c) states the total charge for such treatment; and

(d) is accompanied by cephalometric X-rays, study models, photographs and such other supporting evidence as Canada Life may reasonably require.

(5) "Reasonable and customary charge" means the usual charge made for the covered dental expense, in the absence of coverage, but not more than the prevailing charge in the area where the expense is incurred.

A. PAYMENT OF BENEFITS

After satisfaction of the deductible, a benefit will be paid if a covered person incurs eligible charges for the covered dental procedures described in the List of Dental Services while covered for this coverage. Benefits will be equal to the covered percentage once the deductible has been satisfied, up to the maximum shown in the Summary of Coverages. The deductible and the covered percentage are shown in the Summary of Coverages.

Deductible carry-over provision

Any expenses incurred in the last 3 months of a calendar year which are used toward satisfying the deductible for that year may also be used toward satisfying the deductible for the next calendar year.

Charge incurred

When a covered dental procedure requires multiple appointments to complete, the charge will be considered to have been incurred on the date the procedure was completed, subject to any limitations or exclusions in this coverage.

Materials to be furnished

In order to determine the eligible charges, Canada Life may ask for pre-treatment X-rays and other diagnostic and evaluative materials. If they are not given, Canada Life will determine eligible charges on the basis of the information which is available. This may reduce, or eliminate, the benefits which otherwise would have been payable.

Temporary appliances

A temporary appliance is considered to be a permanent appliance once 12 months have elapsed from the date of insertion. Thereafter, any limitations on the replacement of permanent appliances will apply to temporary appliances on the same basis.

Pre-determination of benefits

Canada Life recommends that a treatment plan, in the form of a report prepared by the dental service provider, be submitted prior to commencement of treatment when:

(1) the course of treatment is expected to cost more than $600; or

(2) there are alternative methods of treatment.

Canada Life will review the treatment plan and advise the covered person of the amount payable under this coverage, **before** the dental work begins.

LIST OF DENTAL SERVICES

BASIC SERVICES

EXAMINATIONS

Complete oral examination, once every 5 years.
Periodic oral examination, once every 9 months.
Specific oral-area examination, twice yearly.
Emergency oral-area examination.

X-RAY EXAMINATIONS (RADIOGRAPHS)

Complete series, including panoramic survey, once every 5 years.
Bitewing films, once yearly.
Extraoral films.
Periapical and intraoral films.
Interpretation of radiographs from another source.
Radiographs related to temporomandibular joint disorders (TMJD).

TESTS AND LABORATORY EXAMINATIONS

Cultures/smears for determining pathologic agents.
Biopsies.
Pulp vitality test.
Diagnostic casts - unmounted.

CASE PRESENTATIONS

Consultation with patient - when performed on a day other than the day of the examination.

PREVENTIVE SERVICES

Polishing - maximum of one time unit every 9 months.
Fluoride treatment, once every 9 months.
Oral hygiene instruction, once every 5 years.
Pit and fissure sealants, once every 3 years, for permanent molars and bicuspids for dependent children.
Caries/pain control.
Interproximal discing - maximum of 2 time units per year.
Space maintainers for children younger than age 16.

RESTORATIONS

(Restorative services which are performed prior to installation of a crown or bridge and are related to installation of that crown or bridge will be considered major services.)

Non-bonded silver amalgams.
Tooth-coloured/composite restorations. (If composites are used on posterior teeth, the eligible charge will be limited to the equivalent amalgam fee.)
Retentive pins, posts.
Stainless-steel crowns and plastic crowns - for primary teeth.
Caries/pain control - as a separate procedure from a restoration.

ENDODONTIC SERVICES

Pulp capping.
Pulpotomy/pulpectomy.
Root canal therapy.
Apexification.
Apicoectomy.
Retrofilling.
Root amputations.
Isolation of tooth.
Hemisection.
Removal, apical filling and replantation.
Open and drain - as a separate emergency procedure.
Perforations.

PERIODONTAL SERVICES

Nonsurgical services.

Exclusion

No benefits paid for training in personal therapeutic periodontal care.

Surgical services.
Post-surgical visits - 4 visits per year.
Occlusal adjustments/equilibration - maximum of 4 time units per lifetime.
Scaling and/or root planing - maximum of 7 time units every 9 months.
Special periodontal appliance for bruxism only.

DENTURE SERVICES

Repairs.
Additions.
Direct relines (functional impression required).
Relines, processed, once every 36 months (functional impression required).
Rebasing, once every 36 months.

ORAL SURGERY

Extractions - uncomplicated and complicated.
Removal of residual roots.
Surgical exposure of teeth.
Alveoloplasty, gingivoplasty, stomatoplasty and osteoplasty.
Surgical excisions.
Surgical incisions.
Frenectomy.
Treatment of fractures.
Miscellaneous surgical services.

ADJUNCTIVE SERVICES

House and hospital visit.
Office visit after regularly scheduled hours and no operative services performed.
Injection of drugs.
Anaesthesia and sedation - only when performed in conjunction with oral surgery.

MAJOR SERVICES

SINGLE RESTORATIONS

Onlays, inlays, crowns

- only if the tooth cannot be restored with a basic restoration.
- transitional (temporary) crowns are considered part of the final restoration.
- limited to full metal crowns on molar teeth.

Porcelain repairs.
Retentive pins, posts and cores.
Recementation.
Removal of crown or inlay.
Crown coping.

PROSTHODONTICS - REMOVABLE

Complete standard dentures.
Immediate completed standard dentures, once every 5 years.
Transitional standard dentures.
Partial dentures - including cast chrome (but not gold).
Denture remake.
Denture adjustments - 3 months after insertion (once each year).
Remount and occlusal equilibration.
Tissue conditioning.

PROSTHODONTICS - FIXED

Retainer inlays/onlays.
Abutment crowns and pontics - limited to full metal crowns and pontics for molars.
Repairs.
Retentive pins, post and cores, copings.
Removal of bridge.

ORTHODONTIC SERVICES

FOR YOUR DEPENDENT CHILDREN YOUNGER THAN AGE 20 ON THE DATE THE ORTHODONTIC PROCEDURE COMMENCES

The amount payable is the covered percentage of the reasonable and customary charge for the covered orthodontic services after satisfaction of the deductible, up to the lifetime maximum. The covered percentage, deductible and lifetime maximum are shown in the Summary of Coverages.

An orthodontic treatment plan should be submitted prior to commencement of the orthodontic procedure. Canada Life will review the treatment plan and advise you of the estimated benefits. The total eligible charges will then be paid in equal monthly installments over a period of time equal to the estimated duration of the orthodontic treatment plan.

The following are covered orthodontic services:

(1) Diagnostic services (once only).

(2) Interceptive orthodontics.

(3) Comprehensive orthodontics.

(4) Habit-inhibiting appliances.

Exclusions

Expenses incurred in connection with any of the following are not covered:

(1) Myofunctional therapy.

(2) Charges for replacement or repair of an orthodontic appliance.

(3) Motivation of a patient.

(4) A procedure for which an active orthodontic appliance was installed before the individual became covered under this coverage.

B. LIMITATIONS AND EXCLUSIONS

Expenses incurred for any of the following are not covered:

(1) Installation of fixed bridgework, removable, partial or complete dentures to replace teeth missing prior to the individual's becoming covered under this coverage, **unless** the partial or full removable denture or fixed bridgework also includes replacement of a natural tooth extracted while the individual was a covered person and the extracted tooth was not an abutment to a partial denture or fixed bridge installed within the immediately preceding 5 years.

(2) Modification or replacement of removable dentures, fixed bridgework, crowns, inlays and onlays within 5 years of installation.

(3) Fixed bridgework to replace removable dentures unless a professionally adequate result can only be achieved with fixed bridgework and fixed bridgework is a covered dental procedure.

(4) Replacement of lost or stolen appliances.

Any charges incurred for, or in connection with, any of the following are not covered:

(1) Expenses for which Canada Life is prohibited by law from providing.

(2) Expenses for which the covered person is not required to make payment, or where payment is received as a result of legal action or settlement.

(3) Expenses payable under Workers' Compensation Act or similar law.

(4) An examination by, or the services of a dentist if required solely for the use of a third party.

(5) Duplication of a recent service by the same, or a different, dentist.

(6) Cosmetic services (including facings on molar crowns or molar pontics) unless necessitated as a result of accidental injuries sustained while a covered person.

(7) Procedures, appliances and restorations used to increase vertical dimension or to restore the occlusion, or for the purpose of splinting.

(8) Services for the correction of temporomandibular joint dysfunctions (TMJD).

(9) Implantology, specialized services (including precision attachments and stress breakers) and services which are experimental in nature.

(10) Laboratory charges exceeding 60% of the fixed fee for the procedure in the fee guide shown in the Summary of Coverages.

(11) Services received for injuries sustained while committing, or attempting to commit, a criminal offence but not when injuries are sustained as a result of driving a vehicle when the covered person's blood contained more than 80 milligrams of alcohol in 100 millilitres of blood (.08).

(12) Sinus examination, hand and wrist radiographs, hard tissue biopsy, hemisection, supra crestal fibrotomy, free connective tissue graft, grafts related to gingival onlay, grafts on osseous tissue, regeneration of guided tissue and procedures for proximal wedge.

Late entrants limitation

If an individual enrolls for the dental care coverage more than 31 days after first becoming eligible to do so, benefits will be limited to $100 per covered person during the first 12 months of coverage.

This limitation will be waived under the following circumstances:

(1) when the covered dental expense is the result of accidental injuries sustained while a covered person;

(2) for a covered dependent child younger than 5 years of age; or

(3) for a dependent

(a) who was previously covered for employee coverage under another group plan;

(b) whose coverage terminated due to termination of employment; and

(c) who enrolls for this coverage within 31 days of the prior coverage's termination.

C. EXTENSION OF COVERAGE ON YOUR DEATH

If your dependents are covered under this coverage on the date of your death, their coverage will continue **on a noncontributory basis** until the earliest of:

(1) 24 months from the date of your death;

(2) the date your spouse remarries;

(3) the date the dependent is no longer a qualified dependent;

(4) the date that similar coverage is obtained elsewhere;

(5) the date this coverage is cancelled; and

(6) the date the contract is cancelled.

D. PROOF OF CLAIM

Written proof of the loss on which a claim may be based must be given to Canada Life within 15 months of the date the expense was incurred.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (TELADOC MEDICAL EXPERTS)

FOR YOU AND YOUR QUALIFIED DEPENDENTS

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 "covered person" for the purpose of this service) can generally access this service.

This service is made up of a unique step-by-step process that may help address questions or concerns about a physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan.

It works as follows:

- access diagnostic and treatment support services by calling 1-877-419-2378 toll free or via teladoc.ca/canadalife/;
- the covered person accessing the service will be connected with a member advocate who will be dedicated to the covered person's case and will provide support through the process; the member advocate will take the necessary medical history and answer the covered 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 covered 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 covered 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 covered person accessing this service; generally, this process takes several weeks; timeframes may vary depending on the complexity of the case and amount of medical records to collect;
- if the covered person decides to seek treatment by a different physician, a member of the Teladoc Medical Experts team can help identify a specialist qualified to meet the covered person's specific medical needs either in their geographic area or outside Canada; and
- the member advocate may identify a Teladoc Medical Experts specialist suited to answer basic questions about health concerns and treatment options; answers will be provided in a written report sent by email to the person accessing the service.

Limitations:

Services are subject to the following limitations:

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

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.

VIRTUAL HEALTH SERVICES

FOR YOU AND YOUR QUALIFIED DEPENDENTS

Virtual health services are available to you and your qualified dependents by downloading the service provider's application specified by Canada Life from time to time. These services include the following:

(1) access to virtual health services 24 hours a day, 7 days a week

(2) unless prohibited by applicable laws, access to an unlimited number of consultations via telephone calls, text messaging and videoconferencing with medical professionals

(3) prescriptions and prescription renewals, when medically needed

(4) where diagnostic or laboratory tests are medically needed:

  (a) completion of necessary requisitions

  (b) results of the diagnostic or laboratory tests provided and accessible through the provider's application

(5) access to specialists such as psychologists, dieticians and work and life coaches for an additional fee

(6) access to self-guided internet-based cognitive behavioral therapy (iCBT)