Employee Benefits Program

Canadian Union of Public Employees (CUPE) Local 5500

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WELCOME TO YOUR EMPLOYEE BENEFITS PROGRAM

About Your Program

As a valued employee, you are entitled to the medical and financial security of your Employee Benefits Program, provided by the City of Ottawa (the City) in partnership with the Canada Life Assurance Company (Canada Life).

Government health plans can provide coverage for medical expenses, such as hospital charges and doctor's fees. In case of disability, government plans (such as Employment Insurance, Canada Pension Plan/Quebec Pension Plan, and provincial worker's compensation benefits, etc.) may provide some financial assistance. But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care plans, disability programs and group life insurance plans – such as the benefits offered by the City and described in this booklet – supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

About This Booklet

This booklet works in conjunction with your *Benefits-at-a-Glance* providing important details about your coverage, such as:

- when group benefits begin and end (in the Eligibility section)
- important limitations to your coverage that you should be aware of (in the What's Not Covered or Limitations sections for each plan)
- the changes in your coverage if you continue to work at the City after age 65 (in the Work Past Age 65 section)

The Glossary provides a brief explanation of the important terms (shown with an underline) used throughout this booklet.

We strongly encourage you to read through this booklet and get to know your Employee Benefits Program.

Applying for Group Benefits

When you are eligible for benefits, Human Resources will have you complete the necessary benefit enrolment forms.

Keeping Your Information Current

To ensure that coverage and personal information is kept up-to-date for you and your dependents, it is important that you report any changes to the Payroll, Pensions and Benefits Service Centre. Keep in mind that changes as a result of a life event must be reported within 31 days to be eligible to make changes to your benefits coverage. Contact the Payroll, Pensions and Benefits Service Centre when you need to:

- change your marital status
- change your coverage level (from family to single or vice versa)
- change or add information about your spouse's coverage under another plan (coordination of benefits)
- change the smoking status (from smoker to non-smoker or vice versa) for Optional Life Insurance and Optional Critical Illness Insurance
- add or remove dependents
- change your beneficiary
- change your address, emergency contact information or name
- apply for coverage previously waived

To make a change, go to the Benefit Forms section on Ozone or contact the Payroll, Pensions and Benefits Service Centre for the appropriate form.

IMPORTANT NOTES

This booklet describes the principal features of the group benefits program sponsored by the City; however, the group policies or contracts issued by Canada Life and Chubb are the governing documents, and if there are variations between the information in this booklet and the provisions of the group policies or contract, the group policies or contracts will prevail.

You should note that your benefits for the Health, Dental and Long Term Disability Plans are provided directly by the City. Canada Life (the carrier) has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices.

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of the City. The information in this booklet is a summary of the provisions of the group policies or contracts. The booklet, in either its paper or electronic form, is provided for information purposes only and does not create or confer any contractual rights or obligations. All rights and obligations of the City and the carrier (s) are governed by the paper versions of the group policies or contracts. Contact the City's Payroll, Pensions and Benefits Service Centre if you require more information. The final interpretation of your coverage is governed solely by the terms of the official group contracts. No alteration of the electronic copy of this booklet is permitted by any person, except by an authorized representative of the City or the carrier(s), as applicable.

Possession of this booklet alone does not mean that you or your dependents are covered. The group policies or contracts must be in effect and you must satisfy all the requirements of the group policies or contracts.

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

Thinking of Printing?

This booklet has been provided in electronic format for easy access and to reduce paper waste. Please consider printing only the pages you need or saving this booklet to your own personal folder.

Access to Documents

You have the right, upon request, to obtain a copy of all the policies, 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 or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, *Quebec Civil Code*).

Non-insured Benefits

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

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.

Non-insured Benefits

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

Benefit Limitation for Overpayment

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

Non-insured Benefits

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

Protecting Your Personal Information

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

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

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

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

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

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

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

Notice of Liability for Benefits

The City has entered into an agreement with the Canada Life Assurance Company whereby where provided and applicable, the Health Plan (excluding Travel Assistance) and Dental Plan benefits outlined in this booklet are not insured through Canada Life, but rather are self-funded through the City of Ottawa.

This means that the Health Plan (excluding Travel Assistance) and Dental Plan benefits are:

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

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

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

If Quebec law applies, any communication that you receive from Canada Life with respect to any uninsured benefit will indicate that it is not under the supervision and control of the Autorité des marchés financiers.

PLAN DETAILS

Eligibility

When Coverage Begins

You are eligible for group benefits if you:

- are actively at work
- work the minimum hours specified in your *Benefits-at-a-Glance*
- are younger than the termination age, as outlined in the Work Past Age 65 section
- reside in Canada

In some cases, there may be a waiting period before you are eligible for coverage under certain plans. Refer to your *Benefits-at-a-Glance* for the details.

If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the day on which you are again actively at work.

For benefits where evidence of insurability is required, your coverage will be effective on the date you become eligible or the date the evidence is approved by Canada Life, whichever is later. See your *Benefits-at-a-Glance* for when evidence is required.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. Keep in mind that you have 31 days following a life event to register a new dependent and be eligible to make changes to your benefits coverage. For Health and Dental benefits, you must apply for coverage for yourself in order for your dependents to be eligible.

You and your dependents must also maintain coverage under the provincial health plan to be eligible for benefits under the City of Ottawa Employee Benefits Program.

For all benefits except Optional Critical Illness Insurance, if one of your dependents (other than a new-born infant) is hospitalized on the date coverage would normally become effective, coverage will begin on the day following discharge from the hospital.

When Coverage Ends

If you continue to work past age 65, your group benefits continue, however, some of your coverage changes or ends. The Work Past Age 65 section provides the details on when coverage ends and what changes if you continue to work after age 65.

Your group coverage will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you enter the armed forces of any country on a full-time basis
- the date the group contracts or policies terminate
- the date you no longer make any required contributions towards the costs of coverage
- your death

Your dependent's coverage terminates on the date your coverage terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

If You Apply Late

If you previously waived dependent life, health or dental coverage for yourself or your dependents because similar coverage was offered under your spouse's plan, and you later apply for dependent life, health or dental benefits, your application is considered late if either of these events occurs:

- you apply for coverage more than 31 days after the date the benefits terminated under your spouse's plan
- you apply for coverage and the benefits under your spouse's plan have not terminated

To apply, contact the Payroll, Pensions and Benefits Service Centre.

If you previously waived or cancelled coverage for a reason other than coverage under your spouse's plan, your request for coverage as a late applicant will be reviewed on a case-by-case basis.

Health Plan

If you apply late for the Health Plan, you will have to provide evidence of insurability and get approval from Canada Life before coverage can begin.

Dental Plan

If you apply late for the Dental Plan, the amount that you can claim will be limited to $125 per person for the first 12 months of coverage.

Dependent Life Insurance

If you apply late for Dependent Life Insurance, you will have to provide evidence of insurability and get approval from Canada Life before coverage can begin.

Health

If you or one of your dependents incurs charges for any of the eligible expenses specified, your Health Plan benefit can provide financial assistance.

Managed care initiatives are intended to be part of the plan. These currently include positive enrolment/coordination of benefits and drug ingredient cost adjudication. Over time, these initiatives could be expanded to include, for example:

- mandatory generic substitution
- managed formularies

Refer to your *Benefits-at-a-Glance* for the reimbursement levels, applicable maximums and other important information, including the lifetime maximum for expenses incurred outside Canada.

All expenses are reimbursed based on Canada Life's assessment of reasonable and customary fees.

What's Covered

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Canada Life, provided they are:

- medically necessary for the treatment of sickness or injury and recommended by a physician, except for the expenses listed under the About Travel Assistance section and as noted under the paramedical practitioners listed under Professional Services
- incurred for the care of a person while insured under this group benefits program
- not covered under the provincial health plan or any other government-sponsored program

Payment of In-Canada Prescription Drugs

The covered expense is subject to any deductible, drug dispensing fee maximum and reimbursement percentage for drugs, as specified in your *Benefits-at-a-Glance*.

The maximum amount for any eligible expense is the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary. If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

Where a prescription contains a written direction from the physician or dentist that the prescribed drug or medication is not to be substituted with another product, the full cost of the prescribed product is covered if it is an eligible expense under this benefit.

Drugs and Medicines

- drugs or medicines dispensed by a licensed pharmacist, and which by law or convention, require the written prescription of a physician, subject to a maximum dispensing fee as specified in your *Benefits-at-a-Glance*. Fertility drugs are subject to a lifetime maximum of $15,000 per person
- injectable drugs
- potassium supplements, as determined by Canada Life to be life-sustaining in nature and which are licensed for sale in Canada as a natural health product
- life-sustaining drugs

The following expenses are not covered:

- the administration of injectable drugs
- smoking cessation drugs
- drugs, biologicals and related preparations, which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home

Preventive

- preventive vaccines and toxoids
- oral contraceptives, intrauterine devices and diaphragms

Health Care Facilities

- hospital charges in excess of the charges for standard ward accommodation, up to the level of accommodation specified in your *Benefits-at-a-Glance*, provided:
  - the person was confined to hospital on an in-patient basis, and
  - the accommodation was specifically elected in writing by the patient
- 90% of expenses incurred in Canada (other than in Ontario), or in the United States, for you, the employee, for participation in a program for the treatment of alcoholism at a detoxification centre or rehabilitation centre, provided the provincial health plan contributes towards the cost and timely treatment is not available in your province of residence, up to $2,000 in any three consecutive calendar years, to a lifetime maximum of $4,000 per person
- 90% of expenses incurred in Ontario for confinement in a detoxification or rehabilitation centre for the treatment of alcoholism
- room, board and normal nursing care in a licensed nursing home or clinic (for convalescent or chronic care, but excluding custodial care), to a maximum of $20 a day
- medical and surgical treatment incurred by a person on an out-patient basis (excluding physicians' and special nurses' fees)

Medical Transportation Services

- licensed ambulance service provided in the covered person's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available
- if medically necessary, transportation by any form of licensed ambulance (including air ambulance) or by any vehicle normally used for public transportation, for:
  - transfer to the nearest appropriate medical facility or hospital for necessary treatment
  - medical evacuation for admission to hospital in the province where the patient normally resides

Ground transportation to and from the hospital and airport, at the point of departure and arrival, is also eligible.

See the Claims section for information about receiving reimbursement for ambulance services.

Medical Supplies and Services

Rental or, at Canada Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician and covered under this provision will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Medical Equipment

- rental or, when approved by Canada Life purchase of:
  - mobility equipment – crutches, canes, walkers, and wheelchairs
  - durable medical equipment – hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses and Supports

- artificial eyes and limbs, including breast prostheses, where the loss of the eye or limb is the result of an accident while the person was covered under the plan
- wigs and hairpieces for patients with temporary hair loss as a result of chemotherapy treatment, to a maximum of $500 per person per lifetime
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear which are attached to and form part of a brace (if the shoes do not form part of a brace, up to two pairs per calendar year will be eligible)
- purchase of casted, custom-made orthotics
- surgical stockings, to a maximum of $150 per person per calendar year
- surgical brassieres

Other Supplies and Services

- the cost of standard syringes, needles and diagnostic aids, including insulin, novolin pens, testing supplies, insulin infusion sets, blood glucose monitoring machines, flash glucose monitors (including sensors), continuous glucose monitors (including sensors and transmitters), and external insulin infusion pumps, if required for treating diabetes (unless specifically included here, charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)
- ileostomy, colostomy and incontinence supplies
- charges for viscosupplementation, to a maximum of $1,200 per person per calendar year
- oxygen
- medicated dressings and burn garments
- microscopic and other similar diagnostic tests, including x-rays, and services

rendered in a licensed laboratory

Dental Services

- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Professional Services

- physicians' services, where permitted by law, for expenses incurred in Canada, whether inside or outside the person's province of residence
- private-duty nursing services that are deemed to be within the practice of nursing and that are provided in the patient's home by a registered nurse or a registered nursing assistant (or equivalent designation) who has completed an approved medications training program
- Eligible expenses are subject to the maximum specified in your *Benefits-at-a-Glance*. Canada Life suggests that a detailed treatment plan be submitted with cost estimates before private-duty nursing services begin. Canada Life will then advise you of any benefit that will be covered.
- Charges for the following services are not eligible:
  - service provided primarily for custodial care, homemaking duties or supervision
  - service performed by a nursing practitioner who is an immediate family member or lives with the patient
  - services performed while the patient is confined in a hospital, nursing home or similar institution
  - services that can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household
- Services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields), to the maximum specified in your *Benefits-at-a-Glance*:
  - physiotherapist, massage therapist, chiropractor, psychologist/psychotherapist/social worker, speech therapist, podiatrist, osteopath and naturopath

Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses before reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this group benefits program are payable only after the provincial plan’s maximum for the benefit year has been paid.

Recommendation by a physician or midwife is required every 12 consecutive months for massage therapy. Recommendation for all other services is not required.

Hearing Aids

- charges for cost, installation, repair and maintenance of a hearing aid or aids (including charges for batteries), to the maximum specified in your *Benefits-at-a-Glance*

Vision Care

- purchase and fitting of prescription glasses, including prescription safety glasses, or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to the maximum specified in your *Benefits-at-a-Glance*
- eye exams, to the limits specified in your *Benefits-at-a-Glance*
- visual training or remedial exercises
- contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea) or aphakia, to a maximum of $250 per person every two consecutive calendar years, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by glasses

Out-of-Province or Out-of-Canada Expenses

- emergency medical treatment of a sickness or injury that occurs while temporarily outside the province of residence. Refer to your *Benefits-at-a-Glance* for the maximum number of days allowed per trip and the lifetime maximum for expenses incurred outside Canada

A medical emergency occurs when a covered person, travelling outside his or her province of residence, requires immediate medical attention due or related to:

- a sudden, unexpected injury that occurs, or a new medical condition which begins while a covered person is travelling outside his or her province of residence
- a previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his or her province of residence

Such medical emergency no longer exists when, supporting medical evidence shows and in the opinion of the attending physician, the covered person is able to return to his or her province of residence.

For all non-emergency medical treatment outside Canada, Canada Life requires that it be recommended by a physician practicing in Canada and suggests that a detailed treatment plan be submitted with cost estimates before treatment begins. Canada Life will then advise you of any benefit that will be provided.

Charges for the following are payable under this expense:

- physicians' services
- hospital room and board at standard ward rates
- the cost of special hospital services
- hospital charges for out-patient treatment

See the Medical Supplies and Services section for the details of coverage for licensed ambulance services and medical evacuation.

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the provincial plan.

All other charges incurred while outside the province of residence are payable under the appropriate eligible expense on the same basis as if they were incurred in the province of residence.

Canada Life, and the company contracted by Canada Life to provide the services described in the About Travel Assistance section, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Travel Assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances that interfere with or prevent the provision of any services.

What's Not Covered

No payment will be made for expenses resulting from:

- a medical emergency related to pregnancy for a covered person who is pregnant and travelling outside her province of residence within four weeks of the due date
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot
- any injury or illness for which the person is entitled to benefits under any provincial worker's compensation act
- examinations required for the use of a third party
- travel for health reasons
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication
- cosmetic surgery or treatment (when so classified by Canada Life) unless such surgery or treatment is for accidental injuries and began within 90 days of an accident
- any charges for services, treatment or supplies:

  - for which there would be no charge except for the existence of coverage
  - which are performed or provided by an immediate family member or a person who lives with the patient
  - which are provided while confined in a hospital on an in-patient basis
  - which are not specified as an eligible expense under this plan
- expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except for specified treatment (as listed in the Out-of-Province or Out-of-Canada Expenses section). Such expenses incurred outside Canada on an elective basis are not payable
- drugs, sera, injectables and supplies that are not approved by Health Canada or are experimental or limited in use whether or not so approved
- experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate medical specialty society
- services, treatments or supplies eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan. Canada Life will only consider that amount of an eligible expense that is over and above the amount that would be payable by the government plan

About Travel Assistance

The Travel Assistance Program provides medical assistance through a worldwide communications network that operates 24 hours a day. The network locates medical services when required as a result of a medical emergency arising while you or your dependents are travelling. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from your home. You must be covered by the government health plan in your home province to be eligible for travel assistance benefits.

A medical emergency occurs when a covered person, travelling outside his or her province of residence, requires immediate medical attention due or related to:

- a sudden, unexpected injury that occurs, or a new medical condition which begins while a covered person is travelling outside his or her province of residence
- a previously identified medical condition that was stable, but not diagnosed as terminal or prescribed for palliative care, at the time of departure from his or her province of residence

Such medical emergency no longer exists when, supporting medical evidence shows and in the opinion of the attending physician, the covered person is able to return to his or her province of residence.

The following assistance services are provided, subject to Canada Life's prior approval, when required as a result of a medical emergency that occurs during the first 180 days while travelling outside your normal province of residence.

- **On-site hospital payment** – When required for admission, to a maximum of $1,000
- **Medical evacuation** – 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
- **Visitation of a family member** – Transportation and lodging for one family member joining a patient hospitalized for more than seven days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket
- **Lodgings for your travel companion** – 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
- **Return transportation** – 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
- **Return of deceased to home** – In case of death, preparation and transportation of the deceased home
- **Return of minor children to 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
- **Vehicle return** – 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. 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. Meal expenses are not covered.

How to Access Travel Assistance – Your Benefits Card

Your benefits card lists the toll-free numbers to call in case of an emergency, while travelling outside your province. The toll-free numbers will put you in touch with the international travel assistance organization.

Your benefits card also lists your plan and identification numbers, which the travel assistance organization needs to confirm that you have Travel Assistance coverage.

If you do not have a benefits card, please contact Canada Life. You can also print a copy of your benefits card from Canada Life's GroupNet™ for Plan Members online site, or access the information using Canada Life's mobile app (for more information, see Canada Life Online under the Contacts section).

Dental

Your Dental Plan provides financial assistance for you and your dependents for the dental services specified below under What's Covered.

Refer to your *Benefits-at-a-Glance* for the reimbursement levels, applicable maximums and the dental and denturist fee guide on which reimbursement is based.

All expenses are reimbursed based on Canada Life's assessment of reasonable and customary fees.

What's Covered

Eligible expenses are those that are recommended as necessary by a dentist, physician or a denturist (when the denturist is permitted by provincial regulations and/or the applicable licensing body to make recommendations) and are not in excess of the suggested fee outlined in the dental association guide or the minimum fee in the denturist association fee guide. Dental treatments are considered eligible if performed by a dentist, denturist or dental hygienist who practices within the scope of his or her license.

There are several dental procedures that are covered by provincial health plans up to certain maximums. If the dentist or dental surgeon chooses to charge more than the amount payable by the provincial plan, legislation in some provinces does not permit the excess charges to be eligible under this plan.

If the cost of any proposed dental treatment is expected to exceed $500, Canada Life suggests that you submit a detailed treatment plan from your dentist before the treatment begins. You will then be advised of the amount you are entitled to receive under this benefit.

Basic Services

- complete oral examinations, once every three years
- full mouth x-rays, once every three years
- polishing, subject to the frequency outlined in your *Benefits-at-a-Glance*
- recall examinations and bitewing x-rays, subject to the frequency outlined in your *Benefits-at-a-Glance*
- fluoride treatment, for children age 18 years and under, subject to the frequency outlined in your *Benefits-at-a-Glance*
- routine diagnostic and laboratory procedures required in relation to dental surgery

- oral hygiene instruction
- fillings (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants. Replacement fillings are covered only if:
  - the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that there is an allergy to amalgam
- pre-fabricated full-coverage restorations (metal and plastic)
- space maintainers (excluding appliances placed for orthodontic purposes)
- appliances to control oral habits
- minor surgical procedures, simple extractions and post surgical care
- complicated extractions including impacted and residual roots
- consultation by the attending dentist
- anaesthesia and conscious sedation required in relation to dental surgery
- denture relines, rebases, resilient liner in relined or rebased dentures, denture adjustments, repairs, including repairs to covered bridgework, additions, tissue conditioning and resetting of denture teeth and denture remakes
- repairing, resurfacing or recementing of crowns, inlays and bridges
- injection of antibiotic drugs when prescribed by a dentist

Supplementary Basic Services

- surgical procedures not included under Basic Services (excluding implants)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth including:
  - scaling combined with root planing, to a maximum of eight units per person per calendar year
  - provisional splinting
  - occlusal equilibration, to a maximum of eight units per person per calendar year

However, procedures for guided tissue regeneration are considered eligible only if performed in conjunction with the following periodontal surgical procedures: flap approach or osseous grafts (autografts or allografts), provided natural teeth are involved.

- endodontic services, which include root canals and therapy, root amputation, apexifications and periapical services. Root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime. Re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

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

Dentures

- 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
- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the new dentures are necessary due to one of the following:
  - a natural tooth is extracted while insured under this policy and the existing appliance cannot be made serviceable
  - the existing appliance is at least 60 months old and cannot be made serviceable
  - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount that would have been allowed for permanent dentures

Major Restorative Services

- crowns, including gold and porcelain, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative materials
- onlays when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative services
- inlays when three or more surfaces are involved and the tooth cannot be restored using basic restorative materials
- replacement of crowns
- initial provision and repairs of fixed bridgework
- replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:
  - a natural tooth is extracted while insured under this policy and the existing appliance cannot be made serviceable
  - the existing appliance is at least three years old and cannot be made serviceable
  - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent bridge. The total amount payable for both the temporary and permanent bridge is the amount that would have been allowed for a permanent bridge

Note: If a denture or bridge would provide professionally adequate results for the condition but an implant is the choice of treatment, Canada Life will pay the cost of the implant and any related services at a cost equal to the lowest-cost alternative

treatment (i.e. the least expensive cost of a denture or bridge).

Orthodontic Services

- correction of malocclusion of the teeth
- observation and adjustment
- appliances for tooth guidance or uncomplicated tooth movement
- retention appliances
- fixed or cemented, unilateral and bilateral appliances

What's Not Covered

No payment will be made for expenses resulting from:

- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot
- any injury or illness for which the person is entitled to benefits under any provincial worker's compensation act
- examinations required for the use of a third party
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication
- cosmetic surgery or treatment (when so classified by Canada Life) unless such surgery or treatment is for accidental injuries and began within 90 days of an accident
- any charges for services, treatment or supplies:
  - for which there would be no charge except for the existence of coverage
  - which are performed or provided by an immediate family member or a person who lives with the patient
  - which are not specified as an eligible expense under this plan
- services, treatments or supplies eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan. Canada Life will only consider that amount of an eligible expense that is over and above the amount that would be payable by the government plan
- dental treatment received from a dental or medical department maintained by an employer, an association or a labour union
- the replacement of an existing dental appliance that has been lost, mislaid or stolen
- dental services and supplies rendered for full-mouth reconstruction, for a vertical dimension correction or for a correction to temporo-mandibular joint dysfunction
- treatment that is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition

- implants or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would provide professionally adequate results for the condition, Canada Life will pay the cost of the implant and any related services at a cost equal to the least expensive cost of a denture or bridge

Employee Basic Life and Dependent Life Insurance

Under the City's Employee Benefits Program, you are provided with a certain level of City-paid life insurance coverage. This coverage provides important financial protection in the event of your death or the death of your spouse or child. Your *Benefits-at-a-Glance* shows the benefit amounts and other important information.

The Employee Benefit

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

Designating a beneficiary – and keeping your beneficiary designation up to date – ensures that your intended beneficiaries are well-protected. To designate or update your beneficiary, go to the Benefit Forms section on Ozone or contact the Payroll, Pensions and Benefits Service Centre for the appropriate form.

The Dependent Life Insurance Benefit

If your spouse or child dies while insured, this benefit is payable to you.

Optional Life Insurance

With Optional Life Insurance, you have the opportunity to benefit from additional financial protection in the event of your death or the death of your spouse. You pay the full cost of optional insurance, but you benefit from the group rates negotiated by the City that are generally lower than individual rates. Your *Benefits-at-a-Glance* shows the benefit amounts for which you are eligible and other important information.

The Benefit

For you – If you die while insured under this plan, the amount of this benefit will be paid to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

Designating a beneficiary – and keeping your beneficiary designation up to date – ensures that your intended beneficiaries are well-protected. To designate or update your beneficiary, go to the Benefit Forms section on Ozone or contact the Payroll, Pensions and Benefits Service Centre for the appropriate form.

For your spouse – If your spouse dies while insured, the amount of this benefit will be paid to you.

Important Note About Smoking Status

If your smoking status or your spouse's status changes from non-smoker to smoker, you must submit a completed *Group Benefits Change Form* to the address on the form so that your premiums can be adjusted. Benefits under the plan may not be paid if you have not submitted the smoking status change.

If your smoking status or your spouse's status changes from smoker to non-smoker, your premiums will only be reduced once you submit a completed *Group Benefits Change Form* to the address on the form.

To make a change, go to the Benefit Forms section on Ozone or contact the Payroll, Pensions and Benefits Service Centre for the form.

Limitation

If your employee or spousal Optional Life Insurance coverage has been in force less than one year, no benefit will be paid if death results directly or indirectly from suicide while sane or insane.

How to Apply

Contact the Payroll, Pensions and Benefits Service Centre if you are interested in applying.

In most cases, when you apply for the first time or when you increase your coverage, you must provide evidence of insurability. Refer to your *Benefits-at-a-Glance* for more information.

Optional Critical Illness Insurance

The Benefit

Optional Critical Illness Insurance provides financial assistance for you, if you, your spouse or children are diagnosed with one of the conditions listed under What's Covered. You pay the full cost of the insurance, but you benefit from the group rates negotiated by the City that are generally lower than individual rates.

Your *Benefits-at-a-Glance* shows the Optional Critical Illness Insurance for which you, your spouse and children are eligible and other important information.

For you – You can choose coverage for yourself. If you are diagnosed with one of the covered conditions, Canada Life pays a lump-sum benefit to you.

For your spouse – You can also choose coverage for your spouse. If your spouse is diagnosed with one of the covered conditions, Canada Life pays a lump-sum benefit to you.

For your children – You can also choose coverage for your children. If your child is diagnosed with one of the covered conditions, Canada Life pays a lump-sum benefit to you.

Entitlement Criteria

The benefit is payable after a waiting period of 30 days following the date of diagnosis or at the end of the condition's specific waiting period, if any (as defined in the *Covered Critical Illness Conditions Appendix* available on Ozone or through the Payroll, Pensions and Benefits Service Centre), whichever is longer. In addition to this benefit, provided it is $10,000 or more, Canada Life will make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for Optional Critical Illness Insurance, you may be required to provide proof of insurability satisfactory to Canada Life.

Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person.

Important Note About Smoking Status

If your status or your spouse's status changes from non-smoker to smoker, you must submit a completed *Group Benefits Change Form* to the address on the form so that your premiums can be adjusted. Benefits under the plan may not be paid if you have not submitted the smoking status change. If your status or your spouse's status changes from smoker to non-smoker, your premiums will only be reduced once you submit a completed *Group Benefits Change Form* to the address on the form.

To make a change, go to the Benefit Forms section on Ozone or contact the Payroll, Pensions and Benefits Service Centre for the form.

What's Covered

The following table lists the critical illnesses that are covered under the plan. The conditions are those recognized within the medical profession as being of a critical nature and are subject to change. Refer to the *Covered Critical Illness Conditions Appendix* available on Ozone or through the Payroll, Pensions and Benefits Service Centre for the full definition of each covered condition.

- Aortic surgery
- Aplastic anaemia
- Bacterial meningitis
- Benign brain tumour
- Blindness
- Cancer (life-threatening)
- Coma
- Coronary artery bypass surgery
- Deafness
- Dementia, including Alzheimer's disease
- Heart attack
- Heart valve replacement or repair
- Kidney failure
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Occupational HIV infection
- Paralysis
- Parkinson's disease and specified atypical parkinsonian disorders
- Severe burns
- Stroke

Additional Covered Critical Illnesses for Dependent Children

In addition to the conditions listed under What's Covered, children are also covered for the following illnesses.

- Autism
- Cerebral palsy
- Congenital heart disease (for which corrective surgery has been performed)
- Cystic fibrosis
- Down's Syndrome
- Muscular dystrophy
- Type 1 diabetes mellitus (juvenile diabetes)

What's Not Covered

No benefits are payable for any critical illness related to:

- any limitation related to any condition, as set out in the *Covered Critical Illness Conditions Appendix* available on Ozone or through the Payroll, Pensions and Benefits Service Centre
- self-inflicted injuries or illnesses, whether sane or insane
- abuse of addictive substances, including but not limited to legal and illegal drugs and alcohol
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the covered person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of the injury
- intentionally taking a poisonous substance or inhaling toxic gases or fumes
- a situation where your child is born and diagnosed with a condition within the first ten months of the effective date of child coverage
- a pre-existing condition incurred or diagnosed during the 24 months prior to the effective date of coverage or latest reinstatement. This limitation applies whether or not the covered person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement. A pre-existing condition is an illness or injury for which the covered person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a physician or has been prescribed medication – or where treatment would have been received by a prudent individual – during the 24 months prior to the effective date of coverage or latest date of reinstatement for this critical illness benefit

- cancer or a benign brain tumour, if within the first 90 days following the later of the effective date of coverage and the effective date of the last reinstatement of coverage, the covered person has any of the following:
  - signs or symptoms that lead to a diagnosis of cancer or a benign brain tumour, regardless of when the diagnosis is made
  - medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or a benign brain tumour, regardless of when the diagnosis is made
  - a diagnosis of cancer or a benign brain tumour

How to Apply

Contact the Payroll, Pensions and Benefits Service Centre if you are interested in applying.

Sick Leave

Your Sick Leave Plan provides important financial security in the event that your income is interrupted by short-term, non-work-related illness or injury.

The Benefit

If you are unable to perform your duties due to non-work-related illness or injury, you will be entitled to Sick Leave Plan benefits for up to 17 weeks, depending on your length of service. If you are still disabled after 17 weeks, you may be eligible for Long Term Disability benefits.

You will receive 75% or 100% of your pre-disability earnings, depending on your length of service.

Public or declared holidays during the period of absence while receiving benefits will not reduce the days of eligibility.

The following table outlines the benefit levels according to length of service.

In terms of service, if you have...	You will receive the following percentage of your pre-disability earnings...
Less than one year	▪ 100% for the first week, and ▪ 75% for the next 16 weeks
One year but less than two years	▪ 100% for the first two weeks, and ▪ 75% for the next 15 weeks
Two years but less than three years	▪ 100% for the first three weeks, and ▪ for the next 14 weeks
Three years but less than four years	▪ 100% for the first four weeks, and ▪ 75% for the next 13 weeks
Four years but less than five years	▪ 100% for the first five weeks, and ▪ 75% for the next 12 weeks
Five years but less than six years	▪ 100% for the first seven weeks, and ▪ 75% for the next 10 weeks
Six years but less than seven years	▪ 100% for the first nine weeks, and ▪ 75% for the next eight weeks

In terms of service, if you have...	You will receive the following percentage of your pre-disability earnings...
Seven years but less than eight years	▪ 100% for the first 11 weeks, and ▪ 75% for the next six weeks
Eight years but less than nine years	▪ 100% for the first 13 weeks, and ▪ 75% for the next four weeks
Nine years but less than 10 years	▪ 100% for the first 15 weeks, and ▪ 75% for the next two weeks
10 or more years	▪ 100% for 17 weeks

Consult your collective agreement for all the details on the plan. Contact your supervisor if you have any questions.

Long Term Disability

If you become totally disabled while covered and meet the entitlement criteria for this benefit, you will receive a disability benefit.

Confinement is not normally required. However, you must be under the regular care of a physician and be prepared to attempt rehabilitative employment, or participate in a rehabilitation program considered appropriate by Canada Life.

If you must hold a government permit or license to perform your duties, you will not be considered totally disabled solely because such permit or license has been withdrawn or not renewed.

The Benefit

Your *Benefits-at-a-Glance* shows the benefits for which you are eligible and the benefit amounts.

Entitlement Criteria

To be entitled to Long Term Disability benefits, you must meet the following criteria:

- you must be continuously totally disabled throughout the qualifying period specified in your *Benefits-at-a-Glance*
- you must be under the continuing care of a physician

At any time, Canada Life may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by Canada Life.

Reduction of the Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the benefit amount shown in your *Benefits-at-a-Glance* reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- disability benefits payable under the Canada Pension Plan/Quebec Pension Plan (CPP/QPP) or a similar plan in another country which has a reciprocal agreement with Canada or Quebec, excluding benefits payable on behalf of your dependents
- benefits payable under any workers' compensation act
- earnings received from an approved rehabilitation plan
- income replacement indemnity payable under any plan of automobile insurance
- income replacement benefits payable from the City (other than benefits payable under this plan) to a maximum of 75% of monthly pre-disability earnings

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 80% of your pre-disability gross earnings. All sources include those sources stated above and:

- benefits to which another member of your family is entitled, on the basis of your disability under CPP/QPP or a similar plan in another country which has a reciprocal agreement with Canada or Quebec. Benefits payable directly to the family member are not included
- earnings or payments from any employer not stated above
- disability benefits payable under any other group, association or franchise insurance plan, except for benefits that were payable for each of the 12 months before a disability period
- disability and income replacement benefits payable under any government plan (excluding Employment Insurance benefits)
- retirement or pension benefits provided by an employer and/or a government
- earnings recovered through a legally enforceable cause of action against some other person or corporation (in accordance with provisions under Third-Party Liability)
- the wage loss portion of any criminal injury award, except for awards that included the long term disability income benefits available under this plan in the calculation of the award

When determining the amount of the income listed above, the following applies:

- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefits you receive from this plan
- the benefit amount will not be reduced by disability benefits payable under a public pension plan (CPP/QPP) until actual determination of the award has been made, if, at the time you submit your claim, you sign an agreement to reimburse Canada Life. Otherwise, CPP/QPP benefits that have not been determined by the time your benefit is payable will be estimated and deducted from your monthly benefit. Adjustments to correct such payments will be made after the award has been determined
- the benefit amount will not be affected by changes in your CPP/QPP benefit unless the changes result from:
  - a correction due to an error made when your award was originally determined
  - a change of 10% or more in the benefit formula under the government plan
  - a change in dependent status (where applicable)
- any change due to a cost-of-living increase will not be taken into account

Cost-of-Living Adjustment

After one full calendar year of total disability, and annually thereafter, you are eligible for a cost-of-living adjustment. Increases will begin with your January payment. Your initial benefit amount will be increased by the ratio between:

- the average of the Consumer Price Indices for the 12 months ending June 30 of the first calendar year of disablement, and
- the average of the Consumer Price Indices for the 12 months ending June 30 of the current calendar year

up to the percentage specified in your *Benefits-at-a-Glance* compounded annually with a cumulative carry-over.

The adjustment used to determine the cost-of-living benefit in any particular year will be the higher of the adjustment reached in the current year or that reached in any previous year. Should the Consumer Price Index decrease, your monthly benefit will remain at its present level.

Third-Party Liability

If your disability is caused by another person and you have a legal right to recover damages, Canada Life will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse those amounts you recover, which, when added to the disability benefits paid to you under this plan, exceed 100% of your lost income.

Tax Status of Benefits

The tax position of any payments you receive under this benefit depends on whether you or the City pays the cost of the benefit.

Since the City pays all of the cost, then any disability benefit payments you receive will be taxable.

Rehabilitation

Once Canada Life determines that you are totally disabled, if appropriate, and at Canada Life's discretion, you may be offered rehabilitation for up to 24 months to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In order to participate in a rehabilitation program not developed by Canada Life, Canada Life must approve the program.

Your income from a rehabilitation program will be used to reduce your benefit payments. While earning income from a rehabilitation program, your income from

all sources cannot be greater than 100% of your earnings before your disability.

Cessation of Benefit Payments

Your monthly payments will cease on the earliest of the following events:

- the date you are no longer totally disabled
- the end of the month in which you reach age 65
- you have received benefits for 24 months and you are eligible for a pension of at least 60% that is not actuarially reduced from the City's Pension Plan (OMERS, COSF, OC Transpo Pension Plan, or any combination of these plans)
- the date you fail to undergo, when requested by Canada Life, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by Canada Life
- the date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program or alcoholism, drug addiction or substance abuse treatment program when recommended by Canada Life
- the date you are incarcerated in a prison or mental institution by authority of a criminal court
- the date you refuse to complete and return a *Reimbursement Agreement/Direction* form or comply with the terms of a signed *Reimbursement Agreement/Direction* form, when requested, in accordance with the provisions under Third-Party Liability
- the date this contract terminates
- the date of your death

Recurrent Disabilities

If you become totally disabled again from the same or related causes within six months of full-time active employment from the end of the period for which Long Term Disability benefits were paid, Canada Life will treat the disability as a continuation of your previous disability.

You will not be required to satisfy any applicable qualifying period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the maximum benefit period for this benefit.

If you cease to be totally disabled at any time during the qualifying period and become totally disabled again, due to the same cause, within 30 consecutive calendar days, the qualifying period will be extended by the number of days during which you were not totally disabled.

Limitations

Disability benefits are not payable for the following:

- any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by the plan administrator
- any period after you fail to participate or cooperate in a recommended or approved rehabilitation plan
- any period after you fail to participate or cooperate in a recommended or approved medical coordination program
- any period after you fail to participate or cooperate in a required medical or vocational assessment
- a disability resulting from insurrection, war, service in the armed forces of any country or participation in a riot
- any period in which you do not participate or cooperate in a reasonable and customary treatment program (which is performed or prescribed by a legally licensed doctor of medicine and is of the nature and frequency usually required for the condition involved). Depending on the severity of the condition, you may be required to be under the care of a specialist for the condition involved. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program
- any period of incarceration, confinement, or imprisonment by authority of law

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for benefits at any time when you are on pregnancy leave of absence or could be placed on such leave by the City in accordance with relevant government legislation or the leave agreed upon by you and the City.

Employee and Family Assistance Program

The Employee and Family Assistance Program (EFAP), provided by Morneau Shepell, offers you, your children and spouse 24/7 voluntary access to free, immediate and confidential support services.

Accessed by phone, web or mobile app, the EFAP offers support for a full range of personal, family and work issues, including:

- personal wellbeing – stress, mental health concerns, grief and loss, crisis situations
- relationships and family – communication, parenting, childcare, schooling, nursing/retirement homes
- dependency issues – alcohol, drugs, tobacco, gambling
- workplace challenges – stress, performance, work-life balance
- financial guidance – debt management, bankruptcy counselling, retirement
- legal advice – family law, separation/divorce, custody
- nutrition and physical health – weight management, cholesterol and blood pressure, diabetes, improved sleep

Remember, the EFAP is completely confidential within the limits of the law. No one, including the City, Canada Life, your manager or supervisor, will ever know that you have used the program unless you choose to tell them.

The EFAP can provide a series of sessions with a professional at no cost to you and if you need more specialized or longer-term support, referrals can be made to an appropriate specialist or service. While fees for these additional services are your responsibility, they may be covered by provincial health plan or the City's Employee Benefits Program.

WHAT HAPPENS WHEN

Change in Family Status – The 31 Day Rule

What Qualifies

When certain life events occur, you are eligible to modify your coverage under the Health and Dental Plans and optional insurance within 31 days of the life event to reflect the change in your family status. The following changes qualify as life events:

- change in marital status (legally married or common-law) – marriage, separation or divorce
- birth or adoption of a child
- death of your spouse or child
- loss or gain of coverage under your spouse's benefits program

What You Need to Do

Consider Your Benefit Options

When a change in your family status occurs, consider whether your current benefit coverage continues to meet your needs and ensure that the necessary updates have been made to the City's files. Here are some of the actions you may have to take.

- Your personal information – change your address, emergency contact, or add or delete a dependent
- Health and Dental Plans
  - change from family to single coverage or vice versa
  - update your coordination of benefits information if you or a dependent has lost or gained coverage under your spouse's plan
  - update your dependent information
- Beneficiary designations – review and update your beneficiary designations
- Optional insurance – consider whether you need to apply for optional insurance or change the amount of your current coverage

Advise the Payroll, Pensions and Benefits Service Centre

Contact the Payroll, Pensions and Benefits Service Centre **within 31 days** of the life event to register the change.

If you apply for new or increased optional insurance within the 31-day deadline,

you may not have to provide evidence of insurability. Consult your *Benefits-at-a-Glance* for when evidence is required.

If you apply for coverage under the Health Plan or Dental Plan and you do not register the change within the 31-day deadline, you will be considered a late applicant. Go to the If You Apply Late section for important information about what you need to do if you apply late and the restrictions on your coverage.

Change in Employment Status

How It Works

In some circumstances, your benefits may be affected when your employment status changes (for example, from full-time to part-time or from full-time to temporary lay-off). Your collective agreement outlines what happens. If your benefits are affected, the Payroll, Pensions and Benefits Service Centre will review your status change and contact you in writing regarding the changes to your benefits and your options.

Disability

What Happens to Your Coverage

Your benefits coverage with the City is maintained while you are receiving benefits under the City's Sick Leave Plan. Any required premiums will continue to be deducted from your pay.

If you begin to receive benefits under the Long Term Disability Plan, your benefits coverage is maintained as outlined in the following table.

Plan	How It Works
▪ Health ▪ Dental ▪ Employee and Family Assistance Program	Coverage continues at no cost to you
▪ Basic Life Insurance	Coverage continues based on the collective agreement and your earnings in effect when your disability began
▪ Dependent Life Insurance	Coverage continues based on the collective agreement and the coverage in effect when your disability began
▪ Optional Life Insurance ▪ Optional Critical Illness Insurance	Coverage continues based on the collective agreement and the coverage in effect when your disability began and – except for Optional Life Insurance– as long as the applicable contract remains in effect. Your premiums are waived as long as you meet the conditions outlined in the Waiver of Premium Conditions for Optional Insurance section

Waiver of Premium Conditions for Optional Insurance

While you are receiving Long Term Disability benefits, coverage for any optional insurance will continue without payment of premium, provided Canada Life receives proof that you are receiving benefits.

Once your application for waiver of premium is approved, premiums for optional insurance will be waived from the premium due date coincident with or

immediately following the Long Term Disability qualifying period, as outlined in your *Benefits-at-a-Glance*, after the date you became totally disabled until the earliest of the following events:

- you are no longer receiving Long Term Disability benefits
- your coverage would normally cease if you were not totally disabled
- you reach age 65
- your death
- for Optional Critical Illness Insurance only, termination of the policy

How It Works

Notify your supervisor when you are absent from work. She or he will advise you on the next steps to take and whether you need a medical certificate. If your absence continues after the qualifying period, as outlined in your *Benefits-at-a-Glance*, the Employee Health and Wellness department will ask you to fill in an application for Long Term Disability benefits.

Leave of Absence

What Happens to Your Coverage

If you are on an approved unpaid leave of absence (including sabbatical leave), your benefits coverage can be extended for up to 12 months, provided you notify the City that you would like benefits to continue and you pay all premiums for the coverage.

You may renew your coverage for another 12-month period with Canada Life's approval. Sabbatical leave cannot be renewed.

How It Works

The Payroll, Pensions and Benefits Service Centre will send you a letter outlining your benefit options during your leave and the premium costs to continue coverage. You will also receive a form for you to authorize direct withdrawal to pay for the benefits that you choose to continue during your absence.

Pregnancy/Parental Leave of Absence

What Happens to Your Coverage

Your benefits coverage automatically continues while you are on pregnancy or parental leave for the duration of the leave, unless you choose otherwise.

How It Works

The Payroll, Pensions and Benefits Service Centre will send you a letter confirming your leave and directing you to inform them if you wish to suspend any or all of your benefits during your leave. If you do nothing, your benefits will automatically continue and any premiums owing will be deducted from your top-up pay.

Leave the City/Employment Ends

What Happens to Your Coverage

Your benefits coverage ends on the day your employment with the City ends, except in the circumstances listed below.

- If you are receiving Long Term Disability benefits when your employment with the City ends, your group benefits – except for health and dental coverage – will extend beyond the date your employment ended until you no longer qualify. Benefits will continue to be paid according to the contract provisions. Canada Life reserves the right to request proof of the continuance of total disability. You may also be required to submit to an examination by Canada Life's medical advisors when requested.
- If you are laid off, you may be eligible to continue your coverage for a maximum of three consecutive months.
- If you retire from the City, coverage extends until the last day of the month in which your retirement occurs.

In specific circumstances, extension of benefits may apply to dental expenses and certain health expenses that are incurred after your coverage ends.

Your Options

When certain types of insurance coverage with the City ends, you have 31 days to take advantage of the conversion option (purchase individual coverage directly from the carrier), without providing evidence of insurability. See the Glossary for all the details about conversion.

Individual coverage for health and dental is available from various insurance providers, including the City's current carrier, Canada Life.

Health and Dental Claims

All health and dental claims must be received by Canada Life no later than 90 days from the day your coverage ends.

How It Works

If you are eligible to continue benefits after your employment has terminated, the Payroll, Pensions and Benefits Service Centre will advise you of your options and any costs associated with continuing your benefits.

Work Past Age 65

What Happens to Your Coverage

If you continue to work past age 65, your group benefits continue, however, some of your coverage changes or ends. Your coverage will end earlier than the dates specified below if you cease to be an eligible employee. For more information on when your benefits coverage ends, go to the section When Coverage Ends.

Plan	What Happens
Health	Coverage continues until the end of the month in which you reach age 69, with the following changes: ▪ Your drug coverage ends at the end of the month in which you reach age 65, but coverage continues for your spouse until he or she reaches age 65 and continues for your children until they are no longer eligible ▪ Out-of-province and out-of-country coverage and Travel Assistance ends at the end of the month in which you reach age 65
Dental	Coverage continues until the end of the month in which you reach age 69
Basic Life Insurance	Coverage reduces to $25,000 when you reach age 65 and ends at the end of the month in which you reach age 69
Dependent Life Insurance	Coverage continues until the end of the month in which you reach age 69
Optional Life Insurance	Coverage for you continues until the end of the month in which you reach age 69 Spousal coverage ends at the end of the month in which you or your spouse reaches age 69, whichever occurs first
Optional Critical Illness Insurance	Coverage for you reduces to $10,000 when you reach age 65 and ends at the end of the month in which you reach age 69 Spousal coverage reduces to $10,000 when your

Plan	What Happens
	covered spouse reaches age 65, and ends at the end of the month in which you or your spouse reaches age 69, whichever occurs first Coverage for children ends at the end of the month in which you reach age 69
Sick Leave	Coverage continues until the end of the month in which you reach age 69
Long Term Disability	Coverage ends at the end of the month in which you reach age 65, less the qualifying period outlined in your *Benefits-at-a-Glance*
Employee and Family Assistance Program	Coverage continues for you regardless of age, and continues for your spouse and children, provided they continue to meet the eligibility criteria for benefits coverage

Before you reach age 65, the Payroll, Pensions and Benefits Service Centre will send you a letter confirming the changes to your coverage.

Your Options When Your Coverage Reduces or Ends

Drug Coverage

Most provincial health plans cover prescription drugs after age 65. For more details, speak to your pharmacist or visit:

- the Ontario Health Insurance Plan's (OHIP) website, at www.health.gov.on.ca– if you live in Ontario
- the Régie de l'assurance maladie du Québec's (RAMQ) website, at www.ramq.gouv.qc.ca– if you live in Quebec

Health and Dental Coverage

Individual coverage is available from various insurance providers, including the City's current provider, Canada Life. There may be deadlines for applying for private coverage, so be sure to research your options and make any necessary arrangements before your coverage ends.

Converting Your Insurance

When certain types of insurance coverage with the City ends or reduces, you have 31 days to take advantage of the conversion option (purchase individual coverage directly from the carrier), without providing evidence of insurability. See the Glossary for all the details about conversion.

Retirement

What Happens to Your Coverage

You are eligible for retiree benefits as described in the following table if you meet the eligibility criteria outlined in your collective agreement and if you (and your dependents, if applicable) are covered under that plan immediately before you retire.

It is important to note that some of the coverage under the plans changes when you retire. For the details of your benefits during retirement, including any benefits for your survivors and who pays the cost, consult your retiree booklet or retiree benefits-at-a-glance.

Plan	What Happens
Health	Coverage continues until the end of the month in which you reach age 65
Dental, Employee Basic Life and Dependent Life Insurance	Coverage continues until the end of the month in which you reach age 65

Coverage under all other plans ends when you retire.

Your Options When Your Coverage Reduces or Ends

Drug Coverage

Most provincial health plans cover prescription drugs after age 65. For more details, speak to your pharmacist or visit:

- the Ontario Health Insurance Plan's (OHIP) website, at www.health.gov.on.ca– if you live in Ontario
- the Régie de l'assurance maladie du Québec's (RAMQ) website, at www.ramq.gouv.qc.ca– if you live in Quebec

Health and Dental Coverage

Individual coverage is available from various insurance providers, including the City's current provider, Canada Life, and through the Municipal Retirees Organization Ontario (MROO). See the Contacts section for phone numbers and email addresses. There may be deadlines for applying for this coverage, so be sure to research your options and make any necessary arrangements before your coverage ends.

Converting Your Insurance

When certain types of insurance coverage with the City ends or reduces, you have 31 days to take advantage of the conversion option (purchase individual coverage directly from the carrier), without providing evidence of insurability. See the Glossary for all the details about conversion.

Death

What Happens to Your Coverage

If you die while your dependents are covered under the Health Plan or Dental Plan, your dependents may continue coverage under these plans for up to six months after your death at no cost to your dependents. Coverage will end before this period if:

- your dependents no longer meet the definition of dependent
- the group contract terminates

If, at your death, you were eligible for a pension, and once the period noted above ends, your spouse may choose to continue coverage under the retiree plan and pay the full cost of the coverage. Consult your collective agreement or contact the Payroll, Pensions and Benefits Service Centre for more information.

Coverage under all other plans ends on the date of your death.

In specific circumstances, extension of benefits may apply to dental expenses and certain health expenses that are incurred after your coverage ends.

Converting Spousal Insurance

When you die, your spouse has 31 days to take advantage of the conversion option (purchase individual coverage directly from the carrier) for some spousal insurance coverage. See the Glossary for all the details about conversion.

How It Works

Your executor or survivor should inform your supervisor or contact the City as soon as possible after your death. The City's Payroll, Pensions and Benefits Service Centre will provide your executor or survivor with all the information and forms needed to maintain benefits, if applicable, and process any life insurance proceeds.

CLAIMS

For Health and Dental Claims

Your Pay-Direct Benefits Card

Canada Life provides you with a pay-direct benefits card when you enrol in the Health Plan. Your spouse and children over age 18 will also receive a benefits card.

To fill a prescription for covered drug expenses:

- present the benefits card to the pharmacist at the time of purchase
- Canada Life reimburses the pharmacist directly for the eligible amount and you pay any amounts that are not covered under the benefit

You will be required to pay the full cost of the prescription at the time of purchase if:

- you cannot locate a participating pay-direct drug pharmacy
- you do not have your benefits card with you
- the prescription is not payable through the benefits card system
- you are not eligible for a benefits card

If you paid the cost of the prescription, you must submit a claim to Canada Life to receive reimbursement. See the sections Online Claims and Paper Claims for how to submit a claim.

Online Claims

If you register for Canada Life's GroupNet for Plan Members online secure site and for direct deposit, you will be able to submit a number of health and dental claims online and receive your reimbursement faster. To register, go to www.canadalife.com and click on GroupNet for Plan Members. Then follow the links to register.

Once your access has been set up, complete the online form with the details of the service or expense; you don't need to send your receipts. Canada Life assesses your claim and deposits your payment to your bank account and sends you an email notifying you of the payment. You are responsible for keeping your original receipts for 12 months following the date you submitted your claim online, in case Canada Life later requests them as part of an audit.

You can also submit claims using Canada Life's mobile app. For more information, see Canada Life Online under the Contacts section.

You have six months from the date an expense is incurred to submit the claim online or using the mobile app. After six months, the expense can only be submitted using a paper claim form.

Paper Claims

To submit a Health Plan claim, you must complete a *Healthcare Claim* form, except when claiming for physician or hospital expenses incurred outside your province of residence. If you paid for an out-of-province or out-of-country expense because you did not contact the Travel Assistance provider, you must complete a *Statement of Claim Out-of-Country Expenses* form. Claim forms are available from the Canada Life site, on the Benefit Forms section of Ozone – the City's Intranet site – or from the Payroll, Pensions and Benefits Service Centre.

Claims for out-of-Canada expenses should be submitted to Canada Life as soon as possible after the expense is incurred, as your provincial medical plan has very strict time limitations for reimbursements. The Canada Life plan will pay all eligible claims including the provincial medical plan portion. The provincial medical plan will then reimburse the Canada Life plan for the government's share of the expenses. For these expenses, you must complete a *Statement of Claim Out-of-Country Expenses* form and, as required, the Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention. Travel Assistance provides a claims payment service that arranges for the payment of most expenses on behalf of the covered person. See the About Travel Assistance section under Health Plan for more information.

For paramedical practitioner services, such as massage therapy and physiotherapy, please ensure that the practitioner's license number is on the receipt. Having the practitioner include their registration or license number will allow for faster payment of your claim.

If you incur ambulance expenses, you are responsible for paying the invoice then submitting a paper claim to Canada Life for reimbursement.

Most dental offices are able to submit your Dental Plan claim electronically. If your dentist doesn't provide this service, have your dentist fill out the Canada Life dental form available from the Canada Life site, on the Benefit Forms section of Ozone – the City's Intranet site – or from the Payroll, Pensions and Benefits Service Centre. Complete it and send it to the address indicated on the form. Or, use the standard dental claim form available at your dentist's office and send it to Canada Life. See Canada Life in the Contacts section for the address.

To avoid any delays in processing your health or dental claim, be sure that all sections of your claim form are complete and that your receipts are attached. Remember, always provide your group contract number and your identification

number. Your group contract number can be found under Canada Life in the Contacts section. Your benefits card shows your identification number. It is important to indicate if you have benefits under another plan, such as your spouse's plan. If this information is not included, your claim cannot be processed. See the section Coordination of Benefits for more information.

Staple receipts and any other required documentation to your claim form before mailing. For drugs, be sure to include the pharmacy receipt. Be sure to keep a copy for your records.

If you're claiming expenses for a spouse or child, be sure to show their name and relationship to you, and show the name of your spouse's plan sponsor or employer or your child's post secondary institution if your child is an over-age dependent.

Deadline

Claims for expenses incurred in the prior year must be received by Canada Life by June 30 of the current year, if they are to be considered for reimbursement.

However, when your coverage ends, all claims must be received by Canada Life no later than 90 days from the termination date.

Prior Authorization

Expensive drugs or drugs that have a high potential for misuse require prior authorization from Canada Life before they can be reimbursed. In most cases, your doctor will know if the drug being prescribed requires prior authorization. To receive the eligible reimbursement, you must submit a prior authorization form to Canada Life. The form will need to be completed by you and your doctor and will provide confirmation that the drug is being used for its intended purpose.

For information on prior authorization, contact Canada Life, or check Canada Life's prior authorization drug list located on the Canada Life site.

Submitting a Treatment Plan for Dental and Private-Duty Nursing Services

If the cost of any proposed dental treatment is expected to exceed $500, Canada Life suggests that you submit a detailed treatment plan from your dentist before the treatment begins. You will then be advised of the amount you are entitled to receive under this benefit.

Canada Life also suggests that a detailed treatment plan be submitted with cost estimates before private-duty nursing services begin. Canada Life will then advise

you of any benefit that will be covered.

Coordination of Benefits

If you or your dependents are also covered for similar benefits under another plan that provides health or dental coverage, Canada Life will take this into account when determining the amount of expenses payable under these plans. This process is known as coordination of benefits. It allows for reimbursement of covered health and dental expenses from all plans, up to a total of 100% of the actual expense incurred.

Order of Benefit Payment

A variety of circumstances will affect which plan is considered the primary carrier (that is, responsible for making the initial payment toward the eligible expense), and which plan is considered the secondary carrier (that is, responsible for making the next payment).

If the other plan does not provide for coordination of benefits, it will be considered as the primary carrier, and will be responsible for making the initial payment toward the eligible expense.

If the other plan does provide for coordination of benefits, submit claims in the order listed below.

For Claims Incurred by You or Your Spouse

- submit claims first to the plan insuring you or your spouse as an employee/member, then to the plan insuring you or your spouse as a dependent
- in situations where you or your spouse have coverage as an employee/member under more than one plan, submit claims:
  - first to the plan where the person is covered as an active full-time employee
  - then to the plan where the person is covered as an active part-time employee
  - then to the plan where the person is covered as a retiree
  - then to the plan insuring you or your spouse as a dependent

For Claims Incurred by Your Child

- submit claims first to the plan covering the parent whose birthday is earlier in the calendar year (month/day). If both parents have the same birthday, submit claims first to the plan covering the parent whose first name begins with the earlier letter in the alphabet
  - however, if you and your spouse are separated or divorced, the order in which you submit claims depends on your custody arrangement
    - **for joint custody**, submit claims:

  - first to the plan of the parent with joint custody of the child whose birthday (month/day) occurs earlier in the calendar year, regardless of age
  - then to the plan of the other parent with joint custody
  - then, if applicable, to the plan of the (new) spouse of the parent whose birthday (month/day) occurs earlier in the calendar year (i.e. if this parent remarries or has a common-law spouse, the new spouse's plan will pay benefits for the child)
  - then, if applicable, to the plan of the (new) spouse of the other parent (i.e. if this parent remarries or has a common-law spouse, the new spouse's plan will pay benefits for the child)
  - if both parents with joint custody have the same birthday, submit claims first to the plan covering the parent whose first name begins with the earlier letter in the alphabet
- **for single custody**, submit claims:
  - first to the plan of the parent with single custody of the child
  - then, if applicable, to the plan of the (new) spouse of the parent with single custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's plan will pay benefits for the child)
  - then to the plan of the parent not having custody of the child
  - then, if applicable, to the plan of the (new) spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's plan will pay benefits for the child)

A claim for accidental injury to natural teeth will be determined under health care plans with accidental dental coverage before it is considered under dental plans.

If the order of benefit payment cannot be determined from the above, the benefits payable under each plan will be in proportion to the amount that would have been payable if coordination of benefits did not exist.

If the covered person is also covered under an individual travel insurance plan, submit the claim first in the order described in this section and then to the individual travel insurance plan.

Submitting a Claim

To submit a claim when coordination of benefits applies, refer to the following guidelines:

- determine which plan is the primary carrier and which is the secondary carrier (as outlined in Order of Benefit Payment)
- submit all necessary claim forms and – if you are submitting a paper claim – submit original receipts to the primary carrier

- keep a photocopy of each receipt
- once your claim has been settled by the primary carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and a copy of the receipts to the secondary carrier for further consideration of payment, if applicable

Payment of Claims

Once your health or dental claim has been processed, Canada Life will send an explanation of benefits to you.

If you submit a paper claim, you should receive settlement of your claim within 15 working days from the date of submission to Canada Life. If you use online claims, you should receive settlement within 7 working days. If you have not received payment or if you have any questions about the explanation of benefits, contact Canada Life.

Advance Supply Limitation

Payment of any eligible expenses under the Health Plan that may be purchased in large quantities will be limited to the purchase of up to a three-month supply at any one time, except for eligible drug expenses.

Drug Expenses

The maximum quantity of drugs or medicines that will be payable for each prescription will be limited to the lesser of the following:

- the quantity prescribed by the physician or dentist
- a 34-day supply

A quantity of up to a 100-day supply may be payable in long-term therapy cases, where the larger quantity is recommended as appropriate by the physician and the pharmacist.

Alternate Dental Treatment

In the event that optional procedures are possible, the procedure involving the lowest fee will be considered as the eligible expense provided it is consistent with good dental care.

For Claims Other Than Health and Dental

If you become sick or disabled, contact your supervisor for assistance with all of the necessary paperwork and the application process for the income replacement plans.

For life insurance claims, contact the Payroll, Pensions and Benefits Service Centre. A completed claim form should be submitted as soon as reasonably possible. For Critical Illness Insurance claims, contact Canada Life directly, or obtain a claim form from the Canada Life site at www.canadalife.com. Critical illness claims should be submitted as soon as possible, but no later than three months after the end of the benefit payment waiting period or three months after the plan terminates, whichever is earlier.

CONTACTS

Canada Life

Health and dental:
1-855-360-4415
1-800-990-6654 (for the deaf or hard of hearing)

Critical illness:
1-866-907-2395

www.canadalife.com

Mailing Your Claim Forms

English Claims	French Claims
Canada Life London Benefit Payments PO Box 5160 Station B London, ON N6A 0C6	La Canada Vie Service des indemnités de Montréal CP 8825 Succursale Centre-Ville Montréal, QC H3C 4K9

About Canada Life

Call or go online when you need details on claims or coverage under the Health Plan and Dental Plan. You should also contact Canada Life if you need a replacement benefits card.

Contact Canada Life to make a claim under the Optional Critical Illness Insurance Plan.

Canada Life administers/insures the following plans for the City.

Plan	Contract Number
Health, Dental	59210
Basic Life Insurance, Dependent Life Insurance, Travel Assistance	168593
Long Term Disability	59211
Optional Life Insurance, Optional Critical Illness Insurance	168594

Canada Life Online

Your health and dental claims are easy to manage when you register to use Canada Life's GroupNet for Plan Members online secure site. Once you've registered, you can:

- get access to personalized information about your coverage
- submit many of your claims online
- track your claims and review your claims history
- arrange for direct deposit for claims reimbursement

Canada Life's GroupNet for Plan Members site also provides you with access to:

- a copy of your benefits card, which you can print directly from the site
- personalized claim forms for paper claim submissions
- extensive health and wellness content

Visit www.canadalife.com or call Canada Life at 1-855-360-4415 for more information about registering.

GroupNet Mobile App

By downloading Canada Life's GroupNet Mobile app, you can access certain features of GroupNet for Plan Members from your mobile device to:

- submit many of your claims online
- access personalized coverage information about benefits, claims and more
- view benefits card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

GroupNet Text

GroupNet Text gives you immediate information specific to your benefits by allowing you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the "Your Profile" tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the "Your

Profile" tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text "Help". For a brief description of the type of information that a keyword provides, text "Help" along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Morneau Shepell

- Call 1-844-880-9142 or 1-877-338-0275 (TTY)
- Visit the website at www.workhealthlife.com
- Download the My EAP mobile app from your device's app store

About Morneau Shepell

Morneau Shepell is the provider of the City's Employee and Family Assistance Program, which offers you and your family immediate and confidential support for any work, health or life concern. Contact Morneau Shepell for questions about the Employee and Family Assistance Program or to access confidential support services.

The City's Payroll, Pensions and Benefits Service Centre

- Call 613-580-2424 ext. 28484
- Email payroll@ottawa.ca

About the Payroll, Pensions and Benefits Service Centre

The Payroll, Pensions and Benefits Service Centre is made up of specialists who can manage your pension, benefits and payroll questions and get you the answers you need. Contact the Payroll, Pensions and Benefits Service Centre for questions on:

- life insurance or long term disability benefits
- benefits coverage if you continue to work after age 65
- adding or removing dependents

Municipal Retirees Organization Ontario (MROO)

c/o ENCON Group Inc.

- Call 1-800-363-7861
- Visit the website at www.encon.ca/mroo
- Email mroo@encon.ca

About MROO

MROO offers a variety of benefit plans for municipal and public service sector pensioners. The plans offer valuable benefits to suit your personal needs, for which you pay the cost. Contact the Payroll, Pensions and Benefits Service Centre for the current MROO package details.

GLOSSARY

Child

Your or your spouse's unmarried, natural, legally adopted, step or foster children who are residents of Canada and are:

- under age 21
- under age 25, if they are full-time students studying within Canada or outside Canada at an accredited institute of learning and depend on you for support
- of any age, if mentally or physically disabled and incapable of self-sustaining employment and totally dependent on you for support, provided the disability began before they reached age 21 or while they were full-time students under age 25, and the disability has been continuous since then

Conversion Option

When your insurance for the plans indicated below ends or reduces, you have 31 days to convert all or a part of the coverage to an individual coverage directly from the carrier. This conversion option could be advantageous for you if you have health problems that would make it difficult to obtain individual insurance at standard rates, since you would not have to provide evidence of insurability for life insurance. If you do not suffer from health problems, you may benefit from shopping around for the best individual policy and rates.

You may also convert the spouse portion of Dependent Life Insurance and any spousal Optional Life Insurance to an individual policy.

For life coverage, if a death occurs during those 31 days, the coverage you could have converted is paid to your beneficiary, even if you didn't apply for conversion. Proof of death must be provided to Canada Life within one year following the date of death.

- Basic Life and Optional Life Insurance conversion is subject to a maximum of $200,000 or your current coverage, whichever is less per type of insurance. Conversion of any Optional Life Insurance for your eligible dependent spouse is subject to the same maximum.

Deductible

The amount of eligible expenses that you are responsible for (you must pay out-of-pocket) before Canada Life will pay benefits.

Dependent

See definitions of Child and Spouse.

Disabled/Disability

See Totally Disabled.

Drugs

Medications that have been approved for use by the Government of Canada and have a drug identification number.

Earnings

Your gross earnings, including commissions but excluding:

- bonus
- overtime

Evidence of Insurability

Generally, a health questionnaire and, depending on the information you provide, possibly a medical or paramedical examination.

Extension of Benefits

Eligible dental expenses incurred after the date coverage ceased will not be reimbursed, regardless of whether or not a treatment plan has been filed with Canada Life, unless the expenses are the result of:

- an impression for a denture, bridge, crown, inlay or onlay that had been taken before the date coverage ceased and the denture, bridge, crown, inlay or onlay is installed within 30 days after the coverage ceased

If you are totally disabled or your eligible dependent is confined to hospital on the date coverage would normally end (for any reason other than contract termination), reimbursement will be made under the Health Plan for expenses incurred due to the disability or hospital confinement, until the earliest of the following events:

- the 365th day following the date coverage would normally end
- the disabled person becomes eligible under another group plan
- the date this policy terminates
- when your disability ends, or in the case of your dependent, the date hospital confinement is no longer necessary

However, if you or your eligible dependent is pregnant on the date coverage would normally end (for any reason other than policy termination), reimbursement will be made for pregnancy-related expenses, provided they are incurred while the policy is in force.

Immediate Family Member

You or your spouse, or your or your spouse's child, parent, brother or sister.

Note: Your or your spouse's parent, brother or sister are not eligible for coverage under the benefit plans outlined in this booklet, except for specific coverage under Travel Assistance. See Child and Spouse for who is eligible for coverage under the benefits program.

Medically Necessary

Broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Non-smoker

A person who has not smoked or used cigarettes, hashish, cigars, pipes, cigarillos, chewing tobacco, nicotine patches and/or gum, betel nuts, or tobacco or nicotine in any other form during the preceding 12 months preceding the date on which the application for insurance is made. If your smoking status changes, you must complete the *Group Benefits Change Form*, available on the Benefit Forms section of Ozone or through the Payroll, Pensions and Benefits Service Centre. Your rates will only be reduced once the Payroll, Pensions and Benefits Service Centre has received the form.

Reasonable and Customary

The plan covers customary charges for 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.

Smoker

A person who has smoked or used cigarettes, hashish, cigars, pipes, cigarillos, chewing tobacco, nicotine patches and/or gum, betel nuts, or tobacco or nicotine in any other form during the preceding 12 months preceding the date on which the application for insurance is made. If your smoking status changes, you must complete the *Group Benefits Change Form*, available on the Benefit Forms section of Ozone or through the Payroll, Pensions and Benefits Service Centre.

Spouse

The person of either sex who is your legal spouse or with whom you have been living in a role like that of a marriage partner continuously for at least 12 months or the earlier of the birth or adoption of a child of the relationship, and who is a resident of Canada. Only one spouse is eligible for coverage at a time.

For Optional Life and Optional Critical Illness Insurance, your spouse must be under age 69.

Stable

For out-of-province or out-of-Canada coverage, stable means that the covered person has not in the 90 days before the departure date of the trip outside their province of residence:

- been under treatment or evaluation for new symptoms or conditions uncovered in a medical examination
- experienced a worsening or increased frequency of existing symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the covered person has been seen by a medical professional in relation to the symptoms
- been prescribed or recommended a change in treatment or medication related to the medical condition by a physician or other medical professional, not including

regular changes in medication that are made as part of an ongoing treatment or a reduction in medication due to an improvement in the medical condition

- been admitted to or treated at a hospital for the medical condition

In addition, the covered person did not have future medical appointment(s) planned with respect to an undiagnosed medical condition and did not have future non-routine tests, investigations or new treatment planned for a previously identified medical condition.

Totally Disabled

For the Sick Leave Plan:

You are ill or injured and unable to work, or are quarantined and unable to leave your home. If you are still disabled after 17 weeks, you may be eligible for Long Term Disability benefits.

During the first 119 calendar days (17 weeks) of disability, you are considered totally disabled if, for medical reasons, you are prevented from doing your own job. If you are still disabled after 119 calendar days (17 weeks), you may be eligible for Long Term Disability benefits.

For the Long Term Disability Plan:

Totally disabled means you are wholly and continuously disabled due to illness or bodily injury and, as a result, you are not physically or mentally fit to perform the essential duties of your normal occupation and any other work available in the bargaining unit during the qualifying period specified in your *Benefits-at-a-Glance* and the succeeding 24 months. After this time, you will still be considered totally disabled provided you are unable to perform the essential duties of your normal occupation and any other occupation for which the two following conditions are met:

- you are, or may become fitted, by education, training and/or experience
- the current monthly earnings are 75% or more of the current monthly earnings for your normal occupation

The availability of employment is not considered in the assessment of your application for disability benefits.