ONE T
Ontario Non-union
Education Trust

To our CAEAS-ECAB Retirees,

Your Retiree Booklet from Canada Life, ONE-T's insurer, is attached for your reference. This booklet is designed to provide you with comprehensive details related to your insurance coverages and serve as a resource to help you better understand the post-retirement benefits for which you may be eligible.

Please note these important points:

- To be eligible to participate in the CAEAS-ECAB post-retirement benefit plan:
  - you must be, or have been, employed as a Non-Union Employee (School Board employee) by a Participating Employer;
  - retired on or before **August 31, 2019**; and
  - at the date of your retirement be, or have been, eligible to receive retiree benefits under an enforceable provision of the terms and conditions of employment with a Participating Employer.

  OR

  - you must be, or have been, a **Designated Executive** whose employment ended **before August 13, 2021**, and
  - the terms and conditions of employment at the time your employment ended contained an enforceable provision entitling you to post-retirement benefits, and
  - you are covered by Part B of a Participation Agreement for CAEAS-ECAB Participants and CAEAS-ECAB Retirees.

- This Canada Life booklet includes information on coverage termination for the standard case. However, your retiree coverage will terminate according to the coverage termination provision in the terms and conditions of employment with your school board.
- You can confirm your termination clause with our administrator *Cowan Insurance Group* at 1-888-330-4010 or one-t@cowangroup.ca.

To determine the post-retirement benefits for which you may be eligible, and determine the amount of your insurance premium(s), please visit the Cowan Insurance Group's website for CAEAS-ECAB retirees at https://clients.cowangroup.ca/clients/content/login/login.cfm.

For any additional questions, please call Cowan Insurance Group at 1-888-330-4010 or one-t@cowangroup.ca.

My group benefit plan

canada life™

ONE T
Ontario Non-union Education Trust

CAEAS-ECAB Retiree Plan Booklet

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 1-866-800-8086.

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 Insurance 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 the group benefits plan sponsored by The Trustees of ONE-T/FENSEO but Group Policy Nos. 172534 and 172535 issued by Canada Life are the governing documents. 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

The plan is sponsored by

The Trustees of ONE-T/FENSEO

and the plan is administered by

Cowan Insurance Group

This booklet was prepared on: December 29, 2020

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

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

Appeals

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

Benefit Limitation for Overpayment

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

Quebec Time Limit for the Payment of Benefits

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

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

Employer Role

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

Protecting Your Personal Information

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

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

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

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

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

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

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

TABLE OF CONTENTS

Benefit Summary

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

Retiree Basic Life Insurance	Flat amount equal to amount at retirement
Optional Life Insurance	
Retiree and Dependents	Flat amount equal to amount at retirement
Retiree Optional Critical Illness Insurance	Flat amount equal to amount at retirement

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
Reimbursement Level	100%
Basic Expense Maximums	
Hospital	Semi-private room
Home Nursing Care	$25,000 every 36 months
In-Canada Prescription Drugs	Included
Fertility Drugs	$5,000 lifetime or as otherwise required by law
Dispensing Fee Limits	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $6.00. This does not apply if you live in Quebec. For maintenance drugs, a maximum of 5 dispensing fees are covered per drug identification number in a benefit year
exception for Drugs Purchased in Saskatchewan	For maintenance drugs purchased in Saskatchewan, a maximum of 5 dispensing fees are covered per drug identification number in a benefit year
exception for Drugs Purchased in Quebec	The dispensing fee frequency limit does not apply to drugs purchased in Quebec

Hearing Aids	$1,000 every 60 months
Insulin Infusion Pumps	$2,000 per pump once every 5 years
Incontinence Supplies	$1,000 every 12 months
Custom-fitted Orthopedic Shoes	$700 combined with Custom-made Foot Orthotics every 24 months
Custom-made Foot Orthotics	1 pair each benefit year to a maximum of $700 combined with Custom-fitted Orthopedic Shoes every 24 months
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 every 12 months to a maximum of $500
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of $2,000
Blood-glucose Monitoring Machines	$150 each benefit year
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each benefit year
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500
Custom-made Compression Hose	2 pairs every 12 months to a maximum of $750
Wigs for Cancer Patients	$1,000 lifetime

Paramedical Expense Maximums

Chiropractors	$500 each benefit year
Massage Therapists	$500 each benefit year
Naturopaths	$500 each benefit year
Osteopaths	$500 each benefit year
Physiotherapists/Athletic Therapists/Occupational Therapists	$1,500 combined each benefit year
Podiatrists/Chiropodists	$500 combined each benefit year
Psychologists/Social Workers /Registered Family Therapists	$750 combined each benefit year
Speech Therapists/Audiologists	$500 combined each benefit year

Visioncare Expense Maximums

Eye Examinations	$120 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	$450 combined every 24 months

Healthcare Maximums

Out-of-Country Emergency Care Expenses	$1,000,000 per trip
All Other Expenses	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. Payment for charges by hygienists practising independently is based on hygienist fee guides. Specialists' charges are limited to general practitioner fees
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	60%
Orthodontic Coverage	50%
Plan Maximums	
Basic Coverage	Unlimited
Major Coverage	$2,500 each benefit year
Orthodontic Coverage	$3,000 lifetime

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your retirement begins, provided you are a resident of 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.

Your coverage terminates when you are no longer eligible, you stop paying the required premiums, or the policy terminates, whichever is earliest.

Please refer to the additional information issued regarding your eligibility and benefits termination. Contact your plan administrator Cowan if you have any questions.

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

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

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your surviving spouse and dependents will be continued, on a premium-paid basis, for a period of 24 months or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.
- Your unmarried children under age 21, or under age 26 if they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 26, 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 participating 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 plan sponsor.

RETIREE 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 sponsor 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 65.

- 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 sponsor for details.

OPTIONAL LIFE INSURANCE

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

When you apply for optional life insurance for yourself or your spouse, you must provide proof of insurability, 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 plan sponsor will explain the claim requirements. If one of your dependents dies you will be paid the amount for which that person was insured.

- If you live in Quebec and your, your spouse's or your child’s optional life insurance terminates, you, your spouse or your child may be eligible for an individual conversion policy without providing proof of insurability.

  If you live elsewhere in Canada and 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 or child, you or your spouse may apply. See your plan sponsor for details.

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. This limitation does not apply to coverage for a dependent child.

RETIREE OPTIONAL CRITICAL ILLNESS INSURANCE

If you or your spouse is diagnosed with one of the illnesses defined below while insured, Canada Life will pay you the optional critical illness insurance benefit. Check the **Benefit Summary** for the amount of insurance available. 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.

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.

Your 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 Plan Sponsor, the insured, or a relative or business associate of the Plan Sponsor 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 Plan Sponsor, the insured, or a relative or business associate of the Plan Sponsor 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.

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.

Except for custom-made foot orthotics and custom-fitted orthopedic shoe expenses, 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 emergency care provision.

  - Drugs are covered if they are listed in the CAEAS/ECAB Formulary, established and maintained by Cubic Health Inc., in effect on the date of purchase.

  The plan will also pay for preventative immunization vaccines and toxoids listed in the CAEAS/ECAB formulary.

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

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

- 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

- 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 treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist, a licensed athletic therapist or a qualified occupational therapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital treatment of foot disorders by a licensed chiropodist
- Out-of-hospital treatment by a registered psychologist, qualified social worker or registered family therapist
- Out-of-hospital treatment of speech impairments by a qualified speech therapist
- Out-of-hospital treatment by a qualified audiologist

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

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 Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is 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 a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

    - 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
    - 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

Limitations

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

Limitations

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 not listed as covered expenses, including power scooters

- Extra medical supplies that are spares or alternates

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

  This limitation does not apply to Global Medical Assistance

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

- Chronic care

- 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 a participating employer as a condition of employment

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

- 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

- Allergy extracts

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

- Smoking cessation products

- Drugs used to treat erectile dysfunction

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 plan sponsor 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 drugs, Cubic Health Inc. maintains a limited list of drugs that require prior authorization.

Prior authorization is intended to help ensure that the eligibility criteria for that drug as developed and maintained by Cubic Health Inc., has been satisfied prior to approving coverage for that drug.

Cubic Health Inc. is responsible for assessing claims for benefits for any drug requiring prior authorization and determining whether or not that claim meets the eligibility requirements for payment.

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 sponsor. 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 1-866-800-8086.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your plan sponsor. 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 sponsor 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.

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, or beginning any orthodontic treatment, 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 once every 9 months (once every 6 months for dependent children under age 19), except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations once every 9 months (once every 6 months for dependent children under age 19)
  - complete series of x-rays every 24 months
  - intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 24 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 once every 9 months (once every 6 months for dependent children under 19)
  - scaling, limited to a maximum combined with periodontal root planing of 10 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - oral hygiene instruction once in a person's lifetime
  - pit and fissure sealants on bicuspids and permanent molars every 60 months

- space maintainers including appliances for the control of harmful habits

- finishing restorations

- interproximal disking

- recontouring of teeth

- Minor restorative services including:

  - caries, trauma, and pain control

  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan

  - retentive pins and prefabricated posts for fillings

  - prefabricated crowns for primary teeth

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months

- Periodontal services including:

  - root planing, limited to a maximum combined with preventive scaling of 10 time units every 12 months

  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

- 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

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Limitations

No benefits are paid for:

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

- The following endodontic services - root canal therapy for primary teeth, 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

- 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

- 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 sponsor 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 6 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 sponsor. 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.

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 retiree 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.