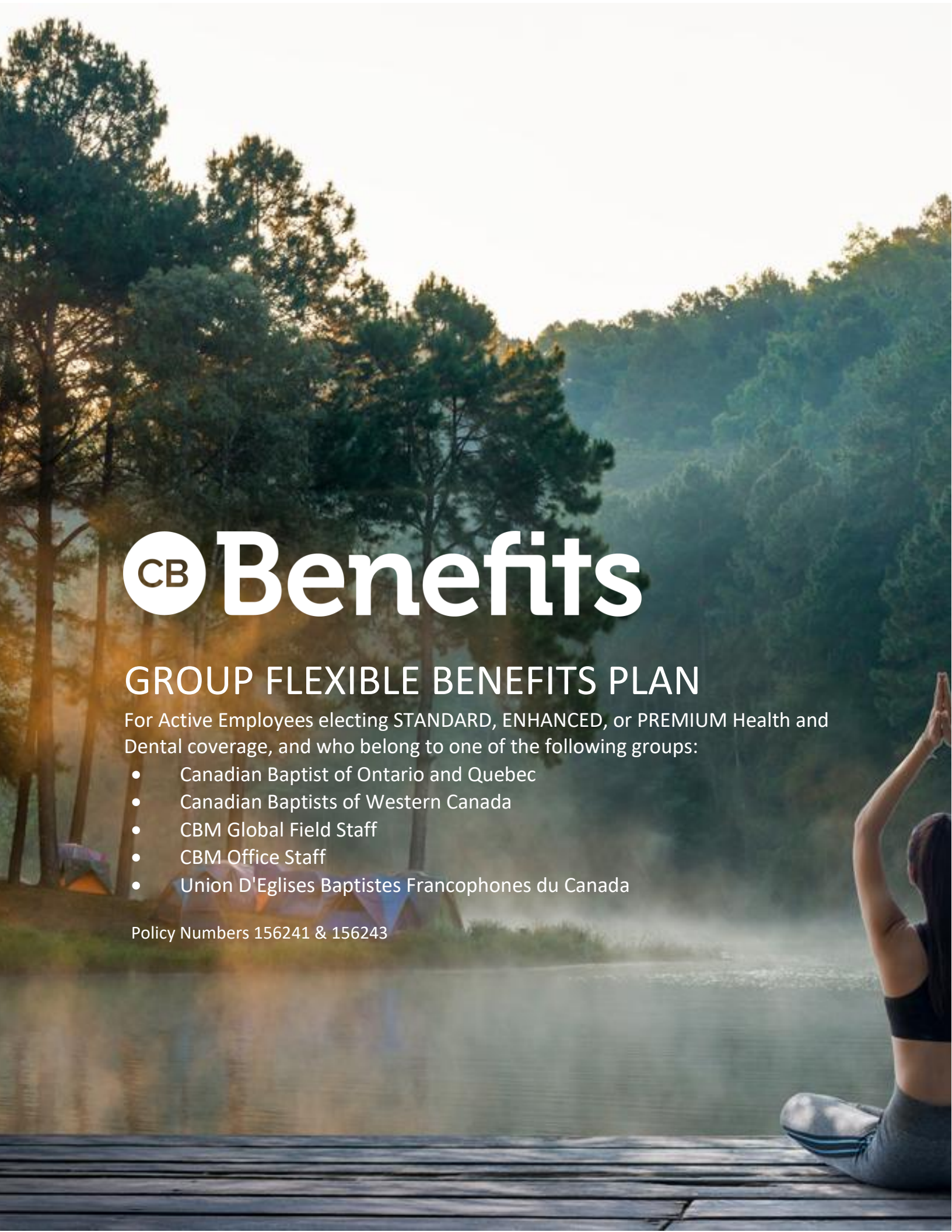


The background of the entire page is a photograph of a peaceful outdoor scene. On the left, several tall, dark green pine trees stand against a soft, hazy sky. In the center, a calm body of water reflects the surrounding greenery, with a light mist rising from its surface. On the right side, a person is seen from the back, sitting in a yoga pose on a wooden dock, with their arms raised in a prayer position. The overall atmosphere is tranquil and natural.

Benefits

GROUP FLEXIBLE BENEFITS PLAN

For Active Employees electing STANDARD, ENHANCED, or PREMIUM Health and Dental coverage, and who belong to one of the following groups:

- Canadian Baptist of Ontario and Quebec
- Canadian Baptists of Western Canada
- CBM Global Field Staff
- CBM Office Staff
- Union D'Eglises Baptistes Francophones du Canada

Policy Numbers 156241 & 156243

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

My Canada Life at Work

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

With My Canada Life at Work you can:

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

Canada Life's Toll-Free Number

- For assistance with your medical, dental and Health Care Spending Account coverage, please call 1-833-900-3853
- For all other inquiries, please call 1-888-252-1847

Process to make a complaint

If you have any concerns regarding these products or Canada Life's services, please let us know. You can call:

Toll-free: 1-888-252-1847

You can also contact Canada Life on our website by visiting www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 156241 and 156243. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail to the extent permitted by law.

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

The Plan is underwritten by



**This booklet was prepared on:
October 9, 2025**

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

Employer Role

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

Protecting Your Personal Information

At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies, and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your [online account](#) or by submitting a request through our [privacy centre](#) at www.canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit www.canadalife.com/privacy.

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Your CBBP at-a-glance

The Canadian Baptist Benefits Plan (CBBP) is a flexible benefits program, giving you the opportunity to choose benefits coverage that meets your unique personal needs and circumstances.

- You automatically receive foundational CORE benefits once your application is approved.
- You can choose one of three options that each include both Health and Dental coverage – **STANDARD, ENHANCED, or PREMIUM**.
- The STANDARD option is provided at no cost to the member; the costs of the ENHANCED and PREMIUM options are shared between you and your employer (see the [Benefits Rate Sheet](#) for details).
- Choices are in place until the next bi-annual re-enrollment (unless you have a qualifying life event).

YOUR CORE BENEFITS

COVERAGE	DETAILS
Basic Life Insurance	• Employee: \$40,000
Dependent Life Insurance	• Spouse: \$20,000; Child(ren): \$8,000
Long Term Disability (LTD)	• 67% of monthly earnings up to a maximum benefit of \$5,000 • Payable after 189 days (27 weeks) of disability • Benefits are integrated with any disability benefits payable to you under the Canada Pension Plan • Benefit payments are taxable as income
Accidental Death and Dismemberment (AD&D)	• Provides a lump-sum cash benefit of up to \$25,000 if you suffer a serious injury or die because of an accident
Healthcare Online by Consult+	• Consult+ provides you and your family with unlimited 24/7 secure online access to Canadian healthcare professionals—when and where you need it • Includes: diagnoses and advice; prescriptions (new and renewals); lab and imaging orders; and specialist referrals
Employee Assistance Program (EAP)	• Provides you and your dependents with access to confidential counselling and information services
Teladoc	• Provides you and your dependents with access to a network of medical specialists if you are diagnosed with a serious illness • Allows you to get a complete explanation of your medical condition, verify a diagnosis, and confirm best treatment options

HEALTH AND DENTAL OPTIONS

	OPTIONS		
	STANDARD	ENHANCED (\$)	PREMIUM (\$\$)
HEALTH			
Prescription Drugs			
All options:			
• Includes a Dispensing Fee cap of \$5, and a Drug Card to be used at the point of sale • Out of pocket maximum of \$5,000 per person, per year, all additional eligible expenses are reimbursed at 100% • Covers preventive vaccines; covers continuous glucose monitors up to \$4,000 per person per calendar year			
Prescription Drug Reimbursement			
• Formulary drugs	75%	80%	90%
• Non-formulary drugs	50%	60%	70%
Other Health coverage expenses are reimbursed based on the percentage below, up to the maximums listed (per person, per year)			
Reimbursement	75%	80%	90%
Paramedical			
• Speech Therapist	\$1,500 per year	\$1,500 per year	\$1,500 per year
• Psychologist	Up to \$1,500 per year combined	Up to \$1,500 per year combined	Up to \$1,500 per year combined
• Social Worker			

HEALTH AND DENTAL OPTIONS (continued)

	OPTIONS		
	STANDARD	ENHANCED (\$)	PREMIUM (\$\$)
Paramedical			
• Psychotherapist	Up to \$1,500 per year combined	Up to \$1,500 per year combined	Up to \$1,500 per year combined
• Certified Counsellor			
• Physiotherapist	Up to \$500 per year for each service. There is a combined annual maximum of \$1,000 in addition to the specific per practitioner maximum indicated above	Up to \$500 per year for each service. There is a combined annual maximum of \$1,250 in addition to the specific per practitioner maximum indicated above	Up to \$750 per year for each service. There is a combined annual maximum of \$1,500 in addition to the specific per practitioner maximum indicated above
• Registered Massage Therapist (RMT)			
• Osteopath			
• Chiropractor			
• Podiatrist / Chiropodist			
• Naturopath			
• Acupuncturist			
• Homeopath			
• Occupational Therapist	n/a	n/a	
Travel insurance			
Under all three options, emergency out-of-country medical insurance is covered up to \$1,000,000 per person per emergency.			
Vision Care			
• Eye exams	n/a	Up to \$50 every 2 years	Up to \$100 every 2 years
• Frames and lenses, contact lenses	n/a	Up to \$150 every 2 years (every year for eligible child(ren))	Up to \$200 every 2 years (up to \$150 every year for eligible child(ren))
Medical services and supplies			
All three options include coverage for the services of an ambulance (including air ambulance).			
• Private-duty nursing	Up to \$5,000 every 3 years	Up to \$5,000 every 3 years	Up to \$10,000 every 3 years
• Orthotics and orthopedic shoes	Up to \$300 per year	Up to \$300 per year	Up to \$300 per year
• Hearing aids	Up to \$300 every 4 years	Up to \$300 every 4 years	Up to \$600 every 5 years
DENTAL			
• Annual maximum	\$500 per calendar year	Up to \$1,500 per year	Up to \$2,000 per year for Basic and Major combined
• Basic services (e.g., routine, preventive, endodontic, periodontic)	75%	80%	80%
• Frequency of Recall exams	Once every 12 months (every 6 months for eligible child(ren))	Once every 12 months (every 6 months for eligible child(ren))	Once every 12 months (every 6 months for eligible child(ren))
• Major restorative services (e.g., crowns, onlays, bridges, and dentures)	n/a	n/a	50%
• Orthodontia	n/a	n/a	50% (to a lifetime maximum of \$2,000 per person)
HEALTHCARE SPENDING ACCOUNT (HCSA): ANNUAL DEPOSIT			
Member only	\$250	\$125	n/a (no HCSA under this option)
Member + 1 dependent	\$500	\$250	
Member + 2 or more dependents	\$750	\$375	

OPTIONAL INSURANCE

Beginning February 1, 2026, Optional Life and Critical Illness insurance coverages are available through Canada Life's Freedom To Choose insurance (FTCi) program. You can learn more about FTCi [here](#). For premium rates and to apply for coverage, log in to [My Canada Life at Work](#).

If you purchased Optional Life, Spousal Life, Dependent Life, and/or Optional Critical Illness insurance *before January 1, 2026*, or would like to learn about Optional Accidental Death & Dismemberment (AD&D) Insurance available through CHUBB, see the [Benefits Rate Sheet](#) and [Election Guide](#) for relevant details.

Benefit Summary

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

	Standard	Enhanced	Premium
Employee Basic Life Insurance			
Amount	\$40,000		
	Coverage reduces to \$5,000 at age 65 and \$2,500 at age 70		
Dependent Basic Life Insurance			
Spouse	\$20,000		
Child	\$8,000		
	Dependent Life Insurance reduces by 50% at age 65		
Optional Life Insurance			
Member and Spouse	Available in \$10,000 units to a maximum of \$500,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both a member and a spouse, you are limited to the \$500,000 maximum		
Child	Available in \$2,000 units to a maximum of \$20,000		
Long Term Disability Income Benefits			
Waiting Period	189 days		
Amount	67% of your monthly earnings to a maximum monthly benefit of \$5,000		

	Standard	Enhanced	Premium
Healthcare			
Covered expenses will not exceed customary charges			
Deductible	Nil		
Reimbursement Levels			
Global Medical Assistance and Out-of-Country Emergency Care Expenses	100%	100%	100%
In-Canada Prescription Drug Expenses			
- Dispensing Fee Portion of the Drug Charge	100%	100%	100%
- Remaining Portion of the Drug Charge	Base Drug Plan: 75% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year Supplementary Drug Plan: 50% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year	Base Drug Plan: 80% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year Supplementary Drug Plan: 60% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year	Base Drug Plan: 90% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year Supplementary Drug Plan: 70% until \$5,000 in benefits has been paid in a calendar year and 100% of the remainder of the calendar year
	Out-of-Pocket Maximum for Quebec Residents - An out-of-pocket maximum is applied to in-province expenses for drugs listed in the <i>Liste de médicaments</i> published by the <i>Régie de l'assurance-maladie du Québec</i> if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows: 1. reimbursement will be made at 100% 2. no further out-of-pocket amounts will apply The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec		
All Other Expenses	75%	80%	90%

	Standard	Enhanced	Premium
Basic Expense Maximums			
Ambulance	Included		
Home Nursing Care	\$5,000 every 3 years		\$10,000 every 3 years
Home Nursing Care Limit	Beginning on your 65 th birthday, the maximum will be reduced by the amount paid during the previous 3 years to a lifetime maximum of \$5,000		N/A
In-Canada Prescription Drugs	Included		
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to \$5.00. This does not apply if you live in Quebec.		
Drugs Used To Treat Erectile Dysfunction	\$1,200 each calendar year		
Hearing Aids	\$300 every 4 years	\$300 every 4 years	\$600 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	\$300 combined each calendar year		
Myoelectric Arms	\$10,000 per prosthesis		
External Breast Prosthesis	Initial prosthesis following a mastectomy and 1 replacement every 2 calendar years		
Surgical Brassieres	2 each calendar year		
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	1 every 4 years		
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	\$4,000 each calendar year		
Insulin Infusion Pumps	\$5,000 per pump once every 5 years		
Needleless Insulin Jet Injectors	1 in a lifetime to a maximum of \$1,000		
Transcutaneous Nerve Stimulators	\$700 lifetime		
Extremity Pumps for Lymphedema or Severe Postphlebotic Syndrome	1 in a lifetime to a maximum of \$1,500		
Custom-made Compression Hose	2 pairs each calendar year		
Wigs			
- For Cancer Patients Undergoing Chemotherapy	\$100 lifetime		
- For Alopecia Totalis	\$250 lifetime		
Diagnostic Laboratory and Imaging Procedures	Included		
Other Medical Supplies	Included		

	Standard	Enhanced	Premium
Paramedical Expense Maximums			
Acupuncturists, Chiropractors, Massage Therapists, Naturopaths, Osteopaths, Physiotherapists, Podiatrists	\$500 per practitioner each calendar year to a combined maximum of \$1,000 each calendar year	\$500 per practitioner each calendar year to a combined maximum of \$1,250 each calendar year	\$750 per practitioner each calendar year to a combined maximum of \$1,500 each calendar year
Psychologists/ Social Workers/ Psychotherapists/ Clinical Counsellors/ Canadian Certified Counsellors	\$1,500 combined each calendar year		
Speech Therapists	\$1,500 each calendar year		
Visioncare Expense Maximums			
Eye Examinations	Not covered	\$50 every 24 months	\$100 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery			
- Dependent Children Under Age 18	Not covered	\$150 combined every 12 months	\$150 combined every 12 months
- All Others	Not covered	\$150 combined every 24 months	\$200 combined every 24 months
Out-of-Country Emergency Care Expense Maximum	\$1,000,000 per emergency		
Global Medical Assistance	Included		
Lifetime Healthcare Maximum	Unlimited		

	Standard	Enhanced	Premium
Dentalcare			
Covered expenses will not exceed customary charges			
Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered		
Deductible	Nil		
Reimbursement Levels			
Basic Coverage	75%	80%	80%
Major Coverage	Not covered	Not covered	50%
Orthodontic Coverage	Not covered	Not covered	50%
Accidental Dental Injury Coverage	100%	100%	100%
Plan Maximums			
Basic Treatment	\$500 each calendar year	\$1,500 each calendar year	\$2,000 each calendar year for Basic and Major Treatment Combined
Major Treatment	Not covered	Not covered	
Orthodontic Treatment	Not covered	Not covered	\$2,000 lifetime
Accidental Dental Injury Treatment	Unlimited	Unlimited	Unlimited
	Standard	Enhanced	Premium
Healthcare Spending Account	See Description	See Description	Not Covered

Information About Your Flex Plan

- Option changes and changes in amounts of optional life insurance take effect every 2 years on January 1, unless the change results from a change in family status. If it does, the option change will take effect on the date the application for the change is made, as long as it is made within 31 days of the status change. Otherwise, the change will not take effect until the next January 1 re-enrollment period.

Note: For health and dental coverage, you can only move up or down one option level at a time. You are locked in at that level for 2 years. These restrictions are waived if you are changing options because of a family status change.

For all increases in optional life insurance (whether as a result of a family status change or otherwise), you must provide proof of insurability and your application for the increase must be approved by Canada Life.

- If you experience a change in family status during a plan year that affects your coverage needs, you may make changes to your benefit options that directly relate to your status change without waiting for the next every 2 years on January 1 re-enrolment period. Any of the following is considered a change in family status:
 - acquiring your first dependent (spouse or child)
 - acquiring a spouse if you have child coverage only
 - acquiring your first child (birth, adoption or step-child) if you have spouse coverage only
 - involuntary loss of similar coverage through your spouse's group benefit program (for example, because of a change in your spouse's employment status)
 - death of your spouse or only child
 - your spouse or only child ceasing to qualify for coverage (for example, through divorce or your child's attainment of a limiting age – see Dependent Coverage in this booklet)

Note: See your administrator for details no later than 31 days after a change in family status occurs. Certain conditions apply.

COMMENCEMENT AND TERMINATION OF COVERAGE

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

- 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.

- 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 employees may not join the plan.

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

- 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 employer for details.
- 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 employer for details.

Survivor Benefits

If you die while your coverage is still in force, the healthcare, dentalcare and Contact 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 36 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

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

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

Children under age 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 employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

EMPLOYEE BASIC LIFE INSURANCE

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

- 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 70th 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 before age 71, 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 employer for details.

DEPENDENT BASIC LIFE INSURANCE

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

- If you are disabled and the premiums for your employee life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.
- Your dependent 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 and your employee life insurance is continued, your dependent life insurance will be continued on the same basis.
- If you live in Quebec and your spouse's or child's insurance terminates before you reach age 71, your spouse or child may be eligible for an individual conversion policy without providing proof of insurability.

If you live elsewhere in Canada and your spouse's insurance terminates before they reach age 71, your spouse may be eligible for an individual conversion policy without providing proof of insurability.

You or your spouse must apply for spouse or child insurance and pay the first premium no later than 31 days after the group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE
(Only employees who elected Optional Life Insurance
before January 1, 2026, are eligible)

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 your application must be approved by Canada Life. When you apply for optional life insurance for your children, proof of insurability is required only if you apply more than 31 days after becoming eligible. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

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

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

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

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.

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. If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the short term disability or sick leave benefit period, but not later than one year after your disability started.
- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.
- After 24 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 provides you with an income of at least 75% of your indexed monthly earnings before you became disabled.
- 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 or Quebec Pension Plan, except for increases that take effect after the benefit period starts
- benefits under any Workers' Compensation Act or similar law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 80% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan
- benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts
- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

- disability benefits under a plan of insurance available through membership in an association
- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, including any increases in Canada or Quebec Pension Plan benefits that take effect after the benefit period starts, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

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

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Any period in which you do not 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.

- The scheduled duration of a lay-off or 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 after you fail to participate or cooperate in an approved rehabilitation plan or program.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any 12-month period in which you do not live in Canada for at least 6 months.
- Any period of confinement in a prison or similar institution.
- 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 employer, 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 6 months after proof of your claim has been requested.

HEALTHCARE

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

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

You are covered for only the Healthcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

Covered Expenses

- Ambulance transportation, including air ambulance, to the nearest centre where adequate treatment is available
- 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.

- 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 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 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.

Covered drugs and drug supplies are categorized as either base plan drugs or supplementary plan drugs for benefit payment purposes.

The base drug plan consists of:

- those drugs listed in the National Formulary or Special Authorization (SA) drug list established by the pharmacy benefits manager in effect on the date of purchase, and
- diabetic supplies.

The supplementary drug plan consists of all covered drugs and drug supplies not included in the base drug plan.

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

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital 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 or qualified social worker, psychotherapist, clinical counsellor, or Canadian certified counsellor
- 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

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

Limitation

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.

General 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, except as may be provided under the prescription drug provision
 - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency 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

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Fertility drugs
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 100 days
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

Special Measures For Quebec Residents Age 65 And Over For Prescription Drug Coverage

If you reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage on the date you reach age 65. At that time, you automatically become covered under the basic prescription drug plan provided by the *Régie de l'assurance-maladie du Québec*. You must pay the applicable premiums under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan. If your dependents are not eligible for private coverage on their own, you must register them under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.

If you are still eligible, you will remain covered for prescription drugs under this plan, but on a supplemental basis. This means that this plan may cover deductible and co-payment amounts you are required to pay under the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.

However, you can instead choose to remain covered as you are now for prescription drugs under this plan. This would provide you with drug coverage that is at least as good as the coverage offered by *Régie de l'assurance-maladie du Québec*. If you do this:

- You must contact *Régie de l'assurance-maladie du Québec* to opt out of the public prescription drug insurance plan.
- Your premiums under this plan may remain the same or they may increase. **It's important you verify this information with your employer before opting out of the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan.**

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

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

Otherwise, we will assume that you have decided to:

- Remain enrolled in the *Régie de l'assurance-maladie du Québec* public prescription drug insurance plan; and
- Maintain your prescription drug coverage offered under this plan on a supplementary basis.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic prescription drug 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*.

How to Make a Claim

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

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

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

Be sure to keep original receipts for your own records.

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

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

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

- **All Other Healthcare Claims**

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

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

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

Paper claims: To submit paper claims, access www.mycanadalifeatwork.com to obtain a personalized claim form, or obtain form M635D from your employer. Complete this form making sure it shows all required information.

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

- **Drug claims**

Your employer 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.

CONTACT – EMPLOYEE ASSISTANCE PROGRAM

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services. Sessions can be conducted in-person, over the telephone or via the internet, for issues that include the following:

- marital/relationship
- family (including child care/elder care concerns)
- personal and emotional
- alcohol/drug misuse and/or abuse
- violence
- single parenting
- bereavement
- work and career
- stress
- smoking cessation

Other services the Contact employee assistance program provides include the following:

- information on child care and elder care issues
- legal assessment and general information on certain legal issues
- information on certain financial issues
- nutrition information on common nutritional questions and concerns
- health coaching

The services provided under the Contact employee assistance program are available in English and French by dialing 1-866-289-6749.

Services for the hearing impaired are available in English and French by dialling 711.

These lines:

- Are toll-free
- Are staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments
- Can be reached from Canada or the United States

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: <https://one.telushealth.com>.

VIRTUAL HEALTH SERVICES

Virtual health services are available to you and your dependents (each a “person” for the purposes of these services) by downloading the service provider’s application specified by Canada Life from time to time. These services include the following:

- Unless prohibited by applicable laws, access to an unlimited number of consultations via telephone calls, text messaging and videoconferencing with medical professionals
- Prescriptions and prescription renewals, when medically needed
- Where diagnostic or laboratory tests are medically needed:
 - completion of necessary requisitions
 - results of the diagnostic or laboratory tests provided and accessible through the provider’s application
 - information on the results of diagnostic/laboratory tests via the service provider’s application
- Details of a person’s care plan provided to the person on request of that person
- Access to self-guided internet-based cognitive behavioral therapy (iCBT)
- Access to specialists such as psychologists, dietitians and work and life coaches for an additional fee

The above services will be available 24 hours a day, 7 days a week.

How to Access these Services

- **Visit the Website**

English: <https://consultplus.dialogue.co/>
French: <https://consultplus.dialogue.co/?lng=fr>

- **Download the App**

Download the Consult+ app to any mobile device.

- **Visit the Help & Support Pages**

English: www.canadalife.com/resources/consult-faq.html
French: www.canadalife.com/fr/resources/consult-faq.html

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 for a general practitioner shown in the **Benefit Summary**, except that:

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

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

You are covered for only the dentalcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

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 36 months
 - limited oral examinations once every 12 months (once every 6 months for dependent children under age 22), 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 12 months (once every 6 months for dependent children under age 22)
 - complete series of x-rays every 36 months
 - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- Preventive services including:
 - polishing and topical application of fluoride each once every 12 months (once every 6 months for dependent children under age 22)
 - scaling, limited to a maximum combined with periodontal root planing of 8 time units each calendar year

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

 - oral hygiene instruction once in a person's lifetime
 - pit and fissure sealants on bicuspid and permanent molars every 60 months
 - space maintainers including appliances for the control of harmful habits
 - finishing restorations
 - interproximal diskings
 - 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 8 time units each calendar year
 - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

Major Coverage
(Applicable to Premium Option only)

- 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 required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only 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 while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

- Denture-related surgical services for remodelling and recontouring oral tissues
- Appliance maintenance following the 3-month post-insertion period including:
 - denture remakes, once every 36 months
 - denture adjustments, once every 12 months
 - denture repairs and additions, tissue conditioning and resetting of denture teeth
 - repairs to covered bridgework
 - removal and recementation of bridgework

Orthodontic Coverage **(Applicable to Premium Option only)**

- Orthodontics are covered for children age 6 to 18 when treatment starts

Accidental Dental Injury Coverage

- 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

General Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, 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.

If you have elected the **Premium Option**, services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture
- For **Standard or Enhanced Options**: Crowns (other than prefabricated crowns), bridgework, dentures or repairs to bridgework or dentures
- For **Premium Option**: Veneers, recontouring existing crowns, and staining porcelain
- For **Premium Option**: 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

- For **Premium Option**: 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

- For **Standard or Enhanced Options**: Orthodontic treatment
- For **Premium Option**: Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- 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 myofascial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

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

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

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

- **For all other Dentalcare claims**, access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA) (Applicable to Standard and Enhanced Options Only)

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).

You may apply for HCSA benefits within 31 days of the date you first become eligible or at your plan's annual enrolment date.

Termination

Your HCSA coverage terminates when your health plan coverage terminates, when you elect to discontinue coverage (at any plan enrolment date) 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.

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.

Credits are available for covered expenses incurred in a plan year. Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan year, they are automatically forfeited.

The maximum annual payment available under your account will consist of the amount of the credit directed to it for the plan year plus any unused amount from the previous year.

General 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 My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online

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:

- 90 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

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 an employee 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 (Teladoc Medical Experts)

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 physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-2378 toll-free or via teladoc.ca/canadalife/.
- 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 several 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, a member of the Teladoc Medical Experts team can help identify a specialist qualified to meet the person's specific medical needs either in their geographic area or outside of Canada.
- The member advocate may identify a Teladoc Medical Experts specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

General Limitations

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

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.



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