My group benefit plan

canada life™

MARITIME RESIDENT DOCTORS

All Members/Residents of
Maritime Resident Doctors

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

BENEFIT DETAILS

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

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

GroupNet for Plan Members

As a Canada Life plan member, you can register for GroupNet™ for Plan Members at www.canadalife.com or on the GroupNet Mobile app. To register, click “Sign in”. From there, click “GroupNet for plan members”, then follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

With GroupNet and GroupNet Mobile you can:

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

Canada Life’s Toll-Free Number

To contact a customer service representative at Canada Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777.
- for assistance with your Health Care Spending Account or your Taxable Wellness Spending Account, please call 1-877-883-7072.

Customer complaints

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

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

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

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

The information provided in the booklet is intended to summarize the provisions of Group Policy No. 178635 and Plan Document No. 50809. If there are variations between the information in the booklet and the provisions of the policy or plan document, the policy or plan document will prevail to the extent permitted by law.

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: July 15, 2021

Access to Documents

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

Legal Actions

Insured benefits

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

Non-insured benefits

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

Appeals

Insured benefits

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

Non-insured benefits

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

Benefit Limitation for Overpayment

Insured benefits

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

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer’s right to use other legal means to recover the overpayment.

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

For insured benefits, the employer's role is limited to providing employees with information and not advice.

Protecting Your Personal Information

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

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment

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

Your employer has an agreement with Canada Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Notice of Liability for Benefits

Your employer has entered into an agreement with The Canada Life Assurance Company whereby the Taxable Wellness Spending Account outlined in this booklet is uninsured and your employer has liability for it.

This means that the Taxable Wellness Spending Account is:

- an unsecured financial obligation and are payable from your employer's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts your employer from the requirements under the Financial Institutions Act (British Columbia).

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

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Benefit Summary

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

A policy year is July 1 to June 30.

Life Insurance	$100,000 Insurance will reduce to the following amounts at: Age 61: $94,000 Age 62: $86,000 Age 63: $80,000 Age 64: $74,000 Age 65: $66,000 Age 66: $64,000 Age 67: $60,000 Age 68: $56,000 Age 69: $54,000
Long Term Disability Income Benefits	
Waiting Period	90 days
Amount	66.7% of your monthly earnings to a maximum benefit of $10,000

Healthcare

Covered expenses will not exceed customary charges

Deductibles

In-Canada Prescription Drug Expenses	
- Diabetic Supplies	Nil
- All Other Drug Expenses	20% of the total cost of each prescription to a maximum of $25 per perscription
All Other Expenses	Nil

Reimbursement Levels

Out-of-Country Expenses	
- Non-Emergency Care	50%
- Emergency Care	100%
All Other Expenses	100%

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	$10,000 each policy year
In-Canada Prescription Drugs	Included
Fertility Drugs	$15,000 lifetime
Hearing Aids	$600 every 3 policy years
Insulin Infusion Pumps	1 pump every 5 years
Insulin Jet Injectors	1 in a lifetime to a maximum of $1,000
Orthopedic Shoes	
- Custom-made Shoes	1 pair each policy year
- Custom-fitted Shoes	$150 each policy year
Custom-made Foot Orthotics	$400 every 3 policy years
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 each policy year
Breast Pumps	once every 4 policy years to a maximum of $500
Surgical Brassieres	4 each policy year

Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 policy years
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of $2,000
Blood-glucose Monitoring Machines	1 every 4 policy years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each policy year
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500
Custom-made Compression Hose	4 pairs each policy year
Wigs and Hairpieces	$250 lifetime

Paramedical Expense Maximums

Acupuncturists, Athletic Therapists/ Physiotherapists, Audiologists, Chiropractors, Dieticians, Massage Therapists, Naturopaths, Occupational Therapists, Osteopaths, Podiatrists/Chiropodists and Speech Therapists	$1,000 per practitioner each policy year to a maximum of $1,500 each policy year for all practitioners combined
Psychologists/Social Workers/ Registered Counselling Therapists/ Marriage and Family Therapists	$2,500 combined each policy year

Visioncare Expense Maximums

Eye Examinations	1 each policy year
Glasses, Contact Lenses and Laser Eye Surgery	
- dependent children under age 18	$250 combined each policy year
- all others	$250 combined every 2 policy years
Contact Lenses for Special Conditions	
- dependent children under age 18	$200 each policy year
- all others	$200 every 2 policy years
Visual Training and Remedial Therapy	$200 lifetime
Occupational Glasses*	$250 every 2 policy years

* Occupational glasses are covered for members only

Out-of-Country Care Expense Maximums	
Emergency Care	Included
Non-Emergency Care	$3,000 every 3 policy years
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered. Specialists' charges are limited to general practitioner fees.
Deductible	Nil
Reimbursement Levels	
Basic Coverage	80%
Major Coverage	50%
Plan Maximum	$1,500 each policy year

Health Care Spending Account Benefits (HSCA)	See benefit description
Taxable Wellness Spending Account	See benefit description

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your employment begins if you are:

- a member under the Dalhousie Medical Education Program;
- a member of Maritime Resident Doctors;
- directly employed by the employer on a permanent and full-time basis;
- compensated for services by the employer;
- residing in Canada

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

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Canada Life, you and your dependents may be required to provide evidence of insurability acceptable to Canada Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

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

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- Temporary, part-time and seasonal members may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the policy terminates, whichever is earliest.

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

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your plan administrator for details.

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

Survivor Benefits

If you die while your coverage is still in force, the healthcare, dentalcare and health care spending account benefits for your dependents will be continued for a period of 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

- Your unmarried children under age 22, or under age 25 if they are full-time students.

  Children under age 22 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 22, or while they are students under 25, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your plan sponsor'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 plan administrator.

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 plan administrator will explain the claim requirements to your beneficiary.

- Your life insurance will not continue past the end of the day before the date you reach age 70.

- If you become disabled while insured, Canada Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

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

LONG TERM DISABILITY (LTD) INCOME BENEFITS

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** or 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 as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

- LTD benefits are payable for the first 60 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 60 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 60% of your indexed monthly earnings before you became disabled.

- 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 your employer contributes to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance will not continue past the end of the day before the date you reach age 65.

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

- employer sponsored short term disability or sick leave benefits

- 50% of earnings received from an approved rehabilitation plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 100% of your indexed monthly earnings 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 (excluding the Ontario Medical Association Plan)

- 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, or individual disability income insurance (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 indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

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.

Inflation Protection

One year after the start of your benefit period and annually after that, the then current amount payable will be adjusted to reflect increases in the Consumer Price Index, to a maximum increase of 3% in any year.

Post-Disability Earnings Protection

You are entitled to a post-disability earnings protection benefit of 20% of your insured earnings if your disability period ends after you have been entitled to LTD benefits for at least 60 months, and your disability prevents you from being fully employed. Full employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides income at least equal to your monthly earnings before you became disabled.

- Post-disability earnings protection benefits continue until you are no longer prevented from being fully employed, but not longer than 5 years or until you reach age 65, whichever comes first.

- The post-disability earnings protection benefit is reduced if the total of it, plus the income listed under the "Other Income" section of this booklet, exceeds your indexed monthly earnings before you became disabled. If it does, your post-disability earnings protection benefit is reduced by the excess amount.

No post-disability earnings protection benefits are paid for:

- Any period in which you are not gainfully employed or actively looking for gainful employment.

- Any period of disability considered part of a previous period of disability.

- Any period in which you receive retirement income under a retirement plan to which your employer has contributed.

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 90 days 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.

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 plan administrator, or online from the Canada Life corporate website. To access the form online, go to www.canadalife.com.

Please ensure that your claim is submitted to Canada Life as soon as possible, but no later than 3 months after proof of your claim has been requested.

HEALTHCARE

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

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

Your healthcare coverage will not continue past the end of the day before the date you reach age 65, unless otherwise required by law.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available

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

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

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

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

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

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

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

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

  Limitation

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

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

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

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

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

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

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

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

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

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

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

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

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician

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

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

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

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

- External insulin infusion pumps prescribed by a physician

- Needleless insulin jet injectors prescribed by a physician

- 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

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

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

  Limitations

  No benefits are paid for:

  - accidental damage to dentures
  - dental treatment completed more than 12 months after the accident
  - orthodontic diagnostic services or treatment

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital services of a qualified athletic therapist
- Out-of-hospital services of a qualified audiologist
- Out-of-hospital services of a qualified chiropodist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital treatment of nutritional disorders by a registered dietician
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a qualified occupational therapist

- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays

- Out-of-hospital treatment of movement disorders by a licensed physiotherapist

- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist

- Out-of-hospital treatment by a registered psychologist, qualified social worker, registered counselling therapist or marriage and family therapist

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

Visioncare

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

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

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

- Visual training and remedial therapy to correct faulty visual skills when performed by a licensed ophthalmologist or optometrist

Global Medical Assistance Program

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

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

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

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

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

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

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

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

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

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

  Limitation

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

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

Limitation

Meal expenses are not covered.

Out-Of-Country Care

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

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

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

  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.

  Limitations

  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.

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

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

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

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

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

    Limitations

    No benefits will be paid for:

    - investigational or experimental treatment

    - transportation or accommodation charges.

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

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

Other Services and Supplies

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

Limitations

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

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

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
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - 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
- Visioncare services and supplies required by an employer as a condition of employment

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

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

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

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

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

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

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment

- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices

- Delivery or extension devices for inhaled medications

- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions

- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances

- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada

- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

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

- Non-injectable allergy extracts

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

- Drugs used to treat erectile dysfunction

Prior Authorization

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

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

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

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

Health Case Management

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

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

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

Health Case Management Limitation

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

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

Health Case Management Expense Benefit

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

Designated Provider Limitation

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

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

Patient Assistance Program

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

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

How to Make a Claim

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

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your plan adminstrator. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

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

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

- **You may submit all Healthcare claims online**. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 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.

- **We also accept paper claims for all Healthcare expenses.** Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your plan adminstrator. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

- **For drug claims**, your plan administrator will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

DENTALCARE

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

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. 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's charges are limited to general practitioner fees.

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.

Your dentalcare coverage will not continue past the end of the day before the date you reach age 65.

Treatment Plan

- Before incurring any large dental expenses, ask your dental service provider to complete a treatment plan and submit it to Canada Life. 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.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination every 24 months
  - limited oral examinations twice each policy year, except that only one limited oral examination is covered in any policy year period that a complete oral examination is also performed
  - limited periodontal examinations twice each policy year
  - complete series of x-rays once every 24 months
  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing and topical application of fluoride each twice each policy year
  - scaling, limited to a maximum combined with periodontal root planing of 16 time units each policy year

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

- finishing restorations
- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 12 months old. The existing filling must be replaced due to significant breakdown or a recurrent decay, or the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth plus one re-treatment per tooth per lifetime. Repeat treatment is covered only if the original treatment fails after the first 12 months
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 16 time units each policy year
  - occlusal adjustment and equilibration, limited to a combined maximum of 8 time units each policy year

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 36 months
    - denture rebases for dentures at least 2 years old, once every 36 months
    - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
    - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
    - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- Oral surgery
- Adjunctive services

Major Coverage

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

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

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues

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

  - denture remakes, once every 36 months

  - tissue conditioning

  - repairs to covered bridgework

  - removal and recementation of bridgework

Limitations

If you do not apply for dentalcare coverage within one month after you become eligible, benefits will be subject to the following restrictions:

- Basic Coverage expenses are limited to $100 during the first 12 months of your coverage

- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage

No benefits are paid for:

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

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

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

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

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

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

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

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

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

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

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

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

- Orthodontic treatment

- Expenses private 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

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

How to Make a Claim

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

  Online claims must be submitted to Canada Life as soon as possible, but no later than 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan administrator. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

A Health Care Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year. These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

Eligibility

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health care benefits or basic dental care benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your group health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the *Income Tax Act* (Canada).

Termination

Your HCSA coverage terminates when your group health plan coverage terminates or when your employer discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

Coverage is provided for those expenses:

- that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time, or
- that Canada Life deems to be eligible medical expenses under a private health services plan, as defined by the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Canada Life toll-free at 1-877-883-7072.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

Covered expenses that exceed the maximum annual payment can be carried forward and submitted for payment in the following plan year. Covered expenses can also be carried forward if credits have been forfeited.

Credits are automatically forfeited 31 days after the end of a plan year.

Limitations

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Claims against the HCSA may be submitted on a claim form. Claims for prescription drugs, paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

- To submit claims using a claim form, use form M445D (HCSA) for dental claims, and form M635D (HCSA) for all other claims
- To submit claims online, you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online

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

Claims against the HCSA must be submitted to the Canada Life Benefit Payment Office before the earliest of the following:

- 180 days after the end of the plan year in which the expenses are incurred
- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

TAXABLE WELLNESS SPENDING ACCOUNT

A Taxable Wellness Spending Account is like a bank account through which you may be reimbursed for the covered expenses listed below, up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year.

Eligibility

You and your dependents are eligible for Taxable Wellness Spending Account credits through your employer if you are covered for basic health care benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your group health plan, Taxable Wellness Spending Account benefits are extended to any financially dependent relative that is considered your dependent for income tax purposes. This may include a grandparent, grandchild, sibling, aunt, uncle, niece or nephew.

Termination

Your coverage terminates when your group health plan coverage terminates or when your employer discontinues the plan.

Your dependents' coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your Taxable Wellness Spending Account. Fees for membership and fitness programs are considered to be incurred on a periodic basis throughout the period of participation. All other expenses are considered to be incurred when they are received.

Covered expenses that exceed the maximum annual payment can be carried forward and submitted for payment in the following plan year. Covered expenses can also be carried forward if credits have been forfeited.

Credits are automatically forfeited 31 days after the end of a plan year.

The following expenses are covered:

- Safety equipment required for work, including specifically, Lead Gowns

- Breast pumps

- Fitness expenses which include, but are not limited to:
  - health club membership/fitness programs/gym memberships/classes (e.g. yoga, Pilates, aerobics, Curves, Good Life, etc.)
  - fitness equipment (e.g. treadmill, Bowflex, exercise bike, etc.)
  - personal trainer
  - fitness/exercise videos, CDs, books, magazines
  - sports registration fees/team fees/passes
  - sports equipment (e.g. hockey, baseball, bowling etc.)
  - sports lessons (e.g. golf, skiing etc.)
  - equipment required to participate in a sporting event
  - fishing and hunting license and equipment
  - horseback riding fees/lessons/equipment
  - self-defense courses

- Day care expenses which include, but are not limited to:
  - child care expenses (private or day care centre)
  - field trip expenses
  - nanny
  - homemaker
  - adult/elder care expenses
  - emergency child care expenses
  - babysitting
  - child camps including day camps or overnight camps
  - Day Away programs

- Dental expenses which include, but are not limited to:
  - cosmetic dentistry
  - toothbrushes, floss, tooth paste
  - whitening strips
  - home bleaching kits
  - bleaching tubes
  - home fluoride
  - denture cleaners and adhesive
  - pre-fabricated mouth guards
  - Water Pik

- Health expenses which include, but are not limited to:
  - any unpaid amounts for drugs/vitamins/supplements not covered under the plan sponsor's group extended health care plan or health care spending account.
  - any unpaid expenses for natural product therapy (e.g. St. John's Wort etc.)
  - drugless practitioners
  - Lifeline monitoring systems
  - Medic Alert bracelet/neck chain
  - massage units
  - heating pad
  - thermometer
  - sunscreen
  - personal items (e.g. condoms, jelly, foam, sponge, lubricant etc.)
  - off the shelf shoe inserts, bunion pads, corn removers
  - dance lessons
  - camping (campground fees and equipment/supplies)

- Longer term care expenses which include, but are not limited to:
  - retirement homes
  - Meals on Wheels
  - nursing home expenses (including laundry, hairdressing etc.)
  - telephone and television charges in hospital

- Counseling services which include, but are not limited to services for:
  - grief counseling
  - addiction counseling
  - lactation consulting
  - parishioner fees
  - nutritional counseling
  - weight loss programs/counseling/books/cds
  - stress management programs/counseling/books/cds
  - smoking cessation programs/counseling/books/cds

- Education expenses which include, but are not limited to:
  - professional courses
  - CPR training
  - first aid courses
  - lodging
  - meals

Limitations

No benefits are paid for:

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

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

- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

The Taxable Wellness Spending Account will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the Taxable Wellness Spending Account.

Claims against the Taxable Wellness Spending Account must be submitted on a claim form available from your plan administrator.

Claims against the Taxable Wellness Spending Account must be submitted to the Canada Life Benefit Payment Office before the earliest of the following:

- 31 days after the end of the plan year in which the expenses are incurred
- the date the Taxable Wellness Spending Account contract terminates, if it terminates because your employer fails to make a required payment
- 31 days after the date the Taxable Wellness Spending Account contract terminates, if it terminates for any other reason

COORDINATION OF BENEFITS

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

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

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

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

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents, parents and parents in-law (each a “person” for the purpose of this service) can generally access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- The person accessing the service will be connected with a member advocate who will be dedicated to the person’s case and will provide support through the process. The member advocate will take the necessary medical history and answer the person’s questions. Any information provided is not shared with either your employer or the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet the person’s health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet the person's specific medical needs.

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

- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Limitations

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

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

These services are not insured services. Canada Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.