



KINETRICS

HEALTH AND DENTAL BENEFITS

**FOR MANAGEMENT EMPLOYEES, PENSIONERS
AND ELIGIBLE DEPENDENTS**

EFFECTIVE JANUARY 2019

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OVERVIEW

SECTION 1.0

The Extended Health Benefits Plan provides eligible employees, pensioners, and their dependents comprehensive medical services that are among the very best available. This includes various levels of coverage for hospitalization, drug products, dental services and many other extended health benefits. The objective of this Plan is to provide comprehensive coverage, in a managed way, to facilitate employees, pensioners, and their dependents in their recovery from illness or injury.

This booklet provides a detailed outline of the products and services covered under these plans. There are, however, limitations to that coverage and employees/pensioners should be aware of these. There are also reasonable and customary limits applied by the carrier (The Canada Life Assurance Company) in administering these benefits. This booklet also provides illustrations of these limits. If employees/pensioners are uncertain of what these limitations are, they are encouraged to contact Canada Life at the telephone number provided below.

CANADA LIFE ASSURANCE COMPANY

1-800-957-9777

The Mailing Address for Claims is:
London Benefit Payments
PO Box 5064, Stn B
London, Ontario
N6A 0C4

Canada Life's business hours for inquiries are from 8:00 am to 4:30 p.m., Monday through Friday (excluding statutory holidays). Messages may be left after 4:30 p.m. and all calls will be returned the following business day.

RESPONSIBILITIES

SECTION 2.0

2.1 Employees and Pensioners

It is the employee's/pensioner's responsibility to ensure that all claims are legitimate. Eligible pensioners are entitled to the current health and dental benefits on the same basis as the employee group they belonged to at time of retirement. Eligible beneficiaries are entitled to the current health and dental benefits on the same basis as the employee group the pension plan member belonged to prior to death or retirement.

It is essential that employees and pensioners keep their "personal information" up to date. For example, if a spouse is added or deleted from coverage, the spouse changes employers and/or insurance carriers, and the addition or deletion of dependent children – employees and pensioners should contact the Kinectrics Human Resources Department.

In the following material, the term "Employee" includes "Pensioners, Beneficiaries, and Eligible Dependents".

2.2 The Canada Life Assurance Company

The Company's claims services provider for health and dental coverage is the Canada Life Assurance Company. It is Canada Life's responsibility to ensure that all legitimate claims for benefits that are covered under the contract, are reimbursed in accordance with the contract.

WHO IS COVERED?

SECTION 3.0

Employee

Probationary and regular employees, including employees receiving LTD benefits, are eligible for coverage immediately from their first day of work and all coverage ceases immediately upon termination.

Employees who go from employee to pensioner without a break in service and who did not transfer 100% of the commuted value of their pension out of the pension plan, and who had a minimum of 15 years of continuous service with The Company prior to retirement, and who had subsidized health and dental coverage and were hired prior to January 1, 2019, will continue to receive benefits during their retirement equivalent to the current benefits available to active employees. No minimum service requirement exists for employees who were eligible for an unreduced pension or had reached age 60 at December 31, 2013. The minimum service requirement for employees who were eligible for an unreduced pension or had reached age 60 between January 1, 2014 and December 31, 2016 (inclusive) is 8 years of continuous service.

Vested/deferred pensioners are eligible for these benefits providing they had them as employees and had a minimum of 25 years of continuous service with The Company prior to their termination date.

Employees hired on or after January 1, 2019 are not eligible for retiree benefits.

Qualified Dependent

Qualified dependents include an employee's spouse and dependent children.

A spouse is any person who:

- (1) Is legally married to the employee; or
- (2) Is publicly represented by the employee as his or her spouse (including same sex spouse).

Only one person shall be considered a Qualified Dependent spouse during a period of time for which any benefits are payable to or for the spouse of an employee.

In the event that an employee takes up residence with an individual and publicly represents that individual as his or her spouse, the spouse status of any other individual shall automatically terminate. An individual who fails or ceases to meet the criteria specified in item (1) or (2) of this paragraph shall immediately be rendered ineligible as a Qualified Dependent spouse. The survivor of a pensioner will continue to be covered for health and dental coverage. If the survivor remarries, the new spouse will not be eligible for any health and dental benefits.

A dependent child is:

- (1) An unmarried child (of an employee or an employee's spouse) including "legally adopted" who is unmarried, unemployed, attending school full-time, up to and including 23 years of age. Coverage for dependent children ceases as of their 24th birthday; or
- (2) A child to whom the employee stands in the position of a parent for purposes of the Income Tax Act, the Divorce Act, or the Family Law Act.
- (3) A child of any age (of an employee or an employee's spouse) who is dependent for financial support upon the employee or the employee's spouse because of physical or mental infirmity, provided the child had the infirmity while eligible for coverage under the above criteria.

Coverage will continue for as long as the child remains continuously dependent for financial support upon the employee or the employee's spouse because of physical or mental infirmity. The Company will determine the eligibility of physically or mentally infirm dependent children as Qualified Dependents and furnish written proof with instructions for Canada Life to continue coverage.

DEFINITIONS

SECTION 4.0

Calendar Year

A period of time commencing January 1 and ending December 31 or any other shorter period of time falling between those dates, during which the Plan is in force.

Covered Individual

An employee who is covered for benefits under the Plan; a Qualified Dependent with respect to whom an employee is covered for benefits under the Plan.

Licensed Practitioner

Includes a duly licensed medical doctor, dentist, physiotherapist, audiologist, optometrist, clinical psychologist, speech therapist, chiropractor, podiatrist, or chiropodist, who is licensed, certified, registered or qualified by the jurisdiction in which the person is practicing within the scope of his or her profession. Only medical doctors, dentists, podiatrists, and chiropodists can prescribe drugs.

Effective Date

The date on which the coverage under the Plan becomes effective for an Employee or Qualified Dependent.

Hospital

An institution accredited as a Hospital by the Canadian Council on Hospital Accreditation or approved for resident in-patient care under a provincial hospital services program. However, it does not include a sanatorium, a mental hospital, a nursing home, a chronic care hospital, a chronic care unit in a public general Hospital, or a facility for the care of the aged; or an institution operated primarily as a school, or whose primary function is to furnish domiciliary or custodial care; or hospitals outside of Canada.

Registered Nurse

A person who is registered as a nurse under the Health Disciplines Act or licensed in the jurisdiction in which her or his professional services are rendered to the Employee or dependent to provide services equivalent to those which are provided by registered nurses in Ontario.

PROCESS FOR SUBMITTING CLAIMS

SECTION 5.0

Employees may pick up Claim Forms from the Human Resources Department or print copies off The Company Intranet. Pensioners will receive a new claim form upon receipt of payment by the carrier for a previous claim. Pensioners can also contact Kinectrics or Canada Life for claim forms.

The mailing address is on the claim form. The claim forms are two-sided to permit you to claim health benefits on one side and dental benefits on the other side. Do not try to claim both health and dental benefits in one submission on one form. If you have both a health and a dental claim use two forms, because the health claim is forwarded to the health unit and the dental claim is forwarded to the dental unit for payment.

When submitting your health or dental claim to the Canada Life Assurance Company, remember to complete the Claim Form in its entirety. To ensure prompt processing of your health claim for **all eligible medical devices and supplies**, include written documentation from the medical practitioner detailing the patient's condition and the **medical necessity** for the device or equipment. This will speed up reimbursement of your claim as Canada Life will not have to ask you for additional information.

For goods and services requiring a prescription, the prescription must be obtained **before** the goods are purchased.

Claim Submission Period – health and dental claims must be submitted within 18 months from the date of the receipt associated with the claim.

RIGHT OF RECOVERY

SECTION 6.0

If at any time payments have been made by Canada Life with respect to Allowable Expenses, and such payments are in excess of the maximum amount necessary at that time to satisfy the intent of the coordination provision, Section 7, Canada Life shall have the right to recover such payments, to the extent of such excess, from any persons to or with respect to whom such payments were made, any insurance companies, and any other organizations.

CO-ORDINATION OF BENEFITS

SECTION 7.0

Employees and pensioners whose spouses have health and/or dental coverage through the same or another employer must co-ordinate their claims through the two insurance plans. This enables couples to maximize the money they get back related to their claims and The Company saves money.

The spouse submits his/her claims to his/her insurance company first. If the full amount of the claim has not been covered, the remainder can then be submitted under Kinectrics plan up to its maximum.

Similarly, when claims are submitted to Kinectrics plan and the full claim is not covered, the unpaid portion can be submitted to the spouse's plan for all, or part of, the amount not covered by Kinectrics plan.

The spouse whose birth date is the earlier in the year (regardless of age) must claim the dependent children on his/her plan first. Any unpaid portion can later be claimed on the other spouse's plan following initial reimbursement.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of this Plan's Co-ordination of Benefits Provision and implementing its terms or those of any provision of similar Plans, Canada Life, without the consent of, or notice to, any person, may release to or obtain from any insurance company, organization, or person any information, with respect to any person, which Canada Life deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to Canada Life such information as may be necessary to implement this provision.

ANNUAL DEDUCTIBLE

SECTION 8.0

The deductible for the Extended Health Benefits Plan is \$10.00 per calendar year for a single subscriber and \$20.00 per calendar year for families. (The only items that are excluded from the annual deductible are vision care and hearing aids.)

Note:

Expenses incurred by a member during the months of October, November and December may be carried over to the following calendar year and applied toward the deductible in that year.

REASONABLE & CUSTOMARY SERVICES

SECTION 9.0

To be considered reasonably necessary, the medical services or products must be ordered by a physician and must be commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed sickness, injury or condition.

These plans will pay the excess over the deductible portion of the reasonable and customary charges and time limitations for the services and supplies set out in this brochure, when necessary for the care and treatment of injury or illness and when ordered or prescribed by a licensed medical practitioner.

The reasonable and customary charge of any service or supply is the usual charge of a similar provider in the area. A "similar service" is one of the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. "Area" means the town or city in which the service or supply is actually provided.

Reasonable and customary applies to all benefits. See page 15 for some examples.

EXCLUDED CHARGES

SECTION 10.0

The following medical services and supplies are not covered by the Extended Health Benefits Plan:

- Services or supplies normally paid through any provincial hospital plan, any provincial medical plan, Workplace Safety & Insurance Board (WSIB), other government agencies or any other source.
- Charges for unnecessary services and supplies for medical care of the patient's sickness, injury, or condition.
- Coverage for the treatment of tuberculosis and mental illness when the patient is confined to a special institution for such treatment.
- Rest cures, travel for health reasons or insurance examinations.
- The portion of any charge, for any service or supply, in excess of the reasonable and customary charge.
- For Benefits Items which may be eligible for coverage under the WSIB and/or the Assistive Devices Program, as well as The Company's Extended Health Benefits (EHB); employees can claim the difference between what they actually pay and the amount reimbursed by the government agency.

<u>Example:</u>	A hearing aid costs	\$600.00
	Assistive Devices Program covers	<u>\$260.00</u>
	Canada Life will reimburse	\$340.00

- For services or supplies provided outside Ontario, the portion of any charge, or service, which exceeds the amount which would normally be paid in Ontario, will not be reimbursed.

SEMI-PRIVATE AND PRIVATE HOSPITAL ROOMS

SECTION 11.0

Semi-Private Hospital Rooms

- The semi-private differential between ward accommodation (covered by Ontario Health Insurance Plan (OHIP)) and semi-private accommodation in an active treatment hospital, such as Toronto Hospital, is covered under this Plan. Also includes the Shouldice Clinic and the Homewood Sanitarium.
- Up to \$30.00 per day for a maximum of 120 days in any period of 365 consecutive days, towards semi-private or private room accommodation in a hospital for the chronically ill or a chronic care unit of a general hospital.
- The semi-private differential between ward accommodation (covered by the Ontario Health Insurance Plan (OHIP)) and semi-private accommodation in contract (private) hospitals, or in a convalescent/rehabilitative hospital, such as St. John's in Toronto, up to a maximum of 120 days per lifetime.

Private Hospital Rooms

The Extended Health Benefits Plan covers the differential between semi-private and private room accommodation (but not a suite) in an active treatment hospital. The private room does not require a physician's authorization.

THE COMPANY'S DRUG PLAN

SECTION 12.0

Drugs listed in The Company's Drug Formulary are covered when purchased on the prescription of a licensed medical practitioner. The Drug Formulary includes drugs that legally require a prescription, life sustaining over the counter (OTC) drugs and selected non-life sustaining OTC drugs.

Employees are eligible for drugs for the current month, plus an additional two months, for a maximum of three months. Pensioners are eligible for the current month, plus an additional seven months, for a maximum of eight months.

The following three conditions apply:

- (1) **Maximum dispensing fee for drugs that "require a prescription by law" = \$11.00 per prescription.** Where an employee is charged a "higher than normal dispensing fee" due to special handling or processing by the Pharmacist, the BCE Emergis Inc. computerized billing will be able to specifically identify all "mixtures" and "compounds" and make the appropriate reimbursement to the pharmacist. In such situations, the dispensing fee is substantially more than the normal dispensing fee charged by the Pharmacist, and the \$11.00 maximum will not apply.
- (2) **For all "brand name drugs" that have a "generic substitute", only the "generic substitute" will be fully paid for, unless the doctor hand writes "no substitutes" on the prescription.** However, your physician must also provide a written supporting rationale when specifying "no substitute" for a brand name drug using the CL Request for Brand Name Drug Coverage form. Prior authorization will be required before Canada Life will consider payment of a brand name drug. If your request is approved, you will be reimbursed the cost of the brand name drug according to the terms of the plan. If the employee/pensioner demands a "brand name product", he/she will have to pay the amount in excess of the price for the "generic substitute" at his/her expense.

It is requested that you use your Drug Card for drugs requiring a prescription by law that are on the Kinectrics Drug Formulary. If the receipt for prescription drugs is submitted on a paper claim it will need to be processed by Canada Life through BCE Emergis and therefore will normally take 7 to 10 days longer to process than claims processed electronically.

BCE Emergis is a company that electronically processes drug claims for the Canada Life Assurance Company and other insurance carriers. The Pharmacist inputs your name, employee number, Kinectrics group number, the Drug Identification Number (DIN), and the cost, for reimbursement. The majority of Pharmacies in Ontario have this capability. BCE Emergis is more efficient and

requires no up-front, out-of-pocket, payment from the employee/pensioner, subject to the limits set out in number (1) above.

When purchasing a drug using your Drug Card, please be sure to give your Pharmacist the relationship of the patient and the accurate date of birth. Relationship is employee/pensioner, spouse, child, or student (dependent child between the ages of 19 and 24 years of age); plus the patient's date of birth. If this information is not accurate, your claim will be rejected and the card will not work.

- (3) **Over-the-counter (OTC) products that do not "require a prescription by law" will be covered if they are on The Company's Drug Formulary and medically required for the treatment of an illness, injury or condition.** That is, when prescribed by a doctor. The doctor should be asked to write out the information pertaining to over-the-counter products, separate from the drugs "requiring a prescription by law". (See Option Two below.)

Claiming Over-The-Counter Products:

Option One - Using Your Drug Card

By presenting your Drug Card, the Pharmacist can electronically submit the claim to BCE Emergis. The Pharmacist will be reimbursed up to a maximum dispensing fee equivalent to the dispensing fee set for the Ontario Drug Benefit (ODB) Plan (currently \$6.11 per prescription). If the Pharmacist demands payment of a dispensing fee in excess of \$6.11, the employee will have to (1) pay the excess amount, or (2) go to another Pharmacist who will agree to a dispensing fee at, or below, the ODB dispensing fee for over-the-counter products, or (3) go to Option Two below.

Option Two - Cash Register Receipts

Employees can manually submit the original copy of the prescription, along with the sales receipt, to Canada Life for reimbursement. Submissions for over-the-counter items will need to be accompanied by a separate prescription, and not combined with those requiring a prescription by law. **Canada Life must be able to readily identify the specific item on the sales receipt corresponding to the specific over-the-counter prescription** in order to process the claim for the price of the over-the-counter product, plus the applicable sales tax. If the cash register receipt does not identify specific items, then the clerk should be asked to hand write the name and drug identification number of the product and initial the sales receipt. In the case of "repeat over-the-counter prescribed drugs", employees and pensioners should attach a photocopy of the "original" doctor's prescription previously submitted to Canada Life. If a photocopy is not available, you should advise Canada Life that this is a "repeat prescription" when the original doctor's prescription is submitted with the first claim.

Using the Drug Card is preferable for employees and The Company. It should be used whenever possible as it is more efficient, no sales tax is charged, no additional

administration fee is charged, and there is no additional up-front, out-of-pocket, payment required on your part.

The following are some reasonable and customary limitations under the Drug Plan that normally apply. They are reviewed regularly in light of current community and medical practices.

(1) Prescription Drugs

Reimbursement to pharmacists for drugs is normally "wholesale price + 10%" (plus the dispensing fee if appropriate). This is generally referred to as Best Available Price (BAP).

When "generic substitution" was introduced in 1996, it was necessary to peg the price of the name brand drugs and their generic substitutes to prevent the price for the generic product from escalating up to, and surpassing, the price for the name brand product. As such, a cap was put on brand name drugs and the generic substitutes. The pharmacies understand this method of pricing as it is a common community practice and pharmacies tend to limit their charges to align with this procedure.

(2) Smoking Cessation Products

Products such as nicorette gum, nicotine patch, or zyban, when prescribed by a physician, up to \$1,000 per person per year.

(3) Fertility Drugs

Fertility drugs (on The Company Drug Formulary) for a period up to 12 months, or to a maximum cost of \$5,000, whichever comes first, per lifetime.

(4) Viagra

Eligible for coverage with a yearly maximum of \$500 per person.

(5) Food Supplements

Food supplements are generally not covered; except for:

- Nutramigen for children, prescribed by a physician -- up to 85% of the cost is covered.
- Boost or Ensure for very sick adults, prescribed by a physician

Questions

Should you have any questions concerning drugs, you may phone Canada Life, or where there are special circumstances you wish to have considered they should be brought to the attention of the Human Resources Department.

ONTARIO DRUG BENEFIT (ODB) PLAN

SECTION 13.0

Pensioners living in Ontario who are seniors age 65, and older, are covered under the Ontario Drug Benefit (ODB) Plan. If a senior is eligible for The Company's Extended Health Benefits Plan and is required to pay the first \$100 per year of the ODB Plan and the dispensing fee thereafter, such payments may be claimed through Canada Life for reimbursement.

Pensioners living outside Ontario who are age 65 or older and eligible for The Company's drug benefits are also entitled to receive the first \$100 per year and the payment for dispensing fees up to \$6.11 (currently) for drugs normally covered by the ODB Plan. These pensioners should attach their receipts to a Health Claim Form and mail them to the Canada Life Assurance Company. Canada Life will not pay for any drugs normally covered by the ODB Plan.

EXTENDED HEALTH BENEFITS PLAN

SECTION 14.0

The Extended Health Benefits Plan includes the following benefits:

(1) Vision Care

Eyeglasses/contact lenses/repairs — up to a total amount of \$400.00 per person in a two-calendar year period, when provided on the written prescription of a medical doctor or optometrist for corrective lenses. Prescription sunglasses are eligible under the EHB Plan. The current two-year calendar period commenced January 1, 2021.

Sunglasses or eyeglasses for cosmetic purposes are not covered. There is no deductible for eyeglasses/contact lenses. Claims should not be submitted to Canada Life until the eyeglasses/contact lenses have been paid for in full and a receipt for "full payment" can be supplied to Canada Life. The date of the final bill is the effective date of your claim.

Radial kerotomy/laser eye surgery — in lieu of eyeglasses or contact lenses, the \$400 per person in a two-calendar year period may be applied towards the cost of laser eye surgery.

Annual **eye examinations** are covered in the year in which the Ontario Health Insurance Plan (OHIP) does not cover the eye examination.

(2) Physiotherapy Treatments

If the physiotherapist is not registered with OHIP, Canada Life will reimburse the entire cost for treatments. If the physiotherapist has an agreement with OHIP, reimbursement will be made by OHIP, not Canada Life. The physiotherapist cannot be a member of, or related to a member of, the employee's family. Some reasonable and customary limits for a Registered Physiotherapists are:

- Assessments — maximum of \$100 per assessment.
- Treatments — maximum of \$60 per treatment.

(3) Orthovisc or Synvisc Injections

Injections for the treatment of Osteoarthritis up to a lifetime maximum of \$3,000.00 per person. Note this coverage is for orthovisc OR synvisc injections, not both.

(4) Chiropractic Charges

Chiropractic charges (including X-rays) in excess of OHIP coverage, will be paid on a per visit basis up to \$500.00 maximum per person in any calendar year. Where an eligible individual is provided with the services of a duly licensed chiropractor, the claims provider will pay those charges, including charges for X-rays, in excess of what OHIP allows/pays, up to the Chiropractic Limit set out above.

(5) Podiatrists'/Chiropodists' Charges

Charges, in excess of OHIP coverage, to a maximum of \$200.00 per person per calendar year.

(6) Paramedical Services - Naturopaths, Clinical Ecologists, Homeopaths,

Acupuncturists, Osteopaths and Registered Masseurs are covered on a "per visit" basis up to an aggregate maximum of \$500.00 per person per calendar year. This is based on 50% co-insurance. For example, if an individual submits a claim for \$300.00, he/she will receive \$150.00. If the claim is for \$1,000.00, he/she will receive \$500.00 (the maximum). Reimbursement is based on the date on which the treatment was administered by the medical practitioner. Drugs and medicines must be prescribed by a medical doctor.

(7) Registered Clinical Psychologist

Payment for the services of a Registered Clinical Psychologist up to a maximum of \$2,000.00 per person during a calendar year. In order to secure benefits for the eligible psychological services, the patient must obtain a full itemized receipt signed by the registered psychologist indicating the dates of the service and the amount charged for each service. Psychologists' fees are normally only paid when the services are provided by a clinical psychologist. However, this benefit will also include payment for psychological training courses, where recommended for families of chronically ill patients (e.g. where the patient is dying), even if such training is not provided by a registered clinical psychologist, so long as such courses are recommended by a physician or registered clinical psychologist.

Some of the reasonable and customary conditions which apply include: Learning disabilities – some charges are covered for initial testing, but no coverage for reports. Aptitude Testing is not covered, as it is not treating an illness, injury, or medical condition. Reports in general are not covered.

(8) Speech Therapists

Payment for the services of qualified Speech Therapists up to \$300.00 per person per calendar year, only when the patient's attending physician or dentist authorizes in writing that such treatment is necessary.

(9) Hearing Aids

Hearing aids, including ear moulds, on the written prescription of an audiologist, or a hearing aid specialist authorized with the Ontario Government's Assistive Devices Program (ADP), once in any period of three consecutive calendar years. This can include purchase or repairs. There is no deductible for hearing aids. Reasonable and customary costs will be reimbursed. If an eligible individual requires hearing aids for both ears, they should be purchased at the same time.

Note: The ADP covers a portion of the costs, for one ear, once every five years. Canada Life will reimburse the outstanding balance.

(10) TENS (Transcutaneous Electronic Nerve Stimulator) Units

Tens units, including associated supplies, on a reasonable and customary basis when prescribed by a physician once every three years.

(11) Wigs and Liquid Meals for Cancer Patients

Wigs - one every three calendar years - for cancer patients receiving chemotherapy or radiation treatment. This does not include hair care products or dry cleaning. The reasonable and customary limit for wigs for cancer patients, when prescribed by a physician, up to \$500 (one every three calendar years). Liquid meals for cancer patients receiving chemotherapy or radiation treatment are also covered.

(12) Blood and Blood Products

On the certificate of the attending physician, Canada Life will pay the customary charge where reasonable for blood and blood products for transfusions, to the extent to which such service is not paid for or provided by a government department or agency (e.g. OHIP, WSIB).

(13) Laboratory Tests

Laboratory tests performed by a qualified person when not covered by any government agency will be covered. Where an eligible individual receives diagnostic services in a Hospital or Laboratory, authorized by a Physician, Canada Life will pay for such diagnostic services to the extent they are not paid by OHIP.

(14) A Lympha Press Pump

The rental or purchase of a lympha press pump and associated equipment will be covered, when medically documented that the patient has lymphedema and has been unresponsive to other types of therapy. The associated equipment includes pumps, pump sleeves, gauntlets and graduated compression sleeves.

(15) Radium and Radioactive Isotope Treatments

When authorized in writing by the patient's attending physician, Canada Life will pay the customary charge where reasonable for radium and radioactive isotope treatments, to the extent to which such service is not provided by a government department or agency (e.g. WSIB or OHIP).

(16) Custom-Made Boots or Shoes / Orthotics

Purchase of custom-made or ready-made boots or shoes, and/or modification to same prescribed by a podiatrist, chiropodist, orthopedic surgeon, or general medical practitioner. Limit of two pairs per calendar year.

Canada Life will pay the reasonable and customary charges for such boots or shoes, or modifications and adjustments to such footwear.

Ready-made extra depth shoes are only covered when medically required and prescribed by a licensed practitioner to treat a skeletal deformity, specifically hammer toes or clawfoot. They are not covered to accommodate orthotics or for extra wide feet. Other items not covered include orthopedic winter boots, sandals, and comfort shoes such as Reebok, Nike, Rockport, or Mephisto.

Orthotics (arch supports) prescribed by a podiatrist, chiropodist, chiropractor, orthopedic surgeon, or general medical practitioner, are covered for one pair of hard/regular orthotics made out of plastic (including semi-rigid) every three calendar years up to a maximum of \$375.00. Soft orthotics (leather or cork), sport orthotics, or fashion orthotics are not covered. However, they will be considered if the individual has a medical condition preventing the wearing of hard orthotics, if supported by justification from the licensed practitioner.

Note: As children's feet grow, reimbursement may be up to \$375.00 per year until age 18.

(17) Respiratory Devices

Respiratory devices, such as aero chambers, nebulizers, prescribed by a physician are covered for the amount above which the Assistive Devices Program (ADP) pays. If ADP does not cover a respiratory device, Canada Life will provide full reimbursement providing the item is the least costly to satisfy the medical necessity.

Note: If a patient is reimbursed for an aero chamber and later requires a compressor, and it qualifies under the ADP, the amount paid for the aero chamber will be deducted from the cost of the compressor.

(18) Most Diabetic Supplies

Most diabetic supplies are covered; including needles and syringes, dextrosticks, glucosticks, autolets, autoclicks, lancets, Preci-jet guns, insulin pumps and necessary hardware, and blood glucose meter (e.g.: glucometer).

Note: a patient does not need to be insulin dependent to be eligible for a blood glucose meter. Replacement of a blood glucose meter, Preci-jetgun, insulin pump and necessary hardware, are eligible once every three calendar years.

(19) Other Medical Equipment

A variety of other items are eligible when prescribed by a physician. Eligible items include prosthetic appliances, crutches, splints, casts, trusses, braces; oxygen and rental of equipment for administration thereof; rental of wheel chairs, respirators and manual hospital-type beds. Consideration may be given to claims for purchase or repair of such articles.

Where an eligible person, on the basis of a written report or prescription from the attending physician, requires an artificial limb or eye, cervical collars, cervical pillows (maximum of one per individual per year), braces, catheters, urinary kits, external breast prosthesis following mastectomies (the additional 25% not covered by the Assistive Devices Program (ADP), once every two years, and up to three brassieres per year), ostomy supplies (where a surgical stoma exists), Canada Life will pay the reasonable and customary charges for such articles.

A lumbo-sacral support belt qualifies as a back brace. The regular Obus Form back support and similar back supports are covered if prescribed by an orthopedic surgeon or chiropractor (but not a general practitioner), up to one per individual, once every five years. The maxi and mini Obus Form back supports are not covered and the seat support is not covered.

Support stockings, such as Jobst or Sigvarius, are covered. An eligible individual may claim a maximum of three pairs per year. The less expensive support stockings, readily available without a prescription, are not covered.

Where an eligible person, on the written advice of the attending physician, requires for therapeutic use a wheelchair (electric wheelchairs are excluded unless a certified orthopedic specialist recommends a power-driven unit because of a medical necessity), a manual hospital bed, crutches, cane, walker, oxygen set and respirator, the claims provider will pay a reasonable rental or other charge; provided, however, in cases where the eligible person is entitled to have the above equipment provided or the rental charges or cost thereof paid for by a government department or agency (e.g. WSIB, OHIP), the Plan shall incur no liability under this clause.

The decision to rent or purchase shall be made by Canada Life and shall be based on the Physician's estimate of the duration of need, but in any event Canada Life will not pay rental charges in excess of the purchase price. Consideration may be given to the repair of the articles listed above when considered reasonable by Canada Life.

- The following items are not covered:
- pacemakers
- morphine pumps
- circulatory pumps
- ortho pac bone growth stimulators
- bathtub bars/hand rails
- commode chairs
- electronic air cleaners
- central/home air conditioners
- water beds
- craftomatic beds
- hot tubs
- exercise equipment
- chair lifts
- access ramps

(20) Private-Duty Nursing

Private duty nursing, by a Registered Nurse who is registered in any of the provinces of Canada (not a relative); either in the hospital or home, providing it is ordered by the attending physician and only to the extent the patient's medical needs for registered nursing cannot be provided through the Community Care Access Centre (CCAC). Custodial care, agency fees, or shift/overtime premiums are not covered. The maximum fee paid is the level set by the largest Nursing Registry in the Province of Ontario. Does not cover services which:

- are mainly custodial;
- are mainly to assist with the functions of daily living or to dispense oral medication; or
- could be provided by someone who does not have the professional qualifications of a Registered Nurse.

(21) Ambulance Services

Coverage is provided for the portion of ambulance services not covered by any government agency. Professional ambulance service will be paid to the nearest facility in Ontario competent to care for the individual when the service is paid for in part by a government plan or agency (e.g. OHIP). This also includes air ambulance, when necessary.

(22) Dental Treatment

Dental treatment is covered for the restoration of the area damaged as the result of an **accident** which happens while the plan is in effect, but not for repair or replacement of artificial teeth. Treatment must be commenced within 90 days of the accident, and the plan will not pay for any charges for treatment performed after the 365th day following the accident or after termination of your coverage, whichever is the earliest.

DENTAL BENEFITS

(EXCLUDING ORTHODONTIC BENEFITS)

SECTION 15.0

Eligible Charges

Class A Services – Preventative & Basic Restorative Services -100% Benefit

Class B Services- Major Restorative Services – 75% Benefit

These are the charges, subject to any limitations or exclusions provided in this coverage, actually made to the Employee for those services which are included for payment in the applicable List of Dental Procedures (see Appendix).

A charge for a service is eligible only to the extent that it does not exceed the scheduled limit for that service in the Ontario Dental Association's (ODA) Suggested Fee Guide for General Practitioners.

Dentists' Fees will only be paid up to the amount shown in the **current Ontario Dental Association's (ODA) Suggested Fee Guide For General Practitioners**.

A charge is deemed to have been incurred on the date the service was completed.

List of Dental Procedures

This List includes only those services listed in the Appendix (as designated by the ODA Suggested Fee Guide for General Practitioners). Any services not listed and so designated will be excluded. Fees for Specialists may be considered up to fee amount for a General Practitioner if applicable.

If two or more services included in this List are separately suitable for the dental care of a specific condition, according to customary dental practices, and if a charge is actually incurred for one of such services, then a charge for only the least expensive of such services will be considered to have been incurred.

Predetermination

For the claimant's protection, if the course of treatment involves charges of \$600.00 or more, it is suggested that the Treatment Plan should be submitted to Canada Life in advance for predetermination of benefits. Canada Life will advise the employee before treatment is started of the amount allowed by the Plan. Predeterminations are valid for a maximum of 6 months.

Charges Not Covered:

- Dental services not listed.
- Charges for a procedure for which an active appliance was installed before the patient was covered.
- A charge incurred while the patient's coverage is not in effect.
- Services not performed by a licensed dentist.
- Cosmetic dentistry or services otherwise not reasonably necessary, or customarily performed, for the dental care of the covered individual.
- Charges in excess of the amount shown in the Ontario Dental Association Fee Guide for General Practitioners.
- Dental services paid through any other sources, such as a government agency or any other insurer.

ORTHODONTIC BENEFITS

SECTION 16.0

Coverage is based on 75% paid by Canada Life and 25% paid by the employee. There is a lifetime maximum of \$4,000.00 per eligible individual.

Prior to the commencement of orthodontic treatments, the Dentist should submit an Orthodontic Treatment Plan to Canada Life which:

- Provides a classification of the malocclusion or malposition,
- Recommends and describes necessary treatment by orthodontic procedures,
- Estimates the duration over which treatment will be completed,
- Estimates the total charge for such treatment, and
- Is accompanied by cephalometric x-rays, study models and such other supporting evidence as Canada Life may reasonably require.

Canada Life will inform the employee of the amount eligible for reimbursement under the Plan.

The total Eligible Charges scheduled to be made in accordance with an Orthodontic Treatment Plan shall be considered to be made in equal quarterly installments (except that the amount of the initial fee shall be 25% of the total treatment costs) over a period of time equal to the estimated duration of the Orthodontic Treatment Plan. The first installment shall be considered to occur on the date on which the orthodontic appliances are first inserted, and subsequent installments shall be considered to occur at the end of each three-month period thereafter.

If benefits are being paid at termination of coverage for orthodontic services, they will be continued for charges incurred during the rest of the quarterly installment period in progress, provided payment for that quarterly installment period has not already been made.

List of Orthodontic Services

- Consultations
- Pretreatment Diagnostic Services
 - Diagnostic Models, X-rays
 - Cephalometric work-up
- Preventive and Interceptive Orthodontics (including Appliances and Maintenance)
 - Habit Inhibiting
 - Space Regaining
 - Space Maintenance
 - Cross Bite Correction
 - Dental Arch Expansion
- Corrective Orthodontics
 - Removable and Fixed Appliance Therapy
 - Retention

Benefits

Payable For

The Eligible Charges incurred in connection with an orthodontic procedure performed on a person.

Condition for Benefit

The charges are incurred during a three-month period, referred to above in ELIGIBLE CHARGES, which commences while the person is a Covered Individual.

Amount Payable

The Benefit Percentage of the ELIGIBLE CHARGES, but not to exceed the Maximum Orthodontic Benefit for all services and supplies furnished a person during his or her lifetime (75% benefit, \$4,000.00 lifetime maximum).

LIMITATIONS ON BENEFITS OUTSIDE ONTARIO

SECTION 17.0

17.1 Extended Health Benefits Plan

This Plan will not pay for any service or supply provided outside Ontario an amount greater than it would pay for such benefit if supplied in Ontario.

17.2 Dental Plan

Treatment received outside the Province of Ontario is covered, but limited to the amount shown in the Ontario Dental Association's Fee Guide for General Practitioners. Patients should obtain a complete written description of the procedures for dental treatments performed outside Canada.

17.3 Reimbursement of Claims Outside of Canada

All moneys payable under the Plan will be paid in Canadian dollars. For claims incurred outside Ontario, the foreign exchange rate will be the rate in effect on the date the charges for services are paid by the employee in the foreign country.

BENEFIT COVERAGE FOR EMPLOYEES TRAVELLING OUTSIDE ONTARIO

SECTION 18.0

(Note: For Management Employees Bands I-M, the following coverage is only in place while the employee remains an active regular employee.)

18.1 OHIP Coverage

If an employee is traveling in the United States or overseas, he/she can continue to be covered by OHIP subject to OHIP regulations. OHIP regulations may change from time to time so it is important to verify current rules.

If the duration is less than 6 months, there is no requirement for the employee to contact OHIP.

If the duration is more than 6 months, the employee must apply to his/her Local District OHIP Office for approval of continuous eligibility.

For people traveling outside Canada, OHIP covers only emergency health services. Many health services outside Canada cost much more than what OHIP covers.

18.2 Health & Dental Benefits

Employees and their dependents have additional health and emergency/travel assistance coverage when they experience an **emergency** illness or injury when traveling outside their province of residence. The Travel Assistance brochure outlines the emergency and travel assistance provided.

After the emergency has been dealt with, this additional out-of-country coverage ceases. On-going medical care, even for the incident/situation which began as an emergency, is not covered by these additional benefits.

18.3 WSIB Compensation

If the employee is paid by the Company, the employee would continue to be eligible for Workplace Safety & Insurance Board (WSIB) benefits subject to WSIB regulations. WSIB regulations may change from time to time so it is important to verify current rules.

OHIP COVERAGE FOR PENSIONERS

SECTION 19.0

To qualify for coverage under the Ontario Health Insurance Plan (OHIP), pensioners must have a principal residence in Ontario and must meet the OHIP minimum residency requirements. Pensioners should contact their local OHIP office prior to spending an extended period of time outside of Ontario.

APPENDIX

List of Dental Procedures

This appendix contains a complete list of dental procedures covered under the Company's Dental Plan.

CLASS A SERVICES – PREVENTIVE & BASIC RESTORATIVE SERVICES **(ELIGIBLE EXPENSES – 100% PAYMENT)**

Examinations

Initial examination of a new patient

Re-examination of a previous patient (once every 6 months)

Periodontal examination (once every 6 months)

Specific examination

Emergency examination

Radiographic Examination and Interpretation (X-Rays)

Intraoral radiographs complete, once every 3 calendar years

Introral radiographs (1 to 15).

Intraoral, Occlusal radiographs

Intraoral, Bitewing radiographs, (from 1 to 6 films), limit once every 6 months.

Extraoral Radiographs

Sinus examination

Sialography

Use of radiopaque dyes to demonstrate lesions

Temporomandibular Joint radiographs

Panoramic (full mouth) radiographs, limit once every 3 calendar years.

Cephalometric radiographs

Tracing of radiographs

Interpretation of radiographs from another source, per unit of time

Hand and wrist radiographs

Tomography radiographs

Tests and laboratory examinations

Diagnostic Photographs

Treatment Planning

Consultations (2 times per year)

Preventive Services

Polishing (once every 6 months)

Scaling, limited to a maximum combined with periodontal root planing of 14 units per calendar year

Preventative recall packages(once every 6 months)

Preventative recall packages for under age 18 only (once every 6 months)
Fluoride treatment for under age 19 (once every 6 months)
Oral hygiene instruction
Finishing Restorations
Pit and Fissure sealant to permanent molars only, once every three calendar years, up to and including age 18
Protective Mouth Guard
Interproximal discing of teeth
Control of Oral Habits
Myofunctional Therapy
Space Maintainers
Carries, Trauma and Pain Control
Restorative Services
Primary teeth – amalgam
Permanent bicuspid and anterior teeth -amalgam
Permanent molars
Retentive pin reinforcement
Acrylic or composite restorations
Surgical Services – Removal of Teeth, Removal of Erupted Tooth - Uncomplicated
Single tooth
Each additional tooth in same quadrant, same appointment
Removal of erupted tooth (complicated)
Removal of impacted tooth
Removal of Residual Roots
Anesthesia
Anesthesia – required in relation to covered services
Periodontal Services (for periodontal disease and therapeutic treatment only, not preventative treatment) – Non-Surgical Services
Displacement Dressing
Nervous and Muscular Disorders
Oral Manifestations
Desensitization
Surgical services
Adjunctive Services
Periodontal splinting
Occlusion
Root Planing, limited to a maximum combined with preventive scaling of 14 units per calendar year
Antimicrobial agents
Periodontal appliances
Maintenance appliances

Endodontic Services

Pulpotomy, permanent teeth

Root Canal Therapy

Apexification

Re-insertion of Dentogenic Media

Apicoectomy

Retrofilling

Miscellaneous Surgical Services

Miscellaneous Endodontic Procedures

Post surgical treatment

Periodontal abscess/pericoronitis

Extensive Oral Surgery

Surgical exposure

Surgical movement

Surgical Enucleation

Alveoloplasty

Excision of bone

Removal of bone

Gingivoplasty and/or stomatoplasty

Vestibuloplasty

Surgical excision and drainage

Surgical incision

Fractures

Frenectomy

Miscellaneous surgical procedures

Adjunctive General Services

Therapeutic injections

In-office laboratory procedures

CLASS B SERVICES - MAJOR RESTORATIVE SERVICES

(ELIGIBLE EXPENSES – 75% PAYMENT)

Prosthodontic Services – Removable

Complete maxillary denture - once every 3 calendar years

Complete mandibular denture - once every 3 calendar years

Complete maxillary and mandibular dentures - once every 3 calendar years

Immediate and transitional dentures- once every 3 calendar years

Transitional partial denture - once every 3 calendar years

Dentures, partial, acrylic - once every 3 calendar years

Complete and partial denture - once every 3 calendar years

Denture adjustments

Denture repairs/additions

Denture rebasing and relining

Tissue conditioning

Note: Denture Therapists/Denturists will be reimbursed under the Denture Therapists' Fee Guide for **full** upper and/or lower dentures at 75%. The fee for construction of full upper and/or lower dentures by a Denture Therapist/Denturist includes lab fees as set out in the Denturist Fee Guide. As such, separate lab fees are not reimbursed, as these are considered to be included in the allowable fees.

Major Restorative Services

Stainless steel crowns

Gold foil restorations

Metal inlay restorations

Retentive pins

Porcelain restorations

Other Restorative Services

Prosthodontic Services - Fixed

Pontics

Repairs, Replacement

Porcelain repair

Retainers, Metal

Retainers – Crowns

Removal/Repairs to Fixed Bridge

Splinting

Retentive pins in fixed prosthetics

Provisional coverage

Temporomandibular Joint Appliances

Temporomandibular Joint Appliances and maintenance charges, to a lifetime maximum of \$1,300.00 per person. After a period of 5 years from the initial date of purchase, on the written recommendation of the attending physician and with the provision of any required supporting evidence, the \$1,300 maximum may be reinstated.
