MY GROUP BENEFITS PLAN

EFFECTIVE AS OF April 1, 2024

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Effective September 1st, 2015 the Government of Newfoundland & Labrador Benefits Plan transitioned to The Canada Life Assurance Company for administration of the group insurance program.

All information in this booklet is a summary of the insurance benefits for the information of employees. This should not be used to determine entitlement to coverage, which is solely governed by the express terms of the group insurance policy. Where there is any conflict between this summary and the express terms of the group insurance policy, the express terms of the group insurance policy shall apply.

My Canada Life at Work

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

With My Canada Life at Work you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed
- Access special authorization forms as well as select administration & claim forms

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

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 1-844-349-5656.

Government of Newfoundland & Labrador Insurance Division Contact Information

To contact a representative at the Insurance Division for assistance with questions related to eligibility, premiums, dependents or beneficiary designations please call 709-729-2310 or email groupinsurance@gov.nl.ca.

For additional group benefit information, please visit the website at https://www.gov.nl.ca/exec/tbs/working-with-us/employee-benefits/.

Customer complaints

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

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

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

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

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 168000, 168001, 168002, 168074, 168075, 168076, 167090, and 169004. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail to the extent permitted by law.

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

The Plan is underwritten by

This booklet was prepared on: March 26, 2024

Access to Documents

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

If you wish to review the current Group Insurance Policy, you may do so upon written request to the Director – HR Client Service Centre Division by calling 709-729-2310 or emailing groupinsurance@gov.nl.ca.

Legal Actions

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

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect. For further information, please call 1-844-349-5656.

Benefit Limitation for Overpayment

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

Insurance Fraud

Fraud happens when someone knowingly lies or falsifies information to obtain a benefit to which they are not entitled. This includes but is not limited to intentionally providing false information to ensure the payment of a claim, withholding information that would affect payment of a claim, or submitting a fictitious claim.

Any incidents of fraud, suspicious activity, or other irregularities will be investigated and may lead to disciplinary action. Police services may also be contacted.

Help protect your benefit plan!

- Examine your forms and receipts to make sure information is correct. You are responsible for the information you submit.

- Do not give a provider pre-signed claim forms, never alter or change a receipt, and keep your plan number and ID secure.

- Review this booklet and understand your benefits.

- Report suspicious situations by calling the Canada Life tip line at 1-866-810-8477.

Quebec Time Limit for the Payment of Benefits

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

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

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

Protecting Your Personal Information

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

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities and analyzing the design options of the plan
- 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 your plan administrator.

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.

Here is how to contact Canada Life's Chief Compliance Officer:

- Email: ChiefComplianceOfficer@canadalife.com
- In writing:

Chief Compliance Officer
Canada Life Assurance Company
100 Osbourne Street North
Winnipeg, Manitoba
R3C 3A5

TABLE OF CONTENTS

Benefit Summary

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

Member Basic Life Insurance	
Active Members	200% of annual earnings to a minimum of $10,000 and a maximum of $1,000,000
Retired Members under age 65	
- Members with less than 5 years as an insured member before age 65 and members hired on or after April 1, 2020	200% of annual pension to a minimum of $10,000 and a maximum of $1,000,000
- Members with 5 or more consecutive years as an insured member immediately before you reach age 65	200% of annual pension to a minimum of $10,000 and a maximum of $1,000,000. If you reach age 65 prior to April 1, 2007, this amount of insurance includes $5,000 on a premium-free basis. If you reach age 65 on or after April 1, 2007, this amount of insurance includes $7,500, on a premium free basis. To be eligible for life insurance on a premium-free basis, you must have paid premiums for 5 years prior to your 65th birthday. If any premium payments have been missed during the 5 years preceding your 65th birthday, you will not be entitled to this insurance

Advanced Life Payment	
Amount	50% of your basic life insurance to a maximum of $50,000

Member Basic Accidental Death, Dismemberment and Specific Loss (Principal Sum) *See the Member Basic Accidental Death, Dismemberment and Specific Loss benefit provision for further details.*	
Amount	An amount equal to your Basic Life Insurance

Dependent Basic Life Insurance (Applicable to members with family Healthcare coverage only)	
Spouse	$10,000
Child	$5,000

Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Basic Expenses	Covered Maximum	Reimbursement Level
Emergency Ambulance		
- Outside your province of residence	$1,000 every calendar year ($500 every calendar year for residents of Labrador)	80%*
- Within your province of residence	$500 every calendar year ($1,000 every calendar year for residents of Labrador)	80%*
Hospital	Private or Semi-private room to a maximum of $85 per day	100%
Convalescent Care	$20 per day of confinement	100%
Home Nursing Care and Personal Care Workers (subject to a pre-approval)	$10,000 lifetime	80%*

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued- Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Medical Supplies	**Covered Maximum**	**Reimbursement Level**
In-Canada Prescription Drugs		
- Retired members hired on or after April 1, 2020		70% of the ingredient cost until $4,000 of out-of-pocket expenses have been accumulated in a calendar year and 100% of the ingredient cost for the remainder of the calendar year
- All other members		100% of the ingredient cost (excluding any additional surcharge over the ingredient cost)
Deductible for your In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge	

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued- Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Medical Supplies	Covered Maximum	Reimbursement Level
Positive Airway Pressure Breathing Machines	1 unit every 5 rolling years to a maximum of $2,500	80%*
Apnea Monitors for Respiratory Dysrhythmias	1 unit every 5 calendar years	80%*
Stock-item and Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	$200 combined every calendar year	80%*
Myoelectric Arms	$10,000 per prosthesis	80%*
External Breast Prosthesis	1 every 12 months for each breast	80%*
Surgical Brassieres (post mastectomy only)	2 brassieres every calendar year to a maximum of $100 for each brassiere	80%*
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 rolling years	80%*
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of $2,000 lifetime	80%*
Wheelchairs	1 every 5 calendar years	80%*
Wheelchair Cushions	1 cushion every calendar year to a maximum of $300	80%*

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued- Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Medical Supplies	Covered Maximum	Reimbursement Level
Hearing Aids	$1,000 for each ear every 3 calendar years	80%*
External Insulin Infusion Pumps - dependent children under age 16 - all others	 $6,000 every 5 rolling years $3,125 every 5 rolling years	 80%* 80%*
Syringes, Diabetic Supplies and Supplies used with an Insulin Pump	$2,170 combined every calendar year	80%*
Transcutaneous Nerve Stimulators	$700 lifetime	80%*
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500 lifetime	80%*
Custom-made Compression Hose (15 mmHg or higher)		80%*
Wigs for Cancer Patients	$200 lifetime	80%*
Incontinence Supplies		80%*
PUVA Therapy for Psoriasis	$300 every calendar year, limited to $20 per visit	80%*

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued- Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Paramedical Expenses	Covered Maximum	Reimbursement Level
Acupuncturists	$500 each calendar year	80%*
Chiropractors	$500 each calendar year, including one x-ray each calendar year	80%*
Massage Therapists (when referred by a physician)	$500 each calendar year	80%*
Naturopaths	$500 each calendar year including one x-ray each calendar year	80%*
Occupational Therapists	$500 each calendar year	80%*
Osteopaths	$500 each calendar year, including one x-ray each calendar year	80%*
Podiatrists/Chiropodists	$500 combined each calendar year, including one x-ray by a podiatrist each calendar year	80%*

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued- Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Paramedical Expenses	Covered Maximum	Reimbursement Level
Physiotherapists / Athletic Therapists	$500 combined each calendar year	80%*
Psychologists / Social Workers	$500 combined each calendar year	80%*
Speech Therapists	$500 each calendar year	80%*

*** For retired members hired on or after April 1, 2020 the reimbursement level is 80% for covered expenses.**

*** For all other members 80% of the first $5,000 of covered expenses incurred in a calendar year, then 90% of the next $5,000 of covered expenses in a calendar year, and then 100% of covered expenses over $10,000 in a calendar year. Amounts are per insured person.**

Continued – Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Visioncare Expenses	Covered Maximum	Reimbursement Level
Eye Examinations		
- dependent children under age 18	$70 every calendar year	80%
- all others	$70 every 3 calendar years	80%
Eyeglasses following Non-Refractive Eye Surgery	$200 lifetime	100%
Glasses and Contact Lenses		
Glasses or contact lenses for a dependent child under age 18 is covered provided there is a change in the strength of the prescription		
- dependent children under age 18	$250 combined each calendar year	100%
- all others	$250 combined every 3 calendar years	100%
Laser Eye Surgery	$450 lifetime	100%
Once a payment is made for laser eye surgery, no benefit for eyeglasses or contact lenses is payable for 6 calendar years		
Contact Lenses for Special Conditions	$250 every 2 calendar years	100%
Visual Training and Remedial Therapy	one approved course of treatment per lifetime	50%

Continued – Healthcare

Healthcare coverage for your family members must be applied for within 31 days of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Out-of-Country Care Expenses	**Covered Maximum**	**Reimbursement Level**
Emergency Care	$2,000,000 per incident, combined with Global Medical Assistance	100%
Non-Emergency Care	Included	80%
Out-of-Country Extension	$2,000,000 per incident	100%

Non-Emergency Medical Transportation in Canada	**Covered Maximum**	**Reimbursement Level**
	$300 every calendar year	80%

Out-of-Pocket Maximum for Quebec Residents	An out-of-pocket maximum is applied to in-province expenses for drugs listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows: 1. reimbursement will be made at 100% 2. no further out-of-pocket amounts will apply The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec.

Continued – Healthcare

Healthcare coverage for your family members must be applied for within <u>31 days</u> of their eligibility for benefits, with the exception of newborn children where coverage can be applied for within <u>24 months</u> of their date of birth, otherwise access to coverage will be subject to medical approval.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

		Reimbursement Level
Global Medical Assistance		100%
Accidental Dental Treatment		100%
Healthcare Maximum		
- Retired members hired on or after April 2020	Maximum reimbursement of $1,500 each calendar year per insured person (Not applicable to Out-of-Country Care, Global Medical Assistance and In-Canada Prescription Drug Expenses)	
All other members	Unlimited	

Optional Dentalcare*

Optional Dentalcare coverage for yourself and your family members must be applied for within 31 days of eligibility for this benefits, with the exception of newborn children where coverage can be applied for within 24 months of their date of birth, otherwise coverage will be limited to $100, per person in a family, in the first 12 months. See your employer for more details.

Covered expenses will not exceed reasonable and customary charges, where applicable.

To confirm reasonable and customary amounts please call a customer service representative at 1-844-349-5656

Payment Basis	The 2023 dental fee guide for the province in which treatment is rendered	
Deductible	Nil	
	Covered Maximum	**Reimbursement Level**
Basic Coverage	Unlimited	80%
Major Coverage	$1,250 each calendar year	70%

*Not Applicable to Members of Workplace NL

Optional Life Insurance	
Member	Available in $10,000 units to a maximum of $300,000, subject to approval of evidence of insurability If you apply for coverage within 31 days of becoming eligible to participate in the plan, the first $100,000 of Optional Life Insurance will not be subject to evidence of insurability If you apply for coverage after 31 days of becoming eligible to participate in the plan, up to $100,000 of Optional Life Insurance will not be subject to evidence of insurability upon signing a Declaration of Good Health. If you are unable to sign a Declaration of Good Health, evidence of insurability will be required.
Spouse	Available in $10,000 units to a maximum of $300,000, subject to approval of evidence of insurability At any time, your spouse may apply for up to $100,000 of Optional Life Insurance upon signing a Declaration of Good Health. If your spouse is unable to sign a Declaration of Good Health, evidence of insurability will be required **If you are covered under this plan as both a member and a spouse, you are limited to the $300,000 maximum**

Optional Accidental Death, Dismemberment and Specific Loss (Principal Sum) *See the Optional Accidental Death, Dismemberment and Specific Loss benefit provision for further details.*	
Member	Available in $10,000 units to a maximum of $300,000 100% of the Principal Sum when resulting from accidental death
Spouse - if there are no children - if there are children	 50% of the member amount 40% of the member amount
Child - if there is no spouse - if there is a spouse	 10% of the member amount 5% of the member amount

Optional Critical Illness Insurance Retirees are not eligible for this benefit.	
Single	
Member	$25,000, subject to approval of evidence of insurability
Family	
Member	$25,000, subject to approval of evidence of insurability
Spouse	$10,000, subject to approval of evidence of insurability
Child - under age 16 - age 16 and over	 $5,000 $5,000, subject to approval of evidence of insurability

Optional Long Term Disability Income Benefits **Optional Long-Term Disability Coverage must be applied for within <u>31 days</u> of eligibility otherwise access to coverage will be subject to medical approval. See your employer for more details.**	
Applicable to Members who participate in the Public Service Pension Plan, Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan under age 65. (Not Applicable to Temporary Call-In/Hourly/Casual Members, Provincial Court Judges, Retirees and Members participating in the Government Money Purchase Plan - GMPP).	
Claim Notification	To permit prompt assessment, initial notice of a long term disability income claim must be submitted to Canada Life no later than 10 months after disability starts. See your employer for more details.
Waiting Period	119 calendar days, or all or a portion of your accumulated sick leave, to a maximum of 480 days, whichever you choose
Proof of Claim	You must submit proof of claim to Canada Life within 3 months from the date the initial notice of claim was received.
Amount	66 2/3% of your monthly earnings to a maximum monthly benefit of $10,000 or 85% of your pre-disability take-home pay, whichever is less

COORDINATION OF BENEFITS

Coverage:

- Benefits for you or a dependent will be directly reduced by any amount payable under a government (federal/provincial) program/ plan.

- If you or a dependent are entitled to benefits for the same expenses under another group plan or as both a member and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated.

- The employee/retiree group plan is designed using a covered maximum benefit when determining the coordinated benefits between group plans. This means it is the eligible amount that accumulates towards the covered benefit maximum, not the amount of the claim that has been paid.

- During the coordination of benefits the maximum that will be eligible from the employee/retiree group plan will not exceed the covered maximum benefit (CMB) established in the employee/retiree group plan. The covered maximum benefit includes eligible amounts submitted under **both** group plans when determining if the maximum limit has been exceeded and if a claim balance will be paid.

- The plan that pays first will calculate benefits as though duplicate coverage does not exist. In other words, it will process the claim as it would any other claim, considering the CMB.

- The plan that pays second calculates benefits for each individual item on the claim, based on the lowest of:
    - the amount that would have been payable had it been the first plan, or
    - 100% of the eligible expenses (not paid claims) minus the benefits paid by the first plan.
    - The CMB is determined based on eligible claims from both plans.

- In some cases, the combined payments from all plans may be less than what you have paid out of your pocket.

Order of Claims

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

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

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

Examples

PARAMEDICAL CLAIMS – TWO (2) GNL PLANS

- John & Mary Smith - Both with Family Health Coverage
- Physiotherapy Claims for John – Coordinated Between Both GNL Plans
- GNL Plan - Physiotherapy **Covered Maximum** = $500 per calendar year (claims paid at 80%)

Date of Service	Submitted Amount	Covered Amount	John's Plan Pays (primary)	Mary's Plan Pays (secondary)
01/06/2016	$50.00	$50.00	$40.00	$10.00
01/29/2016	$50.00	$50.00	$40.00	$10.00
02/05/2016	$50.00	$50.00	$40.00	$10.00
02/19/2016	$50.00	$50.00	$40.00	$10.00
03/12/2016	$50.00	$50.00	$40.00	$10.00
04/08/2016	$50.00	$50.00	$40.00	$10.00
05/26/2016	$50.00	$50.00	$40.00	$10.00
06/17/2016	$50.00	$50.00	$40.00	$10.00
07/20/2016	$50.00	$50.00	$40.00	$10.00
08/25/2016	$50.00	$50.00	$40.00	$10.00
Totals	**$500.00**	**$500.00**	**$400.00**	**$100.00**

**No further claims are eligible for reimbursement, under either John or Mary's plans, as the $500 Covered Maximum has been reached. It is the submitted amount of each claim that accumulates towards the covered maximum.*

PARAMEDICALS CLAIMS– GNL PLAN & OTHER INSURER

- John Smith – GNL Plan - Family Health Coverage
- Mary Smith – Other Insurer – Family Health Coverage
- Massage Therapy Claims for Mary – Coordinated Between GNL Plan & Other Insurer
- GNL Plan – Massage Therapy **Covered Maximum** = $500 per calendar year (claims paid at 80%)
- Other Insurer – Massage Therapy **Paid Maximum** = $500 per calendar year (claims paid at 80%)

Date of Service	Submitted Amount	Covered Amount under GNL Plan	Mary's Plan Pays (primary)	John's Plan Pays (secondary)
01/05/2016	$90.00	$90.00	$72.00	$18.00
02/09/2016	$90.00	$90.00	$72.00	$18.00
03/18/2016	$90.00	$90.00	$72.00	$18.00
04/20/2016	$90.00	$90.00	$72.00	$18.00
05/11/2016	$90.00	$90.00	$72.00	$18.00
06/18/2016	$90.00	$50.00	$72.00	$18.00
Totals	**$540.00**	**$500.00**	**$432.00**	**$108.00**

As per CLHIA Guidelines, a secondary plan's liability is the lesser of:

- what the secondary plan would have paid had it been the primary payer; *or*
- 100% of all eligible expenses reduced by all other insurance.

For the claim above, with a Date of Service of 06/18/2016, the amount that John's Plan Pays was determined as follows;

- If John's plan was first payer the claim would have been calculated as $50 X 80% = **$40**
- The difference between 100% of the eligible expense, which was $90, and the reimbursement from the other insurance, which was $72, is **$18**
- **The lessor of $40 and $18 is what John's Plan Pays**.

**No further claims are eligible for reimbursement, under John's plan, as the $500 Covered Maximum has been reached. It is the submitted amount of each claim that accumulates towards the covered maximum.*

**Mary can continue to submit claims under her plan until she receives the $500 Paid Maximum eligible under her plan.*

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after a period of continuous employment as defined by your employer. Contact your plan administrator for confirmation of the date of your eligibility.

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

  If your spouse is also an employee with the Government of Newfoundland and Labrador and is enrolled with family health coverage you may waive health benefits under this plan. If you lose spousal health coverage, you must apply for health coverage under this plan within 31 days of loss of such coverage. If you do not apply within 31 days of loss of such coverage, you and your dependents will be required to provide evidence of insurability acceptable to Canada Life to be covered for health benefits, and dental benefits will be limited to $100 per person in a family, in the first 12 months.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

- You are eligible for coverage in retirement if;

  - you are in receipt of a pension from the Public Services Pension Plan or the Uniformed Services Pension Plan and you were insured under the Government of Newfoundland & Labrador benefit program the day before you retired, and:

    (a) you meet the eligibility criteria outlined in the Other Post-Employment Benefits Eligibility Modification Act for non-unionized employees; or
    (b) you meet the eligibility criteria outlined in your collective agreement if you are a union employee.

  - you are in receipt of a pension from the the Members of the House of Assembly Pension Plan and/or the Provincial Court Judges Pension Plan and you were insured under the Government of Newfoundland & Labrador benefit program the day before you retired.

If you are an active member your coverage terminates on the earliest of the following dates:

- when your employment ends,
- when you are no longer eligible,
- when the policy terminates or;
- 18 months from the date you start Unpaid Leave

Your coverage as a retiree terminates when you are no longer eligible or the policy terminates, whichever is earlier.

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

Extension of Benefits for Disability

If you are disabled when your coverage terminates, you may be entitled to an extension of benefits under the plan. See your employer for details.

Continuation of Insurance While Not Actively At Work

Your coverage may be continued if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence, provided you are not working for another employer or self-employed during this time. Your employer will provide you with details.

Survivor Benefits

If your dependent coverage is still in effect when you die, your surviving dependents may continue to receive coverage on a premium-paid basis, if they are entitled to and have elected to receive a semi-monthly survivor pension, until they no longer qualify or the policy terminates, whichever happens first.

If you reside in Québec and your dependents are covered for in-Canada prescription drugs benefits under this policy, their benefits will be continued, on a premium-paid basis on the earlier of a period of 2 years following your death, the date your spouse remarries, the date they no longer qualify or the date the policy terminates.

Your employer will provide you with details.

EMPLOYEE AND RETIREE RESPONSIBILITY

You should note that you have responsibilities to fulfill. Your responsibilities include, but are not limited to, the following:

- For ensuring that you have applied for the coverage you wish to have for yourself on your enrolment forms and your dependents within the appropriate time frames.

- To change your coverage from single to family within the appropriate time frame. If the coverage is not changed within 31 days of acquiring your first eligible dependent an Evidence of Insurability on Dependents is required for approval.

- To add a spouse to this plan in the event that he or she loses coverage under another plan within a 31 day period following the loss of coverage to avoid having to provide medical evidence.

- For examining payroll deductions for each pay period for all group insurance benefits. Examples would include family versus single coverage and optional benefit premiums particularly when you have requested changes in coverage and at the annual renewal date when the premiums are adjusted. This will ensure accuracy and allow for corrections on a timely basis. Coverage details can be confirmed through pay stubs, your plan administrator, employer online benefit statements (where available) and at Canada Life via My Canada Life at Work or by calling 1-844-349-5656.

- For amending your coverage to delete any coverage you no longer require. Contributions which you have paid are not refundable if they were consistent with the application on file.

- For effecting conversion of the coverage eligible to be converted upon the earlier of termination of employment or at age 65.

- For accurately completing the necessary forms required for continuing benefits while on maternity leave, sick leave, special leave without pay, retirement, etc. It is extremely important these arrangements be made prior to commencing eligible leave. For continuation of group life and health insurance while on temporary lay-off or on unpaid leave you are responsible for the payment of the full premium amount (employer/employee contributions) and failure to remit will result in termination of coverage. You are also responsible for the payment of the full premium amount (employer/employee contributions) if you are a casual/hourly employee and you maintain benefits during a pay period when you have not worked and have not received pay. Failure to remit premiums will result in the termination of coverage.

- For providing appropriate claim information necessary to process LTD and/or Waiver of Premium claims as well as to ensure notice of claim/proof of claim where necessary has been provided within appropriate time frames as required under the contract.

- For providing appropriate medical information necessary to add a dependent as functionally impaired to continue their coverage beyond the age a dependent would otherwise terminate based on contract guidelines.

- For completing the appropriate forms accurately, completely, and within applicable timeframes for such things as change of address, addition or deletion of a dependent, and other significant matters that can change or otherwise affect your coverage.

- To register overage student dependents between age 21 and 25 at the beginning of each school year. Failure to do so may impact coverage.

- Reviewing the online employee benefit booklet, contacting the insurance carrier and/or your organization's plan administrator to ensure you have a sound knowledge of the benefits available, extent of coverage, eligibility criteria, exclusions, restrictions, medical underwriting requirements, conversion options, continuation of benefits, predeterminations and other important requirements of the program.

- Providing proof of the purchase of a pension service that may reduce LTD premiums. Premiums will only be adjusted when the plan administrator has been notified and received verification despite the date the purchase may have occurred.

- For notifying your plan administrator if the deletion of an overage dependent requires a change in your premiums from family to single coverage.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal, common-law, former or limited member.

  No proof of insurability is required if a legal spouse is added within 31 days of marriage or if a common-law spouse is added within 31 days of eligibility.

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

  A former spouse means a divorced, ex-civil-union, or ex-common-law spouse for whom insurance protection for some of the benefits available under the Government of Newfoundland & Labrador benefit program is mandated by court order.

  A limited member means a spouse or former spouse who elects to receive a separate pension from one of the government defined benefit pension plans.

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

  No proof of insurability is required if a child is added as a dependent within 31 days of their eligibility for benefits or 24 months from their date of birth. Children are covered for all benefits, including stillbirth, if the gestation period was 23 weeks or more.

  Children who are incapable of supporting themselves because of physical or psychiatric disorder may be covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time. Coverage is subject to approval by Canada Life.

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

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

MEMBER BASIC LIFE INSURANCE

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

Waiver of Premium

If you are an active member and become disabled while insured, Canada Life may waive the premiums on your life insurance, after the waiting period, throughout the benefit period. If approved, this means you will maintain your member basic life insurance equal to 2 times your annual earnings throughout the benefit period, subject to certain conditions. See below for more details. Your designated beneficiary will receive this member basic life insurance amount in the event of your death.

Claim Notification

Initial notice of a life insurance waiver of premium claim should be submitted to Canada Life no more than 10 months after the disability starts.

Canada Life will not be liable for open and unreported life waiver of premium claims incurred prior to termination.

A qualifying disability is one that satisfies the definition of disability under this policy's long term disability income benefit.

Proof of Claim

You must then submit proof of claim to Canada Life within 6 months from the date the initial notice of your claim was received.

Waiting Period

If approved your life insurance premiums will be waived after the waiting period which is 119 calendar days, or all or a portion of your accumulated sick leave, to a maximum of 480 days, whichever you choose.

Benefit Period

Your life insurance premiums will continue to be waived until you are no longer disabled as defined by the policy, until your retirement, or until you reach age 65, whichever occurs first.

Transfer of Claims

If responsibility for the continued assessment of your existing life waiver of premium claim is transferred from Canada Life, Canada Life has the right, without your authorization, to disclose claim information to the party assuming the responsibility for the existing claim

Conversion Privilege

If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability up to a maximum of $300,000. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for confirmation of benefits and amounts that are eligible for conversion.

ADVANCED LIFE PAYMENT

Canada Life may, at its discretion, pay a portion of your amount of basic insurance prior to your death. You may be eligible for an Advanced Life Payment if:

- you are eligible for waiver of premium benefits,
- the prognosis of your illness is terminal and you are not expected to live longer than 24 months from the date of your application,
- your attending physician provides sufficient medical evidence, including the diagnosis and prognosis, to allow a thorough assessment of your life expectancy,
- your employer authorizes the request for the payment of this benefit, and
- you have not named an irrevocable beneficiary.

Canada Life, at its sole discretion, shall have the right to decline to make any such "advanced payment". Further, if a plan member applies whose basic life benefit is within 24 months of being reduced or terminated, that application will be handled on a case by case basis, however generally will not be approved.

Check the **Benefit Summary** for the amount of the Advanced Life Payment available. You must sign a valid release form for the amount paid in advance of your death. At the time of your death, the amount of the benefits payable will be reduced by the amount of the Advanced Life Payment plus accumulated interest to the date of your death. Interest will be calculated at Canada Life's current one-year rate.

How to Make a Claim

Claims for life insurance are not subject to a specified time limit for submission.

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

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

If you die as a result of an accident, Canada Life will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident.

If you elect Optional Accidental Death, Dismemberment and Specific Loss benefits, the total principal sum is the sum of your basic and optional amounts.

Exposure and Disappearance

Benefits will be paid for loss suffered from unavoidable exposure to the elements as if they occurred as a result of an accident.

If your body is not found within 365 days after the disappearance, wrecking, or sinking of the plane, boat, or vehicle in which you were riding at the time of the accident, you will be considered to have suffered loss of life.

Coma Benefit

If you are injured in an accident that occurs while you are insured and the injury directly results in a coma, Canada Life will pay an amount equal to the Principal Sum as specified in the **Benefit Summary**, on the date of the accident.

A coma is a state of complete and total unconsciousness with no reaction to external stimuli or internal needs persisting with the use of life support systems for at least 60 consecutive days.

If benefits are payable for a loss due to the same accident, and a subsequent coma occurs, benefits for the subsequent coma will be the difference, if any, between the amount payable for the loss and the Principal Sum.

Paraplegia, Hemiplegia, Quadriplegia

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

Benefits will be paid for loss suffered from unavoidable exposure to the elements as a result of the accident.

If your body is not found within 365 days after the date of sinking or disappearance of a conveyance in which you were riding at the time of the accident, you will be considered to have suffered loss of life as a result of a bodily injury caused by the accident.

Schedule of Losses

Loss	**Amount Payable**
Life	Principal Sum
Sight of one eye	Principal Sum
Speech	Principal Sum
Hearing in one ear	2/3 Principal Sum
All toes of one foot	1/3 Principal Sum
One arm	Principal Sum
One leg	Principal Sum
One hand	Principal Sum
One foot	Principal Sum
Thumb and index finger	2/3 Principal Sum
Four fingers of one hand	2/3 Principal Sum

Loss of Use

One arm	Principal Sum
One leg	Principal Sum
One hand	Principal Sum
One foot	Principal Sum
Thumb and index finger	2/3 Principal Sum
Four fingers of one hand	2/3 Principal Sum
Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum

If you are a retiree under age 65, your AD&D insurance will not continue past the end of the day before the date you reach age 65.

AD&D Insurance will be continued without further premium payment during any period your Life Insurance is being continued under the waiver of premium benefit. Your insurance under this waiver of premium will terminate automatically when this benefit terminates.

Cosmetic Disfigurement Benefit

Canada Life will pay benefits if you suffer cosmetic disfigurement due to a 3rd degree burn as a result of an accident.

The amount payable is based on the percentage of the amount of insurance, as shown in the cosmetic burn schedule below, where the percentage is determined by the area classification factor times the percentage of body surface actually burned.

The maximum allowable percentage for body surface burned, as shown in the following cosmetic burn schedule, is based on 100% of the specific body part that was burned. Your attending physician will determine the actual percentage applicable to each burn.

Example:
Torso (front):if your AD&D benefit is $100,000 and your attending physician confirms the percentage allowable for your front torso burn is 18%, your benefit amount would be calculated as follows: 18% x 2 = 36% x $100,000 = $36,000.

If you suffer burns to more than one body part as a result of any one accident, benefits payable for all such burns will be limited to 100% of the Principal Sum specified in the Benefit Summary.

Cosmetic Burn Schedule

Body Part	**Area Classification Factor**
Neck, face, head	11
Hand and forearm (right)	5
Hand and forearm (left)	5
Upper arm (right)	3
Upper arm (left)	3
Torso (front)	2
Torso (back)	2
Thigh (right)	1
Thigh (left)	1
Lower leg – below knee (right)	3
Lower leg – below knee (left)	3

Body Part	Maximum Allowable Percentage for Body Surface Burned
Neck, face, head	9%
Hand and forearm (right)	4.5%
Hand and forearm (left)	4.5%
Upper arm (right)	4.5%
Upper arm (left)	4.5%
Torso (front)	18%
Torso (back)	18%
Thigh (right)	9%
Thigh (left)	9%
Lower leg – below knee (right)	9%
Lower leg – below knee (left)	9%

Body Part	Maximum Percentage of Amount of Insurance payable
Neck, face, head	99.9%
Hand and forearm (right)	22.5%
Hand and forearm (left)	22.5%
Upper arm (right)	13.5%
Upper arm (left)	13.5%
Torso (front)	36%
Torso (back)	36%
Thigh (right)	9%
Thigh (left)	9%
Lower leg – below knee (right)	27%
Lower leg – below knee (left)	27%

Repatriation Benefit

If you die as the result of an accident that is at least 50 kilometres away from your home, Canada Life will pay the reasonable and customary charges, excluding the cost of a coffin, for the preparation and transportation of your body to the place of burial or cremation. The amount payable is the actual expense incurred reduced by any amounts paid under this plan's global medical assistance benefit.

The amount payable under the Basic AD&D Benefit and the Optional AD&D insurance for repatriation may not exceed $20,000 per accident, per person.

Identification Benefit

If you die as a result of an accident and the police or similar governmental authority requires identification of your body, Canada Life will pay the reasonable and customary charges incurred by a member of your immediate family or a family representative, for hotel and transportation by the most direct route to the location of your body and return to their normal place of residence.

If personal transportation is used in lieu of public conveyance, expenses are limited to $0.35 per kilometer travelled.

Canada Life will pay up to a maximum of $15,000 for all expenses, provided that your body is located more than 150 kilometers from the immediate family or representative's residence.

Workplace Modification and Accommodation Benefit

If you require special adaptive equipment and/or workplace modification in order to accommodate your return to active full-time work with your employer as a result of a loss, Canada Life will pay the reasonable and customary charges incurred by your employer.

Canada Life will pay up to a maximum of $10,000 for any one accident provided:

- your employer agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and acceptable to your needs,
- your employer acknowledges in writing that the performance of the essential duties of your job may be altered,
- the proposed special adaptive equipment and/or workplace accommodation must have prior written approval by Canada Life
- Canada Life has the right to examine you to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to your employer upon your return to active full-time work and Canada Life has been provided written proof the expenses incurred.

No benefits will be paid when your employer does not incur any cost in providing the special adaptive equipment and/or workplace accommodation.

Family Transportation Benefit for Members

If you are hospitalized as a result of a covered loss for which benefits are payable under this benefit provision, Canada Life will pay the reasonable and customary charges for transportation and lodging expenses for immediate family members to join you if:

- the hospital is more than 100 kilometers from your home, and
- you are confined for at least 4 days as a result of an injury, and
- you are under the regular care of a physician

Canada Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's global medical assistance benefit up to a lifetime maximum of $10,000.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses by the most direct route to the hospital are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $0.35 per kilometer travelled.

Occupational Training Benefit

- **For a member:**

If you require training as a result of a loss, Canada Life will pay the reasonable and customary charges for expenses associated with your enrolment in an accredited occupational training program. The purpose of the training program must be to provide you with at least the minimum qualifications required for employment in an occupation for which you would not otherwise qualify.

Canada Life will pay up to a maximum of $20,000.

No benefits will be paid for expenses incurred more than 3 years after the accident resulting in a loss, or room or board or other ordinary living, travelling, or clothing expenses.

- **For a spouse:**

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

Canada Life will pay up to a maximum of $20,000.

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

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Canada Life will pay the reasonable and customary charges for tuition fees and related fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must satisfy one of the following conditions:

- must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death or;
- must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrolls as a full-time student at a post-secondary institution within 365 days after the accident

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

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

If you have no dependents eligible for the educational benefit, Canada Life will pay an additional $1,000 to the designated beneficiary.

Wheelchair Benefit

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

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

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

Canada Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's healthcare benefit, up to $20,000 for all home and vehicle modifications combined.

No benefits will be paid for expenses incurred more than 3 years after the accident and any subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

Hospital Confinement Benefit for Members

If benefits are payable under this benefit provision for a loss due to an injury which requires in-patient hospital confinement for 4 days or more, Canada Life will pay a daily hospital confinement benefit as long as:

- you are under the care of a legally licensed doctor of medicine; and
- the hospital confinement begins while you are covered.

A successive period of hospital confinement is considered a recurrence if it arises from the same loss and starts within 3 months after the previous confinement ends.

The amount payable is 1/30th of 1% of the Principal Sum for each day of confinement. Benefits are payable for a maximum of 365 days per accident, beginning on the first day of confinement. The maximum amount payable is $2,500 per month.

Your monthly benefit under this provision is reduced if the total of the monthly benefit and the income benefit you are entitled to receive under the optional long term disability income benefit exceeds 100% of your monthly earnings prior to the date of your disability. If it does, your monthly benefit is reduced by the amount in excess of 100%.

Daycare Benefit

If benefits are payable under this benefit provision for your death, Canada Life will pay for daycare expenses on behalf of your dependent children 12 years of age and under who are enrolled in a licensed daycare centre when the accident causing the loss occurs, or who enroll within 365 days after the accident.

The amount payable for each child each year is 5% of the Principal Sum, or $5,000, whichever is less to a maximum of 4 consecutive years.

If you have no dependents eligible for the daycare benefit, Canada Life will pay an additional $2,500 to the designated beneficiary.

Seat Belt Benefit

If benefits are payable under this benefit provision for a loss due to an injury that occurs while you are driving or riding in a motor vehicle, Canada Life will increase the Principal Sum by 25% to a maximum of $25,000 per accident, as long as all of the following conditions are met:

- you must have been wearing a properly fastened seat belt at the time of the accident.
- the driver at the time of the accident must have had a valid driver's license for the vehicle involved.
- the driver at the time of the accident must not have been intoxicated or under the influence of drugs, unless the drugs had been taken as prescribed by a physician. Intoxicated and under the influence of drugs are as defined by the jurisdiction in which the accident occurred.
- proof of seat belt use satisfactory to Canada Life must be given to Canada Life at the time a claim is made.

General Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment
- War, insurrection or voluntary participation in a riot
- Service, including part-time or temporary service, in the armed forces of any country

How to Make a Claim

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

DEPENDENT BASIC LIFE INSURANCE

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

- If you are an active member, or a retiree under age 65, you are automatically eligible for dependent life insurance if you are enrolled with family healthcare expense benefits. If you change your coverage to single healthcare expense benefits, your dependent life insurance will automatically terminate.

- If you live in Quebec and your spouse's or child's insurance terminates on or before your 65th birthday, your spouse or child may be eligible for an individual conversion policy without providing proof of insurability.

  If you live elsewhere in Canada and your spouse's insurance terminates on or before their 65th birthday, your spouse may be eligible for an individual conversion policy without providing proof of insurability.

  You or your spouse must apply for spouse or child insurance and pay the first premium no later than 31 days after the group insurance terminates. See your employer for confirmation of benefits and amounts that are eligible for conversion.

HEALTHCARE

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

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

Where coverage indicates a prescription drug or medical supply must be prescribed by a physician, a prescription by a Nurse Practitioner will also be accepted.

Covered Expenses

Ambulance

- Emergency transportation, including air ambulance, to the nearest centre where adequate treatment is available when provided by a licensed ambulance company

Hospital

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

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

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

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

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

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

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

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

  Limitation

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

Home Nursing Care

It is recommended that you apply for a pre-care assessment before home nursing begins.

- Canada Life covers home nursing care provided in Canada. Nursing care is care that:

  - requires the skills and training of a professional nurse; and
  - is provided by a professional nurse who is not a member of the patient's family.

  A professional nurse is:

  - a registered nurse;
  - a registered practical nurse, if the person is a resident of Ontario; or
  - a licensed practical nurse, if the person is a resident of any other province.

  Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be recognized in determining the level of skill needed.

  Nursing Foot Care is covered if there is localized illness, injury or symptoms involving the foot; and if it is provided by a professional nurse in the patient's home, for one hour, every 4 to 6 weeks.

  Chronic Care is covered if it starts while the person is insured under this benefit provision and it is provided in Canada. Chronic care is the management of a condition where significant improvement or deterioration is unlikely within the next 12 months.

Personal Care

- Services provided by an approved personal care worker when provided in Canada are covered to a maximum of 28 hours each week. When no active medical care is required, personal care services are limited to 3 consecutive months per disability. Personal care is care that:

  - requires the specific skills of a trained personal care worker,

  - is under the supervision of a health care professional; and

  - is provided by a personal care worker who is not a member of your family.

  You should apply for a pre-care assessment before Personal Care Services begins. A written referral by a physician must be provided in order to be eligible for Personal Care Services.

Prescription Drugs

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

  Covered Drugs

  Coverage is provided for most drugs and drug supplies which require a prescription according to:

  - the Food and Drugs Act, Canada; or
  - the provincial legislation in effect where the drug is dispensed.

- Interchangeable Drug Limitation

  Canada Life can limit the covered expense 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:

  - a generic equivalent of the brand name drug deemed to be interchangeable by law where the drug is dispensed; or
  - a subsequent entry biologic drug.

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

- Special Authorization Drug Coverage

  These drugs require prior approval from Canada Life where specific criteria for using these drugs must be met before the drug can be considered for reimbursement under the plan.

  A special authorization form must be completed by a physician and submitted to Canada Life. This can be done before the prescription is filled or submitted with receipts and a paper claim form.

  Some drugs eligible under the Special Authorization program do not require a form to be completed by a physician. If the appropriate prerequisite drug(s) has been tried then the Special Authorization drug will automatically be processed electronically at the pharmacy. This program is referred to as **Step Therapy**.

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

  Disclaimer: The Government of Newfoundland and Labrador, through a consultation process with Canada Life and drug experts, determines the drugs that are covered under the plan. There is no guarantee or obligation expressed or implied that all drugs recommended by physicians will be covered by the plan.

Medical Supplies

- Rental or, at Canada Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician or nurse practitioner entitled by law to prescribe them

- Custom-made foot orthotics when prescribed by a physician, podiatrist, chiropodist, or nurse practitioner, and stock-item and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician or nurse practitioner. The maximum covered expense is $200 in a calendar year.

- Wheelchairs, limited to one every 5 calendar years, including repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered. One wheelchair cushion is covered and limited to a maximum covered expense of $300 in a calendar year.

- Artificial eyes, including rebuilding and polishing of artificial eyes

- Standard artificial limbs, including repairs, stump socks, and shoulder harnesses

- Myoelectric arms, including repairs. Repair charges do not apply to the maximum shown in the Benefit Summary.

- Hearing aids, batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician, an otologist, otolaryngologist, ENT, audiologist or nurse practitioner. Repairs are not covered. No benefits will be paid for audiology services.

- Diabetic supplies including syringes, Novolin pens, testing supplies, insulin infusion sets and alcohol swabs, when prescribed by a physician or nurse practitioner

- External insulin infusion pumps and supplies when prescribed by a physician or nurse practitioner

- Wigs for cancer patients undergoing chemotherapy

- Incontinence supplies (Children under age 10 are not covered)

- Ultraviolet light therapy (P.U.V.A) for psoriasis when performed by a dermatologist

- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

Accidental Dental Treatment

- Treatment of accidental injury, a biting accident, or an eating accident to sound natural teeth. A treatment plan must be submitted or reported and approved by Canada Life within 6 months after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

  No benefits are paid for:

  - accidental damage to dentures

  - orthodontic diagnostic services or treatment

Paramedical Practitioners

- Out-of-hospital services of a qualified acupuncturist. The maximum covered expense is $500 each calendar year.

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor. The maximum covered expense is $500 each calendar year.

- Out-of-hospital services of a qualified massage therapist when referred by a physician. The maximum covered expense is $500 each calendar year.

- Out-of-hospital services of a licensed naturopath, including diagnostic x-rays. The maximum covered expense is $500 each calendar year.

- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays. The maximum covered expense is $500 each calendar year.

- Out-of-hospital treatment of movement disorders by a licensed physiotherapist or a qualified athletic therapist. The maximum covered expense for all treatment combined is $500 each calendar year.

- Out-of-hospital services of a qualified occupational therapist. The maximum covered expense is $500 each calendar year.

- Out-of-hospital treatment of foot disorders by a licensed podiatrist or qualified chiropodist, excluding surgery fees. Coverage also includes one diagnostic x-ray each calendar year by a licensed podiatrist. The maximum covered expense is $500 each calendar year.

- Out-of-hospital treatment by a registered psychologist or qualified social worker. The maximum covered expense is $500 each calendar year.

- Out-of-hospital treatment of speech impairments by a qualified speech therapist. The maximum covered expense is $500 each calendar year.

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan. The maximum covered expense is $70 in a calendar year for a dependent child under age 18 and $70 every 3 calendar years for any other person.

- Eyeglasses following non-refractive eye surgery are also covered, limited to a maximum covered expense of $200 per lifetime.

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician. The maximum covered expense:

    - $250 each calendar year for dependent children under age 18 with a change in prescription and $250 every 3 calendar years for any other person

- Contact lenses when prescribed by a licensed ophthalmologist for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, and if the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses. The maximum covered expense is $250 every 2 calendar years.

- Visual training and remedial therapy to correct faulty visual skills when performed by a licensed ophthalmologist or optometrist, one approved course of treatment per lifetime.

- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist. The maximum covered expense is $450 per lifetime.

Non-Emergency Medical Transportation in Canada

The plan will pay for the following expenses if you are referred away from home by a medical practitioner for non-emergency medical treatment by another physician within your own province or elsewhere in Canada and the distance travelled is at least 80 kilometres (one way) from the community in which you reside to the community where medical treatment will be provided.

Travelling expenses for the person requiring the treatment and one companion if recommended by the attending medical practitioner, to a maximum covered expense of $300 in a calendar year. The travelling companion must be the age of majority in the province where the person requiring treatment resides.

Benefits are limited to either round trip economy class travel by a commercial airline, train, or bus, or personal vehicle transportation. Taxicab, car rental charges and automobile repair charges are not covered. If personal transportation is used in lieu of public conveyance, a rate of $0.125 per kilometer will be paid.

No coverage is available for meal expenses, hotel accommodations or gas expenses.

No benefits will be paid for travel expenses associated with treatment that is not provided in a hospital, licensed medical facility, or licensed medical doctor's office.

Global Medical Assistance Program

Coverage Period: First 90 days after the date of departure from the patient's home.

This program provides coverage related to a medical emergency arising while you or your dependent is travelling for vacation, business or education.

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

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

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

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

- Transportation and lodging for one family member or a close friend joining a patient who has died or who has been hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings

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

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

- In case of death, preparation and transportation of the deceased home by the most direct route, up to a maximum of $3,000

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

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $500. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Limitation

Benefits payable for moderate quality accommodation for the area of hospitalization. Meal expenses are included. The maximum covered expense for lodging and meal expenses is $100 per day to a maximum of 7 days, limited to $700 for each confinement.

No benefits will be paid for expenses incurred more than 90 days after the date of departure from the patient’s

Out-Of-Country Care

Emergency care

Coverage Period: First 30 days after your date of departure from Canada.

Emergency care outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes.

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

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

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

Expenses related to a pre-existing condition will only be considered if the pre-existing condition has been stable for 3 months prior to travelling. Stable means that there has been no period of hospitalization, no increase or modification in treatment or prescribed medication, or no symptom for which a reasonably prudent person would consult a physician. Stable dosage does not apply for a diabetic.

Limitations

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

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

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

No benefits are paid for:

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

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

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

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

- expenses incurred more than 30 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 30-day period, benefits will be extended to the end of the confinement. You are required to return to your province of residence for a minimum of 48 hours before your coverage period will begin again.

Extension of Coverage

You are eligible to extend your Out-of-Country Emergency Care (including your Global Medical Assistance) coverage for an additional 7, 15 or 30 days. You must purchase the additional coverage prior to the end of your Out-of-Country Emergency Care benefit period. For more information, contact Individual Health Services at 1-800-565-4066 during regular business hours.

Non-emergency care

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

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

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

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

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

Limitations

No benefits will be paid for:

- investigational or experimental treatment

- transportation or accommodation charges.

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

- treatment by a physician

- diagnostic x-ray and laboratory services

- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered

- medical supplies provided during a covered hospital confinement

- paramedical services for treatment by a chiropractor, osteopath, podiatrist and physiotherapist

- hospital out-patient services and supplies

- wheelchairs, crutches and canes

- medical supplies provided out-of-hospital if they would have been covered in Canada

- drugs

- out-of-hospital services of a professional nurse

- for emergency care only:

    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada to a maximum of $1,000 for each accident. Treatment must be reported or start within 180 days of the accident and be supported by proper certification

Other Services and Supplies

Canada Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment, unless advised otherwise by the Government of Newfoundland.

General Healthcare Limitations

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

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

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

- Expenses private insurers are not permitted to cover by law

- Services or supplies for which a charge is made only because you have insurance coverage

- Any expense if you are not covered under your provincial or territorial or government healthcare plan

- The portion of the expense for services or supplies that is payable by the government health plan in your home province

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

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:

  - treatment performed only for cosmetic purposes

  - recreation or sports rather than with other daily living activities

  - the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision

  - contraception, other than contraceptive drugs and products containing a contraceptive drug

- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Canada Life to be a covered service or supply

- Extra medical supplies that are spares or alternates

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

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

  This limitation does not apply to Global Medical Assistance

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

- Chronic care

- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid

- Visioncare services and supplies required by an employer as a condition of employment

- Prescription sunglasses and safety glasses

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances normally used for contraception
- Contact lens care products
- Lozenges, cough and cold preparations
- Any single purchase of drugs which would not reasonably be used within 100 days
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Preventative immunization vaccines and toxoids
- Smoking cessation products
- Drugs used to treat erectile dysfunction
- Anti-obesity drugs
- Sclerosing injected drugs
- Drugs or drug supplies that are not listed in the GNL Formulary

- Drugs or drug supplies that appear on the Government of Newfoundland & Labrador Drug EXCLUSION LIST (aka, GNL EXCLUSION LIST) maintained by Canada Life, even where a drug or drug supply is otherwise listed in the GNL Formulary. The GNL EXCLUSION LIST may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. A drug or drug supply may be added or removed from the GNL EXCLUSION LIST at any time

  For greater certainty, a drug or drug supply may be added to the GNL EXCLUSION LIST for any reason including, but not limited to, the following:

  a) where its determined that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or
  b) where its determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

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

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

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

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

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

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

Prior Authorization

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

Lower Cost Alternative

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

Health Case Management

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

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

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

The following six (6) conditions have been identified by Canada Life for Health Case Management; Asthma, Ankylosing Spondylitis, Crohn's Disease, Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis. Note: these conditions are subject to change as deemed appropriate by Canada Life.

Health Case Management Limitation

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

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

Health Case Management Expense Benefit

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

Patient Assistance Program

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

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

How to Make a Claim

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

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

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

  Be sure to keep original receipts for your own records.

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

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

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

- **All Other Healthcare Claims**

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

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

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

  Paper claims: For claim submissions older than 12 months or for all paper claim submissions, access www.mycanadalifeatwork.com to obtain a personalized claim form, or obtain form M635D from your employer. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 24 months after you incur the expense..

- **Drug claims**

  You will be provided with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

OPTIONAL DENTALCARE

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits will be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

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

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

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

Treatment Plan

- Before incurring any large dental expenses in excess of $500, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to Canada Life. (The dental service provider who submits the treatment plan must be the same provider who will be providing the service). Canada Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

Treatment performed for a COSMETIC PURPOSE is not covered for any service provided.

Basic Coverage The following expenses will be covered:	
Diagnostic Services	
Examinations	
Complete oral examination	Once every 36 months
Oral pathology, periodontal, surgical, prosthodontic and endodontic examinations	Included
Limited oral examinations	Once every 5 months for a dependent child between the ages 13 to 17 and once every calendar year for any other person
Limited periodontal examinations:	Once every 5 months for a dependent child between the ages 13 to 17 and once every calendar year for any other person
Specific and emergency examinations	Included
Stomatognathic dysfunction examinations	Included
Mixed dentition analysis	Once in a person's lifetime
Orthodontic examinations	Included
Orthodontic diagnostic casts, equilibration diagnostic casts, diagnostic wax-up, diagnostic split cast mounting	Included
X-rays	
Complete series of intra-oral x-rays	Once every 36 months
Periapical x-rays	Included
Tomography x-rays	Included
Occlusal intra-oral x-rays	4 films every 5 months
Bitewing intra-oral x-rays	4 films every 5 months
Other intra-oral x-rays	15 films every 36 months. Services provided in the same 12 months as a complete series are not covered
Temporomandibular joint (tmj) x-rays	4 films every 12 months
Cephalometric x-rays	5 every 24 months
Hand and wrist x-rays	Included
Diagnostic photographs	Included
Sialography	Included
Extra-oral x-rays (other than panoramic and sialography)	4 films every 5 months
Panoramic x-ray	Once every 12 months
Radiopaque dyes used to demonstrate lesions	Included
Interpretation of radiographs or models from another source	Included

Tests and Laboratory Reports	
Microbiological, histological, cytological and pulp vitality tests	Included
Laboratory reports	Included
Diagnostic casts	Included
Treatment planning	Included
Consultation	
Consultation with the patient	Included

Preventive Services	
A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval	
Polishing, Scaling and Fluoride	
Polishing	Once every 5 months for a dependent child between the ages 13 to 17 Once every calendar year for any other person
Scaling	Combined with periodontal root planing of 12 time units every calendar year
Topical application of fluoride	Once every 5 months for a dependent child between the ages 13 to 17 Once every calendar year for any other person
Fluoride supervised brush-in and fluoride custom appliances	Included
Oral Hygiene Instruction	
Oral hygiene instruction	Once in a person's lifetime
Sealants	
Pit and fissure sealants on bicuspids and permanent molars	Once every 5 years
Space Maintainers	
Space maintainers. Acid etched pontic type space maintainers are covered only when provided for missing central and lateral teeth	Included
Maintenance of space maintainers	Included
Mouthguards	
Mouthguards	Once every 12 months

Other Services	
Appliances for the control of harmful habits, including related observations, adjustments, repairs, alterations and removal	Included
Finishing restorations	Included
Interproximal disking	Included
Recontouring of teeth	Included
Nutritional counselling	Included

Minor Restorative Services	
Caries, trauma, and pain control	Included
Amalgam and tooth-coloured fillings	Included Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
Retentive pins and prefabricated posts for fillings	Included
Removal of previously placed posts	Included
Prefabricated crowns for primary teeth	Included
Prefabricated restorations for permanent teeth	Included
Tooth-coloured and lab processed veneer applications	Included
Porcelain staining	Included
Recontouring of existing crowns and natural teeth for aesthetic reasons	Included
Repairs to inlays, onlays and crowns	Included
Removal, rebonding and recementation of inlays, onlays, crowns and tooth-coloured veneers	Included
Direct overdentures restorative procedures	Included
Cores	Included
Veneers	Included Replacement veneers are covered when the existing restoration is at least 5 years old and cannot be made serviceable

Endodontic Services	
Root Canal Therapy	
Treatment of the pulp chamber	Included
Root canal therapy for permanent teeth	One course of treatment per tooth in a person's lifetime
Apexification	Included
Periapical services	Included Apicoectomies are covered for permanent teeth only
Isolation of teeth	Included
Enlargement of pulp chambers	Included
Endosseous intra coronal implants	Included
Bleaching of endodontically treated teeth	Included

Periodontal Services	
A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval	
Root planing	Combined with preventive scaling of 12 time units every calendar year
Periodontal surgery	Included
Occlusal adjustment and equilibration	Combined maximum of 4 time units every 12 months
Periodontal appliance (Including adjustments, relines and repairs)	One upper and one lower appliance every 24 months
Subgingival periodontal irrigation	Included
Charges for post surgical treatment	Included
Periodontal re-evaluation	Included
Desensitization	Included
Topical application of antimicrobial agents	Included
Temporomandibular joint disorder appliances (TMJ)	One upper and one lower appliance every 24 months
Myofacial pain syndrome appliances	One upper appliance every 24 months

Denture and Bridgework Maintenance	
Denture	
Denture relines	Once every 24 months
Denture rebases	Once every 24 months
Resilient liner in relined or rebased dentures	Included
Denture adjustments after the 3-month post-insertion care period has elapsed	Included
Denture repairs, tissue conditioning and resetting of denture teeth	Included
Denture remakes	Once every 24 months
Denture cleaning and polishing	Included
Recontouring of retainers or pontics	Included
Duplicate dentures	Included
Bridgework	
Repairs to covered bridgework	Included
Removal and recementation of bridgework	Included
Oral Surgery	
Removal of teeth	Included
Surgical enucliation	Included
Transplantation of erupted or unerupted teeth	Included
Surgical exposure and movement of teeth	Included
Frenectomy	Included
Antral Surgery	
Remodelling and recontouring oral tissues such as minor alveoloplasty, gingivoplasty and stomatoplasty	Included
Surgical excision of cysts and granulomas	Included
Surgical incisions	Included
Sequestrectomy	Included

Adjunctive Services	
Minor remedies for relief of dental pain when provided on an emergency basis	Included
Therapeutic injections	Included
Anaesthesia required in relation to covered services	Included The provision of general aesthetic facilities, equipment and supplies is covered only when a separate anaesthetist is required

Major Coverage The following expenses will be covered:	
Crowns, Inlays and Onlays	
Crowns and Onlays are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures	
Metal, plastic, porcelain and ceramic crowns.	Coverage for crowns on molars is limited to the cost of metal crowns and coverage for complicated crowns is limited to the cost of standard crowns
Inlays and Onlays	Coverage for tooth-coloured onlays and inlays on molars is limited to the cost of metal inlays and onlays
Posts and pins related to covered crowns	Included
Copings related to covered crowns	Included
Repairs to covered tooth-coloured materials	Included
Replacements	
Replacement inlays, onlays and crowns	Covered when the existing restoration is at least 5 years old and cannot be made serviceable
Dentures and Bridgework	
Standard complete dentures	Included
Standard cast or acrylic partial dentures	Included
Complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options	Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics.
Equilibrated and gnathological dentures	Included
Dentures with stress breaker, precision and semi-precision attachments	Included
Complete and partial overdentures	
Dentures related to implants	Included
Replacement appliances are covered only when: - the existing appliance is a covered temporary appliance - the existing appliance is at least **5 years old** and cannot be made serviceable. If the existing appliance is less than **5 years old**, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth	

Denture Related Surgery	
Augmentation of the alveolar bone	Included
Reconstruction of the alveolar ridge	Included
Related surgical grafts	Included
Surgical movement of teeth	Included

General Limitations

If you do not apply for dentalcare coverage within 31 days after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic and Major Coverage expenses are limited to $100, per person in a family, during the first 12 months of your coverage

No benefits are paid for:

- Duplicate x-rays and audio-visual oral hygiene instruction

- The following endodontic services - root canal therapy for primary teeth, intentional removal of tooth, apical filling and replantation, pulp mummification

- The following oral surgery services – malignant tumor surgical excisions, cheiloplasty, prosthetic augmentations of the jaw, treatment of fractures including related bone grafts to the jaw, treatment of maxillofacial deformities, including related bone grafts to the jaw, treatment of the salivary glands, mandibulectomy, maxillectomy, implantology, services performed to remodel or recontour oral tissues (other than those listed above) and alveoplasty performed in conjunction with extractions

  Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

- The following adjunctive services – treatment of neurological disturbances, emergency office procedures, treatment of muscular disorders and intramuscular injections of sedative drugs.

- Veneers, except as provided under your Basic Coverage

- Inlays, except as provided under the alternative benefit provision

- The following denture-related surgery services - remodelling of the floor of the mouth, vestibuloplasty, extensions of mucous folds

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

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

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

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

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

- Expenses covered under another group plan's extension of benefits provision

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

- Expenses private plans are not permitted to cover by law

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

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

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

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain (except as provided under Basic Coverage)

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

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

- **For all other Dentalcare claims**, access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 24 months after the dental treatment.

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance, you may be required to provide proof of insurability as described in the Benefit Summary, and the application must be approved by Canada Life. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If your spouse dies you will be paid the amount for which your spouse was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your spouse will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your employer for confirmation of benefits and amounts that are eligible for conversion.

- If you are a retiree under age 65, your optional life insurance will not continue past the end of the day before the date you reach age 65. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever comes first.

  If you are an active member, your optional life insurance will not continue past the end of the day before the date you reach age 75. Your spouse’s coverage will not continue past the end of the day before the date you or your spouse reaches age 75, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received.

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

Optional Accidental Death, Dismemberment and Specific Loss Insurance allows you to choose additional coverage. It also allows you to cover your dependents. Check the **Benefit Summary** for the amount of Optional AD&D available to you and your dependents.

If you elect Optional Accidental Death, Dismemberment and Specific Loss benefits, the total principal sum is the sum of your basic and optional amounts.

In addition to all benefits available under your Basic AD&D coverage you will also have the following benefits under your Optional AD&D coverage:

Child Enhancement Benefit

With the exception of loss of life, all amounts of optional accidental death, dismemberment and specific loss benefits payable in accordance with the Schedule of Losses are doubled with respect to your dependent child, provided your child remains alive for at least 90 days after the date of the accident.

Escalation Benefit

For optional accidental death, dismemberment and specific loss benefits only, the amount payable will be recalculated on each anniversary date of this policy, and annually after that, for a maximum of 5 years. On those dates, Canada Life will increase the amount of insurance by 3%. The amount of such increase will not form part of your amount of insurance when calculating subsequent increases under this provision.

Common Disaster

For optional accidental death, dismemberment and specific loss benefits only, if death as a result of the same accident occurs for both you and your spouse, within 90 days of the accident, the amount payable for your spouse will be equal to the Principal Sum payable for you.

Funeral Expense Benefit

If you die as a result of an accident, Canada Life will pay the reasonable and customary charges incurred at the time of your death for the following expenses:

- the services and/ or materials provided by a mortician, undertaker, crematorium or funeral home, related to the burial or cremation of a deceased,
- charges for the purchase of burial plot, gravesite or mausoleum for the interment of the remains thereof, and
- any markers or monuments

Canada Life will pay up to a maximum of $5,000, less any charges for preparation of the remains which are reimbursed under the repatriation provision.

Business Venture Benefit for Members

If benefits are payable under this benefit provision for a loss due to an injury that results in your disability, Canada Life will pay for initial business costs associated with your development of a new business enterprise in Canada. To qualify for a business venture benefit, all of the following conditions must be met:

- the initial business costs must be incurred after the disability starts and before the end of the second year of disability,
- the disability must start within one year after the accident and continue for a period of at least one year,
- proof of disability satisfactory to Canada Life must be given to Canada Life during the first year of disability, and
- you must submit a business plan satisfactory to Canada Life before the end of the first year of disability.

Canada Life will pay up to 20% of the Principal Sum, or $50,000, whichever is less.

If you operate your business in a partnership or under an agreement where facilities are shared by more than one person, the initial business costs will include only your share.

Weekly Benefit for Members

If you become disabled as a result of an accident, Canada Life will pay $150 each week, up to a maximum period of 26 weeks, provided:

- disability begins within 30 days of the date of the accident, and
- disability has continued for a period of 7 days, remains continuous and prevents you from performing any and all regular household and/or child-caring duties, and
- you are under the regular care of the attending physician.

One seventh of the income benefit is payable for each day of any period less than a full week.

Extended Family Benefit

If you die as a result of an accident and an amount is payable for a loss of life under this benefit, insurance for the specified losses will continue for insured dependents, without payment of premium, for a period of 6 months following your death.

Termination

- If you are a retiree under age 65, your optional AD&D insurance terminates when you reach age 65. Your dependent's optional AD&D insurance terminates when they reach age 65, when you reach age 65, or when he or she is no longer an eligible dependent, whichever comes first.

  If you are an active member, your optional AD&D insurance terminates when you reach age 75. Your dependent's optional AD&D insurance terminates when they reach age 75, when you reach age 75, or when he or she is no longer an eligible dependent, whichever comes first.

General Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment
- War, insurrection or participation in a riot
- Service, including part-time or temporary service, in the armed forces of any country

How to Make a Claim

- To claim benefits, ask your employer for a claim form. Complete it and return it to your employer.
- If you die accidentally, your employer will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 120 days after the loss.

OPTIONAL CRITICAL ILLNESS INSURANCE
Retirees are not eligible for this benefit

If you or your dependents are diagnosed with one of the illnesses defined below while insured, Canada Life will pay you the optional critical illness insurance benefit. Where a survival period is specified for a condition below, Canada Life will not pay the benefit until the end of the survival period. In addition to this benefit, provided it is $10,000 or more, Canada Life will make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for this optional benefit, you will be required to provide proof of insurability satisfactory to Canada Life. Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person. However, if you have family critical illness coverage you may maintain this coverage for other family members by continuing to pay family critical illness premiums.

Your optional critical illness insurance and your child's optional critical illness insurance will not continue past the end of the day before the date you reach age 65. Spouse coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever is earlier.

Covered Illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a specialist as defined by the policy. The specialist must not be the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

The diagnosis must be supported by objective medical evidence.

Heart Attack

"Heart Attack" means the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Limitations

No benefits will be paid under this condition for:

- elevated biochemical cardiac markers after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Stroke

"Stroke" means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Limitations

No benefits will be paid under this condition for:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Coronary Artery Bypass Surgery

“Coronary Artery Bypass Surgery" means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Cancer (Life-Threatening)

"Cancer (Life-Threatening)" means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

Limitations

No benefits will be paid under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

The term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer Exclusion Period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

Kidney Failure

"Kidney Failure" means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Blindness

"Blindness" means the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

Major Organ Transplant

"Major Organ Transplant" means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

Dementia, Including Alzheimer's Disease

"Dementia, Including Alzheimer's Disease" means dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive deterioration in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

Limitations

No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

"Parkinson's Disease" means primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

- muscular rigidity; or
- rest tremor.

The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

"Specified Atypical Parkinsonian Disorders" mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Limitation

No benefits will be paid under this condition for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Paralysis

"Paralysis" means total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Multiple Sclerosis

"Multiple Sclerosis" means at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Deafness

"Deafness" means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3000 hertz.

Loss of Speech

"Loss of Speech" means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

Limitation

No benefits will be paid under this condition for all psychiatric related causes.

Coma

"Coma" means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

Limitation

No benefits will be paid under this condition for a medically induced coma.

Severe Burns

"Severe Burns" means third degree burns over at least 20% of the body surface.

Aortic Surgery

"Aortic Surgery" means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Benign Brain Tumour

"Benign Brain Tumour" means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

Limitation

No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

Benign brain tumour exclusion period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Heart Valve Replacement or Repair

"Heart Valve Replacement or Repair" means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

The benefit is payable after a survival period of 30 days following the date of surgery.

Loss of Independent Existence

"Loss of Independent Existence" means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;

- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs

"Loss of Limbs" means the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

Motor Neuron Disease

"Motor Neuron Disease" means one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

Occupational HIV Infection

"Occupational HIV Infection" means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person’s effective date of insurance or, for an increase, the effective date of the increase.

Payment under this condition requires satisfaction of all the following:

- the accidental injury must be reported to Canada Life within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

Limitations

No benefits will be paid under this condition if:

- the person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to the accidental injury.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

Bacterial Meningitis

"Bacterial Meningitis" means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

Limitation

No benefits will be paid under this condition for viral meningitis.

Aplastic Anaemia

"Aplastic Anaemia" – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

General Limitations

No benefits are paid for a critical illness resulting directly or indirectly from or associated with any of the following:

- intentionally self-inflicted injury or attempt at suicide, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions
- war, insurrection or voluntary participation in a riot
- participation in a criminal offence or provoking an assault
- use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
- operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

How to Make a Claim

- To claim benefits, obtain a claim form at the Canada Life website **www.canadalife.com**. Complete it and return it to the address shown on the form.

- Claims should be submitted as soon as possible, but no later than 3 months after the earlier of:

    - the end of the critical illness survival period, where applicable; or
    - the date the plan terminates.

OPTIONAL LONG TERM DISABILITY (LTD) INCOME BENEFITS
Retirees are not eligible for this benefit

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled as defined by the policy, the date you retire unless your retirement results in you receiving an award of a medical disablity pension, or the date you reach age 65, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period except that an interruption longer than 2 weeks will nullify all days accumulated and the disabilities that arose from the same disease or injury.

- LTD benefits are payable for the first 12 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, **and**, except for any employment under an approved rehabilitation plan, you are **not** employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the **Benefit Summary**.

- After 12 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job.

  Gainful employment means work:

  - you are medically able to perform,
  - for which you have at least the minimum qualifications,
  - which provides you with an income of at least 60% of your monthly earnings before you became disabled, and
  - that exists either in the province or territory where you worked when you became disabled or where you currently live.

- Loss of any license required for work will not be considered in assessing disability.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

- Because you pay the entire cost of LTD coverage, benefits will be payable to you on a tax-free basis.

- Your LTD enrollment terminates when you reach age 65 or when you retire, whichever is earlier.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan
- benefits under any Workers' Compensation Act or similar law
- loss of income benefits under an automobile insurance plan, to the extent permitted by law
- pension benefits due to disability from the Public Service Pension Plan, Uniformed Services Pension Plan or Members of the House of Assembly Pension Plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan
- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability
- the wage loss portion of any criminal injury award
- disability benefits under a plan of insurance available through an association
- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

The balance of any earnings received from an approved rehabilitation plan is not used to further reduce your LTD benefit unless that balance, together with your income from this plan and the other income listed above, would exceed your monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

If other income has not been awarded or received, Canada Life will have the right to estimate it according to the terms of any plans or legislation involved.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Vocational Rehabilitation

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Canada Life. In considering whether to recommend or approve a rehabilitation plan, Canada Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination

Medical coordination is a program, recommended or approved by Canada Life, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Canada Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

General Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 6 months ending on or after the date your insurance took effect.

- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

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

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

- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Canada Life.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- Any period after you fail to participate or cooperate in a required medical or vocational assessment.

- The scheduled duration of a leave of absence.

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

- Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Canada Life pre-authorized the absence prior to your departure.

- Any period of incarceration, confinement, or imprisonment by authority of law.

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

Claim Notification

To permit prompt assessment, initial notice of a long term disability income claim must be submitted to Canada Life no later than 10 months after disability starts. See your employer for more details.

Proof of Claim

You must then submit proof of claim to Canada Life within 3 months from the date the initial notice of your claim was received.

How to Make a Claim

- To submit claims online, go to www.canadalife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions.

  You can get this form from your employer, or online from the Canada Life corporate website. To access the form online, go to www.canadalife.com.

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job or become self-employed, and you must start your new job or become self employed no later than 6 months after you leave your present one. Your application must be acceptable according to Canada Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your employer for confirmation of benefits and amounts that are eligible for conversion.