ONE T
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CAEAS-ECAB
Benefits Plan



Member Booklet

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HEALTH, SECURITY AND PEACE OF MIND – YOUR CAEAS-ECAB BENEFITS

The Ontario Non-Union Education Trust (ONE-T) is an Employee Life and Health Trust (ELHT) established exclusively for non-union education sector employees in Ontario.

ONE-T's Board of Trustees operates with the goal of offering a meaningful, affordable, and sustainable benefits package that supports you and your family's health and well-being.

This booklet details the benefits and optional insurance coverage available to all eligible active Members of the CAEAS-ECAB Plan, including Life insurance, Accident insurance, Critical Illness insurance, Health, Dental, and Health Care Spending Account (HCSA).

The information provided in the booklet is intended to summarize the provisions of the CAEAS-ECAB benefit plan sponsored by The Trustees of ONE-T, but the policies issued by Canada Life and CHUBB Life Insurance Company of Canada are the governing documents.

If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail to the extent permitted by law.

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

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ENROLLING IN THE PLAN

You are eligible for the CAEAS-ECAB Plan on the day your employment begins, provided you are a resident of Canada and you are a permanent full-time employee.

Part-time employees and employees with a contract period of 12 months or longer are also eligible for the Plan.

You may opt out of health and/or dental coverage if you are already covered for these benefits under your spouse's plan.

You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work. Increases in your benefits while you are covered by this Plan will only become effective if you are actively at work.

Your coverage ends when your employment ends, you are no longer eligible, or the Plan terminates, whichever happens first.

Your dependents' coverage ends when your coverage ends or your dependent no longer qualifies, whichever happens first.

Your eligible dependents

A dependent is someone residing in Canada and who receives coverage under your plan, such as your spouse, whether legally married or common-law.

Your unmarried children are also considered dependents, if they are under age 21, or are full-time students under age 26.

Also, children who can't support themselves because of a physical or mental disorder are considered dependents and are covered without age limit if the disorder begins before they turn 21, or while they are students under 26, and the disorder has been continuous since that time.

Changes in coverage

If you experience a life event (e.g., getting married, having a baby, loss of spousal coverage, etc.) please contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca to notify of your change in coverage as soon as possible but within 12 months of the event.

Any changes reported after 12 months will be subject to evidence of good health acceptable to Canada Life to be covered for Health benefits.

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The cost of coverage

Your status…	Premium or funding: cost sharing contribution
Actively at work	• Health, Dental, Basic Life and Accidental Death & Dismemberment (AD&D) insurance premiums are cost shared and Members pay 5% • Optional benefits are fully Member-paid (or subject to any applicable personal service contracts) • There is an additional Member cost share for those Members with FTE under 1.0
On Long Term Disability (LTD) or WSIB leave	• For the first 24 months of disability, you pay the same amount as a Member who is actively at work • After 24 months of disability, you pay 100% of the premiums

Other leaves	• For Statutory leaves, such as Maternity/Parental leave, you pay the same amount as a Member who is actively at work
	• For an unpaid sick/unpaid medical leave of absence (other than Maternity or Parental leave):
	  • First 24 months – you pay the same amount as a Member who is actively at work
	  • Beyond 24 months – you pay the full premium for all benefits
	  • Coverage ends after 36 months
	• For Deferred Salary leaves, you pay the full premium for all benefits during the leave for up to 12 months, after which, coverage ends
	• For leaves without pay, you pay the full premium for all benefits during the leave for up to 12 months, after which, coverage ends
	• For Statutory Compassionate Care leaves, you pay the same amount as a Member who is actively at work, subject to the applicable time limit for that type of leave

Survivors	• Following Member's death, coverage may continue for a maximum of 24 months for the surviving eligible dependents. Survivors pay 5% of the benefit costs for the first 12 months and 100% for the next 12 months. Coverage ceases thereafter.

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What is FTE?

FTE stands for full-time equivalent. It is the basis for calculating the amount of funding we receive to help pay for your benefits.

Full-time employees have an FTE of 1.0 and have a cost sharing of 5% of the costs of benefits.

Part-time employees have an FTE of less than 1.0, and the calculation of cost share is based on the percentage of hours worked.

For example: If you are a part-time employee who works 75% of the hours of a full-time employee, your plan sponsor will pay 75% of the total cost of benefits and you will pay the remaining 25%. This is referred to as FTE under 1.0.

YOUR BENEFITS

On the pages that follow, you will find information about all of your CAEAS-ECAB benefits. These benefits are here for you and your dependents when you need them.

Reminder:
Your Benefit Plan Year is September 1 through August 31, except where otherwise indicated.

General information	
Deductible	• No deductible
Reimbursement	• 100% of eligible claims, unless otherwise stated (subject to reasonable and customary limits)

What are reasonable and customary limits?

Reasonable and customary (R&C) limits are the usual range of fees for Health and Dental services and supplies in a specific geographic area. Some paramedical practitioners and medical service providers – such as massage therapists or physiotherapists – charge higher rates.

These higher rates drive up plan costs, which make R&C limits useful to ensure claims to our plan are not excessive. R&C limits also help reduce the likelihood of benefits fraud.

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HEALTH

What is covered under Health

Your Health coverage has been designed to provide you with comprehensive benefits to support your well-being. The following pages detail your coverage for:

- Prescription drugs
- Paramedical services
- Vision care
- Medical services and supplies
- Emergency travel medical coverage

Benefits may be subject to Plan maximums and frequency limits as noted. Unless specifically noted, all covered services and supplies are subject to **reasonable treatment**. A 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.

Prescription Drugs

Prescription formulary	• 100% coverage of eligible prescribed drugs, drug supplies (e.g., for diabetes), and certain preventative vaccines, according to the plan's approved formulary • Ingredient cost mark-up for generic drugs is a maximum of 10% • No deductible • May be subject to Prior Authorization • Pay-direct drug card available • Mandatory generic substitution • Therapeutic class pricing • $8 maximum dispensing fee • Limit of five dispensing fees paid by the Plan per maintenance medication per year (note, this limit does not apply to drugs purchased in Quebec) • $5,000 lifetime maximum for fertility drugs (except as may be provided by law, such as in Quebec) • $700 lifetime maximum for smoking cessation products and expenses (counselling, nicotine replacement and certain medications) • Effective September 1, 2026, no coverage for prescribed drugs for anti-obesity

- Drugs and drug supplies are eligible when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada
- Drugs that are not subjected to Prior Authorization will be covered if they are listed in the CAEAS-ECAB Formulary, which is maintained monthly by Cubic Health Inc.(Cubic) and Canada Life, in effect on the date of purchase
- Drugs that are subject to Prior Authorization, in other words drugs requiring a Member to meet certain clinical criteria before a medication can be approved, are discussed in more detail below
- Prescriptions requiring vaccines and toxoids are covered, as well as preventative vaccines and toxoids that are not covered under public immunization programs for a given Member in the region of the claim at the time of the claim, subject to the covered expense limitation for interchangeable drugs. Non-life-sustaining over-the-counter vaccines are not covered
- Unless medical evidence is provided to Canada Life that indicates why a drug cannot be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable drug (described below)
- For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan
- Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision

Your drug coverage is an important and valuable part of your Benefits Plan, and the CAEAS-ECAB Plan includes certain approaches designed to keep the Plan affordable and sustainable.

Drug claims will be assessed to determine coverage as a general drug benefit, prior authorization drug benefit, or ineligible.

General Drug Benefit: a drug product that is covered under the Plan for any eligible Member, without need for Prior Authorization, pursuant to a valid prescription from an authorized prescriber.

Prior Authorization Drug Benefit: a drug product that is only covered by the Plan for Members who meet specific, evidence-based clinical and pharmacoeconomic criteria that have been established to manage drug therapy related to the underlying medical condition being treated.

A Prior Authorization Drug Benefit is a drug product that is on the Prior Authorization Drug List developed and is managed by Cubic Health Inc. (Cubic). The drug products on the Prior Authorization Drug List are biologic and non-biologic specialty drug products as well as a small number of other medications that require active management to ensure safe and appropriate utilization. For a claim for a Prior Authorization Drug Benefit that is part of the Prior Authorization Drug List to be considered for reimbursement under the Plan, an appropriate Prior Authorization form must be completed and submitted for independent clinical assessment by Cubic's FACET Prior Authorization Program. A Prior Authorization claim is reviewed by an independent drug therapy expert and approved for reimbursement under the Plan if a Member meets the relevant evidence-based clinical and pharmacoeconomic criteria.

A Prior Authorization claim that does not meet established criteria will include a detailed, transparent rationale that cites the existing evidence-base and will be provided to both the Member and the prescribing Physician. A Prior Authorization claim that is not approved is not intended to dictate the treatment plan for the Member. Prior Authorization is only concerned with determining what will be

reimbursed under the Plan. A Member that has a Prior Authorization claim declined under the Plan can decide to proceed with a prescribed therapy, but reimbursement will not be available under the Plan.

The Prior Authorization Drug List and relevant Prior Authorization claim forms can be found at https://www.facetprogram.ca.

The Prior Authorization review requires a Member to provide consent to Cubic for the appropriate collection, use and disclosure of personal information necessary to assess and manage a Prior Authorization claim and requires completion of the relevant FACET Prior Authorization Program form.

Most Prior Authorization Drug Benefits will have a maximum approval period of one (1) year. A renewal form must be completed prior to the end of the coverage period to be considered for an extension of the Prior Authorization approval. An initial Prior Authorization Drug Benefit approval for a specific product does not guarantee renewal at a subsequent renewal interval(s). Renewals are approved based on demonstrated safety and clinical effectiveness of a given Prior Authorization Drug Benefit for a given Member, and appropriate Member adherence to therapy.

A specific Prior Authorization Drug Benefit that is included on the Prior Authorization Drug List may not be covered for a given Member if it has been determined that the Member has not attempted another Prior Authorization Drug Benefit which is considered more cost-effective.

In addition, a specific Prior Authorization Drug Benefit may not be reimbursed under the Plan if the Plan has decided to preferentially reimburse one or more alternative products of the same active ingredient, strength and dosage form that have been approved by Health Canada and/or in cases where the Plan requires mandatory biosimilar switching from a given reference biologic product that is a Prior Authorization Drug Benefit to a preferred or non-preferred biosimilar, unless an approved medical exception is granted.

If a Prior Authorization Drug Benefit is approved, reimbursement will be subject to any drug deductible, dispensing fee maximum, co-insurance as outlined in the Benefit Schedule, and, if applicable, any additional terms or conditions required for a specific Prior Authorization Drug Benefit to become eligible for a given Member.

All Prior Authorization claims have a goal of being completed within two (2) business days upon receipt of all of the required information by the FACET Clinical Team. The majority of Prior Authorization claims under the FACET Program are completed same day to ensure Members and their Specialists have very responsive turnaround. If any changes need to be considered with a Prior Authorization claim, the FACET Clinical Team will communicate directly with a Member's physician.

Ineligible Drug Benefit: a drug product that is not eligible for reimbursement under the Plan for any Member and includes:

- A drug product defined as ineligible for reimbursement under the Plan pursuant to this contract.
- A drug product that has not received an unconditional recommendation for listing by Canada's Drug Agency (CDA-AMC) or by another internally recognized not-for-profit, government sponsored Health Technology Assessment agency.
- An active ingredient that is being used for an indication that has not been approved by Health Canada (commonly referred to off-label use).

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Lowest cost alternative limitation

The covered expense for a **non-biologic** General Drug Benefit or an approved **non-biologic** Prior Authorization Drug Benefit may be limited to that of a lowest cost alternative at the time of the claim. That lowest cost alternative could include a multi-source brand drug, or one or more Health Canada approved generic equivalents of a multi-source brand name drug deemed to be interchangeable by law where the drug is dispensed, or a different drug product with the same dosage form belonging to the same drug class.

The Plan reserves the right to eliminate reimbursement of any **non-biologic** General Drug Benefit or an approved **non-biologic** Prior Authorization Drug Benefit in favour of reimbursing one or more preferred products in a lower cost alternative category.

The covered expense for a **biologic** General Drug Benefit or approved **biologic** Prior Authorization Drug Benefit may be limited to the lower of the cost of the either the least expensive Health Canada approved biosimilar for a given reference biologic drug or the reference biologic drug product itself.

The Plan reserves the right to eliminate reimbursement of any **biologic** General Drug Benefit or **biologic** Prior Authorization Drug Benefit in favour of reimbursing one or more preferred products within a set of reference biologic and biosimilar drug products for a given active ingredient(s) in a given strength(s).

The right to limit or eliminate reimbursement of any non-biologic or biologic General Drug Benefit or Prior Authorization Drug Benefit can be removed by the Plan if appropriate medical information has been provided that demonstrates evidence of a contraindication to preferentially reimbursed alternatives or biosimilars.

What does it mean for you?

- If you fill your prescription under the CAEAS-ECAB Plan, you will be reimbursed based on the lower cost alternative, even if your doctor writes “no substitution” on the prescription.
- Of course, you can always purchase the drug you want to – you will just have to pay the difference out-of-pocket and/or inquire with your pharmacist if the manufacturer has any financial support program available.
- If your request for Drug Coverage is denied but you believe it should be approved, there is an escalation process allowing you to appeal the decision with medical evidence.

MemberRx

Claims for certain specialty drugs (generally, those that cost more than $5,000 per year) must be filled through MemberRx to be reimbursed by the Plan.

MemberRx is a pharmacy specializing in complex and high-cost medications, where you can:

- Submit a prescription online
- Receive delivery to your home or preferred location*, at no cost
- Receive additional support to help manage complex conditions

Filling a prescription through MemberRx means better monitoring, adherence, and pricing – supporting better health outcomes for Plan Members while helping manage overall Plan costs.

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MemberRx has been widely adopted across the education sector as a safe and effective tool to help members with chronic, rare, or complex conditions.

Learn more about MemberRx.

*Note: delivery through MemberRx may not be available in certain remote locations

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Therapeutic Class Pricing (TCP)

Within certain drug classes, there are a range of medications that are all equally safe and effective. Therapeutic class pricing (TCP) – also known as reference based pricing – means your reimbursement for drugs within those classes will be capped at a fixed amount. The table below outlines the therapeutic classes, conditions treated and reference drugs under the CAEAS-ECAB Plan.

Therapeutic Class	Used to Treat	Drug Examples	Reference Drug
Angiotensin converting enzyme inhibitors (ACEI)	• High blood pressure	• Altace, Coversyl, Vasotec, Accupril, Mavik, Prinivil	• Ramipril (generic of Altace)
Angiotensin receptor blockers (ARB)		• Diovan, Avapro, Atacand, Micardis, Edarbi	• Telmisartan (generic of Micardis)
Calcium channel blockers (CCB)		• Norvasc, Plendil, Adalat	• Amlodipine (generic of Norvasc)
Proton pump inhibitors (PPI)	• Stomach acid/Ulcers	• Nexium, Dexilant, Losec, Prevacid, Pariet, Pantoloc, Rabeprazole	• Rabeprazole (generic of Pariet)
Statins	• High cholesterol	• Crestor, Lipitor	• Rosuvastatin (generic of Crestor)

Why these classes?

Within each of these classes, there are many different drugs available for physicians to prescribe, all of which are equally safe and effective. The drugs work the same way in the body and are chemically very similar – for the vast majority of patients, the only difference is cost.

For example: A prescription for a proton pump inhibitor (PPI) means a physician has selected one of the six products listed above. That drug isn't the only one in the class that can treat that condition; it's just the one the physician has chosen.

The reference drug in each class is selected based on several factors, including clinical studies, safety data, utilization, approved indications, expert opinion, and cost.

How TCP works

For any drug to which TCP applies under the CAEAS-ECAB Plan, you will be reimbursed up to the cost of the reference product. You will be responsible for covering any difference in cost out-of-pocket.

For example: Let's say you're taking Losartan (the generic version of Cozaar) for high blood pressure. Each dose costs $0.31, but the price of the reference drug is $0.22. In this case, you would be responsible for covering the cost difference ($0.09 cents per dose) between the two drugs.

Sometimes, the cost differences are small. But in other cases (like Dexilant, which costs $2.30 per dose), compared to Rabeprazole (generic version of Pariet) which costs $0.13, the difference per dose can be significant.

No benefits will be paid for:

- Any single purchase of drugs which would not reasonably be used within 34 days – in the case of certain maintenance drugs, a 100-day supply will be covered.
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.
- Drugs used to treat erectile dysfunction.
- Drugs used for anti-obesity.
- Any drug that does not have a drug identification number (DIN) defined by Canada's *Food and Drugs Act.*

Quebec residents

If you live in Quebec, an out-of-pocket maximum is applied to in-province expenses for drugs listed in the Liste de médicaments (provincial formulary) published by the Régie de l'assurance-maladie du Québec (RAMQ).

If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows:

- Reimbursement will be made at 100%.
- No further out-of-pocket amounts will apply.

The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec.

When you turn age 65 and reside in Quebec, you cease to be covered under this Plan for basic prescription drug coverage and are covered under the basic plan provided by the RAMQ, unless you elect to be covered under this Plan as set out below. A one-time election may be made, to be covered under this Plan, by the end of the 60-day period immediately following the date you reach age 65 or the date you become a resident of Quebec, within the meaning of the *Health Insurance Act, Quebec*.

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Paramedical Services

Chiropodist/Podiatrist	• 90% coverage • Maximum $550 per Benefit Plan Year
Naturopath	• 90% coverage • Maximum $550 per Benefit Plan Year
Chiropractor	• 90% coverage • Maximum $550 per Benefit Plan Year
Dietitian	• 90% coverage • Maximum $550 per Benefit Plan Year
Acupuncturist	• 90% coverage • Maximum $550 per Benefit Plan Year
Osteopath	• 90% coverage • Maximum $550 per Benefit Plan Year
Psychologist, Social worker, Psychotherapist and Registered family therapist	• 90% coverage • Maximum $3,000 per Benefit Plan Year (combined)
Registered massage therapist	• 90% coverage • Maximum $550 per Benefit Plan Year
Speech therapist/Speech language pathologist/ Audiologist	• 90% coverage • Maximum $550 per Benefit Plan Year (combined)
Physiotherapist/Athletic therapist and Occupational therapist	• 90% coverage • Maximum $1,500 per Benefit Plan Year (combined)

- Covered expenses include out-of-hospital services or treatment by the following licensed, certified, or registered paramedical practitioners when operating within their recognized fields of expertise:
  - A qualified acupuncturist.
  - A registered massage therapist.
  - A licensed naturopath.
  - A licensed osteopath, including diagnostic x-rays.

- A licensed physiotherapist, a licensed athletic therapist, or a qualified occupational therapist.
- A registered psychologist, qualified social worker, registered family therapist, or registered psychotherapist.
- A qualified audiologist.
- Treatment of foot disorders, including diagnostic x- rays, by a licensed podiatrist/chiropodist.
- Treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor.
- Treatment of speech impairments by a qualified speech therapist.
- Treatment of nutritional disorders by a registered dietitian.

Vision Care

Glasses and contacts	• Maximum $500 per 24 months
Eye exam	• Maximum $120 per 24 months
Laser eye surgery	• $1,500 lifetime maximum

- Eye examinations, including refractions, are covered when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan.
- Glasses and contact lenses required to correct vision are covered when provided by a licensed ophthalmologist, optometrist, or optician.
- Laser eye surgery required to correct vision is covered when performed by a licensed ophthalmologist.

Medical Services and Supplies

Orthotics	• $450 per Benefit Plan Year
Orthopedic shoes	• $450 per Benefit Plan Year
Hearing aids	• $4,000 per 60 months
Ambulance	• Transport to nearest facility • Includes air ambulance
Private duty nursing (nursing care)	• $25,000 per Benefit Plan Year

Semi-private hospital	• Covered (the Trust will pay the difference between semi-private and ward accommodation)
Incontinence supplies	• $1,000 every 12 rolling months
Myoelectric arms	• $10,000 per prosthesis
External breast prosthesis	• One every 12 months
Surgical brassieres	• Two every 12 rolling months to a maximum of $500
Mechanical or Hydraulic patient lifters	• $2,000 per lifter once every five years
Outdoor wheelchair ramps	• $2,000 once in a lifetime
Diabetic Supplies	• Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs. • Blood-glucose monitoring machines, $150 each Benefit Plan Year • Flash glucose monitoring machines • Continuous glucose monitoring machines including Sensors and Transmitters, $4,000 each Benefit Plan Year • External insulin infusion pumps, $2,000 per pump once every five years
Transcutaneous nerve stimulators	• $700 lifetime
Extremity pumps for lymphedema	• $1,500 once in a lifetime
Custom-made compression hose	• Two pairs every 12 rolling months to a maximum of $750
Wigs for cancer patients	• $1,000 lifetime
Other eligible medical services and supplies	• Covered, except for those noted under limitations

Medical services and supplies are subject to Plan maximums and frequency limits as shown in the summary table above.

Additional details of covered services and supplies are determined by Canada Life and are outlined below.

- Rental or, at the Plan's discretion, purchase of certain medical supplies, appliances, and prosthetic devices, such as a wheelchair, prescribed by a physician.
- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician.
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician. The maximum amount payable is $4,000 every 60 months.
- Intraocular lenses following cataract surgery, not including the surgery.
- Diabetic supplies must be prescribed by a physician.
- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. However, a procedure is **not** eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan.
- Ambulance transportation to the nearest centre where adequate treatment is available.
- Accommodation in a licenced hospital or nursing home confinement or home nursing care is covered if the patient is receiving acute, convalescent, or palliative care.
    - Acute care means active intervention required to diagnose or manage a condition that would otherwise get worse.
    - Convalescent care means active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a three-day confinement for acute care.
    - Palliative care means treatment for the relief of pain in the final stages of a terminal condition.
- Preferred accommodation in a hospital or accommodation in a nursing home is covered when the accommodation is provided in Canada.
    - For hospital accommodation, the Plan covers the difference between the hospital's semi-private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered. This benefit only covers emergency treatment, not referrals.
    - The Plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person's home province.
    - For accommodation in a nursing home, the Plan covers the government authorized co-payment.
    - You should apply for a pre-care assessment before home nursing begins.
- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition. A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced. No benefits will be paid for:
    - Accidental damage to dentures.
    - Dental treatment completed more than 12 months after the accident.
    - Orthodontic diagnostic services or treatment.

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Emergency Travel Medical Coverage

The Plan covers expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business, or education purposes. Coverage includes Global Medical Assistance and Out-of-Country Emergency Care,

- Up to 60 days per trip
- $1 million per trip

Global Medical Assistance (GMA)

GMA provides help through a worldwide communications network which operates 24-hours-a-day. The network locates medical services when required as a result of a medical emergency while you or your dependent is travelling for vacation, business, or education.

Coverage for travel within Canada is limited to emergencies arising more than 500 kilometers from home. You must be covered by the government health plan in your home province to be eligible for GMA benefits.

The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000.
- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment. When services are covered under this provision, they are not covered under other provisions described in this booklet.
- Transportation and lodging for one family Member joining a patient hospitalized for more than 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.
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500.
- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.
- In case of death, preparation and transportation of the deceased to return home.
- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of you or your dependent’s hospitalization or death. Return or round-trip transportation for an escort for the children is also covered when considered necessary.
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving to a maximum of $1,000. 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.

No benefits will be paid for:

- Meal expenses.

Out-of-Country Emergency Care

The Plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business, or education purposes. A medical emergency is a sudden, unexpected injury or an acute episode of disease.

To qualify for benefits, you must be covered by the government health plan in your home province.

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

- Treatment by a physician.
- Diagnostic x-ray and laboratory services.
- Hospital accommodation in a standard or semi-private ward or intensive care unit if the confinement begins while you or your dependent is covered.
- Medical supplies provided during a covered hospital confinement.
- Paramedical services provided during a covered hospital confinement.
- Hospital out-patient services and supplies.
- Medical supplies provided out-of-hospital if they would have been covered in Canada.
- Drugs.
- Out-of-hospital services of a professional nurse.
- Ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available.
- Dental accident treatment if it would have been covered in Canada.

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

No benefits will be paid for:

- Expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is confined to a hospital at the end of the 60-day period, benefits will be extended to the end of the confinement.

General Health Benefit Limitations

- Expenses private benefit plans are not permitted to cover by law.
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are covered under the government health plan.
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (government plan), without regard to whether coverage would have otherwise been available under this Plan. Government plan does not include a group plan for government employees.
- Services or supplies that do not represent reasonable treatment.
- Services or supplies associated with: treatment performed only for cosmetic purposes; recreation or sports rather than with other daily living activities; the diagnosis or treatment of infertility, other than drugs; contraception, other than contraceptive drugs and products containing a contraceptive drug.
- Services or supplies not listed as covered expenses, including power scooters.
- Extra medical supplies that are spares or alternates.
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this Plan for the same services or supplies if they had been received in your home province. This limitation does not apply to GMA.
- Expenses arising from war, insurrection, or voluntary participation in a riot.
- Chronic care, except as listed under Home Nursing Care.
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid.
- Vision care services and supplies required by a participating employer as a condition of employment.
- Residences established primarily for senior citizens, or which provide personal, rather than medical care are not covered.
- The Plan covers home nursing services, including chronic care, of a registered nurse or a registered practical nurse if the person is a resident of Ontario, or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada.
- Nursing care is defined as care that requires the skills and training of a professional nurse and is provided by a professional nurse who is not a Member of the patient's family.

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DENTAL

What is covered under Dental

Your Dental coverage has been designed to provide you with solid financial support to ensure your dental health. The following pages detail your coverage for:

- Basic services
- Major restorative services
- Orthodontics

All covered Dental services and supplies must represent **reasonable treatment**. Reasonable treatment means it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of your dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist's supervision, performed by a dental hygienist entitled by law to practice independently, or performed by a denturist. Reimbursement is based on the current dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered.

Basic Services

Basic Services	• 100% of check-ups, x-rays, fillings, etc. • No annual maximum • Recall exams every nine months for adults; every six months for children under age 19 • Ten units of basic/periodontal scaling (combined) per rolling 12 months
Periodontics/Endodontics	• 100% coverage for root canals and related services • 100% coverage for scaling, root planing, gum treatments, etc.

Diagnostic services including:

- One complete oral examination every 24 months.
- Limited oral examinations once every nine months (once every six months for dependent children under age 19), except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed.
- Limited periodontal examinations once every nine months (once every six months for dependent children under age 19).
- Complete series of x-rays every 24 months.
- Intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 24 months. Services provided in the same 12 months as a complete series are not covered.

Preventive services including:

- Polishing and topical application of fluoride each once every nine months (once every six months for dependent children under 19).
- Scaling, limited to a maximum combined with periodontal root planing of 10-time units every 12 rolling months (a time unit is a 15-minute interval or any portion of a 15-minute interval).
- Oral hygiene instruction once in a person's lifetime.
- Pit and fissure sealants on bicuspids and permanent molars every 60 months.
- Space maintainers including appliances for the control of harmful habits.
- Finishing restorations.
- Interproximal disking.
- Recontouring of teeth.

Minor restorative services including:

- Caries, trauma, and pain control.
- Amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least two years old or the existing filling was not covered under this Plan.
- Retentive pins and prefabricated posts for fillings.
- Prefabricated crowns for primary teeth.

Endodontic and Periodontic services including:

- Endodontics: Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months.
- Periodontal services:
  - Root planing, limited to a maximum combined with preventive scaling of ten-time units every 12 rolling months.
  - Occlusal adjustment and equilibration, limited to a combined maximum of four-time units every 12 rolling months (a time unit is a 15-minute interval or any portion of a 15-minute interval).

Denture maintenance including:

- Denture relines for dentures at least six months old, once every 36 months.
- Denture rebases for dentures at least two years old, once every 36 months.
- Resilient liner in relined or rebased dentures after the three-month post-insertion care period has elapsed, once every 36 months.
- Denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed.
- Denture adjustments after the three-month post-insertion care period has elapsed, once every 12 months.

Other covered Basic Services:

- Oral surgery includes but is not limited to:
  - Removal of teeth.
  - Surgical exposure of teeth. Procedures for remodeling and recontouring oral tissues:

    (a) minor alveoloplasty, and

    (b) gingivoplasty and stomatoplasty.
  - Surgical incisions.
  - Surgical excision of tumors, cysts, and granulomas.
  - Treatment of fractures, including related bone grafts to the jaw.
  - Treatment of maxillofacial deformities (related bone grafts to the jaw and cheiloplasty).
  - Palatal obturators are covered. Cleft palate obturators are not covered.
- Adjunctive services including:
  - Minor remedies for relief of dental pain when provided on an emergency basis.
  - Therapeutic injections.
  - Anesthesia required in relation to covered services. The provision of general anesthetic facilities, equipment and supplies is covered only when a separate anesthetist is required.

No benefits will be paid for:

- Duplicate x-rays.
- Custom fluoride appliances, audio-visual oral hygiene instruction, and nutritional counselling.
- Root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants.
- Desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post- surgical treatment and periodontal re-evaluations.
- Implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage.
- Hypnosis or acupuncture.

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Major Restorative Services

Major Restorative Services	• 65% coverage • $2,500 maximum per Benefit Plan Year

The following services are considered Major Restorative Services:

Crowns and onlays:

- Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns.
- Onlays: coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays.
- Replacement crowns and onlays are covered when the existing restoration is at least five years old and cannot be made serviceable.

Dentures and bridgework:

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
  - The existing appliance is a covered temporary appliance.
  - The existing appliance is at least five years old and cannot be made serviceable. If the existing appliance is less than five years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.
  - If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.
- Denture-related surgical services for remodelling and recontouring oral tissues.
- Appliance maintenance following the three-month post-insertion period including:
  - Denture remakes, once every 36 months.
  - Tissue conditioning.
  - Repairs to covered bridgework.
  - Removal and recementation of bridgework.

No benefits will be paid for:

- Veneers, recontouring existing crowns, and staining porcelain.
- Crowns or onlays if the tooth could have been restored using other procedures.
- Alternative benefits: If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings.
- Overdentures or initial bridgework if provided when standard complete or partial dentures would

have been a viable treatment option.

- If overdentures are provided, coverage will be limited to standard complete dentures.
- If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework.
- If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework.
- Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.

Orthodontic Services

Orthodontics	• 50% coverage for adults and children • $3,000 lifetime maximum

- Orthodontics are covered for persons age six or over when treatment starts.
- Diagnostic services covered include examinations, radiographics, photographs, casts.
- Treatment for fixed and removable appliances.
- No benefits will be paid for expenses covered under another group plan's extension of benefits.

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General Dental Limitations

- Expenses private benefit plans are not permitted to cover by law.
- Services or supplies that do not represent reasonable treatment.
- Treatment performed for cosmetic purposes only.
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics.
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain.
- Services or supplies covered under Health: If the amount payable would be greater under this Dental benefit, then benefits will be paid under Dental and not Health.
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage.
- Expenses arising from war, insurrection, or voluntary participation in a riot.
- Late applications for dental coverage are not assessed according to underwriting rules. Instead, coverage for the first 12 months is limited to a maximum benefit of $200 per person.

Treatment plan/predetermination

Before incurring any large dental expenses – like bridges, crowns, dentures, and wisdom tooth extractions – ask your dental service provider to complete a treatment plan and submit it to Canada Life.

A predetermination is basically an estimate of the work needed and the costs involved. It's a useful tool to help you make more informed dental care decisions, because you can see in advance the approximate portion the plan will cover, and what you will have to pay.

To get a dental predetermination:

- Have your provider complete a dental claim form (either electronic or hard copy) and make sure it's clearly marked as a predetermination request;
- Include any supporting documentation (e.g., x-rays and/or models); and
- Submit the predetermination request to Canada Life for review.

Once you hear back from Canada Life, you and your provider can determine the appropriate next steps.

Your predetermination is only valid for 90 days – be sure to schedule your appointments and procedures accordingly.

Survivor benefits

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

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HEALTH CARE SPENDING ACCOUNT (HCSA)

As part of your Plan, you have a Health Care Spending Account (HCSA). It's like a bank account that you can use to pay for eligible health-related expenses not otherwise covered by the Plan.

The HCSA supplements your benefits coverage and provides you with some added flexibility when managing your health claims and costs. Also, since annual credits are before-tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

The amount of HCSA credits will be established prior to each Benefit Plan Year by the Trustees of ONE-T.

The following is a summary of your HCSA.

HCSA Benefit Plan Year	
September 1, 2025 – August 31, 2026	• $500 allocated to your HCSA for this period
September 1, 2026 – August 31, 2027	• $500 allocated to your HCSA for this period
Future HCSA amounts will be assessed and determined based on the CAEAS-ECAB Plan performance	

What is covered under the HCSA

Covered expenses include those:

- That qualify for a medical expense tax credit under the *Income Tax Act* (Canada), as may be amended from time to time.
- That Canada Life deems to be eligible medical expenses under a private health services plan, as defined by the *Income Tax Act* (Canada), as may be amended from time to time.
- The Canada Revenue Agency website provides information on medical expenses that qualify for the medical expense tax credit under the *Income Tax Act* (Canada).
- Benefits will be paid for expenses that are incurred while you and your dependents are covered, up to a maximum annual payment that is equal to the credits amount you have in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.
- If you don't use your full HCSA balance in a given Benefit Plan Year, you can carry forward the unused portion to the next Benefit Plan Year. However, you must use the carry-forward amount by the end of year two. Otherwise, according to Canadian tax rules, the carry-forward amount will be forfeited. Any HCSA claims submitted in year two will automatically be applied first to any carry-forward balance from the prior year, and then to the new allocation.

No benefits will be paid for:

- Expenses that private benefit plans are not permitted to cover by law.
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan.

- Any portion of the expense for services or supplies for which benefits have been paid under your health plan, another group plan, or a government plan.

You can find additional details about the HCSA – including some helpful videos – at **https://one-t.ca > Your benefits > Health Care Spending Account**.

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LIFE INSURANCE

Life insurance provides a one-time payment to your designated beneficiary(ies) in the event of your death. Your Plan includes coverage for Basic Life, plus access to optional coverage for you, your spouse, and eligible children.

For Optional Life, proof of good health is required and is subject to approval by Canada Life. Benefit costs are payable from the approval date.

What is covered under Life insurance

Your Life insurance benefits, both Basic and Optional, are outlined below. Your Basic coverage is included with your other Health and Dental benefits, while Optional coverage for your dependents is Member-paid and can be purchased in units of coverage up to a maximum amount.

Member Basic Life

Basic Life (Member only)	• 2x annual salary up to $1,000,000 combined maximum with Member Optional Life • No reduction at age 65 • Coverage ends at retirement

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

Waiver of premium

If you become disabled while insured, you may be eligible to have your Basic Life insurance premium waived. You must apply for waiver of premium benefits within 12 months of becoming eligible. If you believe you may be eligible, contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca.

Conversion

If any or all of your insurance ends, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. Canada Life will determine your qualification. You must apply and pay the first premium no later than 31 days after your group insurance ends. The maximum allowed on conversion is $200,000 for all Life insurance benefits (Basic Life and Optional Life combined), unless you are a resident of Quebec, then the maximum is $400,000.

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Optional Life – Member, Spouse, Child

Member Optional Life	• Member-paid, based on gender, age, and smoking status • Coverage available in $10,000 units to a maximum of $500,000, subject to approval of evidence of insurability
Spousal Optional Life	• Member-paid, based on gender, age, and smoking status • Coverage available in $10,000 units to a maximum of $500,000 subject to approval of evidence of insurability
Child Optional Life	• Member paid • Available in $5,000 units to a maximum of $25,000

When you apply for Optional Life insurance for yourself or your spouse, you must provide proof of insurability, and the application must be approved by Canada Life. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

When you die, Canada Life will pay your Life insurance to your named beneficiary. If you have not named one or there is no surviving beneficiary at the time of your death, payment will be made to your estate.

Any Optional Life insurance for you and your children will not continue past the end of the day before the date you reach age 70 or the day you retire, whichever comes first. Your spouse's coverage will not continue past the end of the day before the date your coverage ends or your spouse reaches age 65, whichever comes first.

Waiver of premium for Optional Life

If you become disabled while insured, you may be eligible to have your Optional Life Insurance premium waived.

If you are approved for waiver of premium, any Optional Life Insurance for you and/or for your dependents will continue without premium payment. The waiver of premium will not extend beyond the date your Optional Life Insurance would otherwise terminate, or the date you reach age 65, whichever is earlier.

You must apply for waiver of premium benefits within 12 months of becoming eligible. If you believe you may be eligible, contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca.

Conversion

If you live in Quebec and your, your spouse's or your child's Optional Life insurance ends, you, your spouse, or your child may be eligible for an individual conversion policy without providing proof of insurability.

If you live elsewhere in Canada and your or your spouse's Optional Life insurance ends, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability.

Canada Life will determine your qualification. You must apply and pay the first premium no later than 31 days after the group insurance ends.

No benefits will be paid for:

Suicide within the first two years of initial or increased Optional Life coverage.

In such a situation, Canada Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

Waiver of premium

If you believe you may be eligible for waiver of premium, contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca.

What qualifies as disabled, for this purpose?

If you are insured and approved for Long Term Disability (LTD) with your school board, then that approval can be provided for consideration of the life waiver of premium. The waiting period for life waiver of premium is the same as the waiting period under your Long Term Disability plan. The waiver of premium will continue as long as you are approved for LTD.

If you don't have LTD coverage with your school board, and your sickness or injury prevents you from being gainfully employed, you can still apply for the waiver if you have been disabled for six months or more.

If you are currently receiving WSIB/CSPAAT benefits, then please remember that you also need to apply for waiver of premium to have your life premiums waived.

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ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

AD&D insurance is also referred to as accident insurance – it provides a one-time payment if you experience a serious accident resulting in loss of limb or function.

Your Plan includes coverage for Basic AD&D and access to optional coverage for you and your spouse.

The following is a summary of your AD&D coverage.

Basic AD&D (Member only)	• 2x annual salary up to $500,000 maximum • No reduction at age 65 • Coverage ends at retirement or age 70 (whichever is earlier)
Member Optional AD&D	• Member-paid • Coverage available in $10,000 units to a maximum of $250,000 • Coverage ends at retirement or age 70 (whichever is earlier)
Spousal Optional AD&D	• Member-paid • Coverage available in $10,000 units to a maximum of $250,000 • Coverage ends at Member's retirement or when Member or spouse turns age 70 (whichever is earlier)

What is covered under AD&D

Member Basic AD&D and Optional AD&D

The Plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history. All active, permanent Members of ONE-T, under age 70 are eligible for this benefit.

In the event of your death, the covered benefit amount is payable to the beneficiary you have named or, if you haven't named one, to your estate.

The benefit paid will depend on the nature of the loss. If you have an accident and suffer injuries that result in any one of the following specific losses within one year from the date of the accident, the insurer Chubb Life will pay the percentage of the benefit amount covered. However, if multiple injuries occur in the same accident, the largest of such benefits will be the only one paid.

On the following chart, you will see the schedule of losses, which indicates what percentage of the benefit amount the insurance company will pay based on the injury incurred.

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Schedule of Losses and Percentage of Benefit Amount	
Loss of life	• 100%
Loss of entire sight of both eyes	• 100%
Loss of one hand and one foot	• 100%
Loss of use of one hand and one foot	• 100%
Loss of one hand and entire sight of one eye	• 100%
Loss of one foot and entire sight of one eye	• 100%
Loss of speech and hearing in both ears	• 100%
Coma	• 100%
Brain death	• 100%
Loss of both arms, both hands, both legs or both feet	• 200%
Loss of use of both arms, both hands, both legs or both feet	• 200%
Quadriplegia	• 200%
Paraplegia	• 200%
Hemiplegia	• 200%
Loss of one arm or one leg	• 75%
Loss of use of one arm or one leg	• 75%
Loss of one hand or one foot	• 75%

Schedule of Losses and Percentage of Benefit Amount (cont'd)	
Loss of use of one hand or one foot	• 75%
Loss of entire sight of one eye	• 75%
Loss of speech or hearing in both ears	• 75%
Loss of thumb and index finger of same hand	• 33 1/3%
Loss of use of thumb and index finger of same hand	• 33 1/3%
Loss of four fingers of same hand	• 33 1/3%
Loss of hearing in one ear	• 33 1/3%
Loss of all toes of same foot	• 25%

Waiver of premium

If you become disabled while insured, you may be eligible to have your AD&D Insurance premium waived.

If you are approved for waiver of premium, any AD&D Insurance for you and/or for your dependents will continue without premium payment. The waiver of premium will not extend beyond the date your AD&D Insurance would otherwise terminate, or the date you reach age 65, whichever is earlier.

You must apply for waiver of premium benefits within 12 months of becoming eligible. If you believe you may be eligible, contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca.

Conversion

On the date your employment ends or during the 31-day period following the end of your employment, you may convert your insurance to an individual AD&D-only insurance policy of Chubb Life.

The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as a person would ordinarily pay when applying for an individual policy at that time.

The amount of insurance benefit converted will not exceed that amount of issued during employment, up to a combined policy maximum of $500,000.

Definitions

Loss means:

- With respect to hand or foot, the actual severance through or above the wrist or ankle joint.
- With respect to arm or leg, the actual severance through or above the elbow or knee joint.
- With respect to eye, the total and irrecoverable loss of sight.
- With respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree.
- With respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device.
- With respect to Loss of Thumb and Index finger of Same Hand or Loss of Four Fingers of Same Hand, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- With regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot.
- If you suffer complete severance of a hand, foot, arm, or leg as described above, then Chubb Life will pay the amount even if the severed limb is surgically reattached, whether successful or not.

Loss as used with reference to:

- Quadriplegia (paralysis of both upper and lower limbs).
- Paraplegia (paralysis of both lower limbs).
- Hemiplegia (total paralysis of upper and lower limbs of one side of the body) means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

Loss of Use means the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

Brain Death means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Coma means the Insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A physician who is certified as a neurologist must confirm diagnosis in writing.

All benefits that are payable at 200% are subject to an all policies combined maximum benefit amount of $1,000,000.

Repatriation Benefit

When injuries covered by this Plan result in a loss of life for you or your dependent and it happens outside 150 km from your city of permanent residence or outside of Canada, and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, to a limit of $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

- Such training is required because of such injuries and in order for the Insured to become qualified to engage in an occupation in which he/she would not have been engaged except for such injuries.
- Expenses are to be incurred within two years from the date of the accident.
- No payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in you or your dependent being confined as an in-patient in a hospital outside 150 km from your city of permanent residence or outside of Canada and requires personal attendance of a Member of the immediate family as recommended by the attending physician in writing, Chubb Life will pay for the expense incurred by the Member of the family for the transportation by the most direct route by a licensed common carrier to the confined insured person, to a limit of $15,000.

Member of the Immediate Family means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition, the expenses actually incurred by your spouse for a formal occupation training program for the purpose of qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum benefit is $15,000. These expenses must be incurred within 365 days of the accident.

Home Alteration and Vehicle Modification Benefit

In the event you or your dependent sustains an injury which results in a payment being made under this Plan, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to move around, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

- The one-time cost of alterations to you or your dependent's principal residence to make it wheelchair accessible and habitable.
- The one-time cost of modifications necessary to a motor vehicle utilized by you or your dependent to make the vehicle accessible or operable.

Benefit payments herein will not be paid unless:

- Home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users.
- Vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items shall be 10% of the Insured's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If you (the employee) suffers a loss of life in a covered accident while this policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The **Day Care Benefit** will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

Dependent child means the employee's eligible unmarried natural legitimate, illegitimate, adopted, step-child or common-law child who is principally dependent on the Member or the Member's spouse for financial support.

Special Education Benefit

If you or your dependent suffers a loss of life in a covered accident under this policy, Chubb Life will pay, in addition to all other benefits payable under this policy, a Special Education Benefit equal to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of your dependent child who, on the date of the accident, is enrolled as a full-time student in any post – secondary institution or was at the 12th grade level and subsequently enrolls as a full-time student in a post-secondary institution within 365 days following the date of the accident.

The **Special Education Benefit** is payable annually for a maximum of four consecutive annual payments but only if your dependent child continues his/her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by this policy result in loss of life of the Insured within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured for up to six sessions of grief counseling, by a professional counsellor, subject to a maximum of $1,000.

Professional counsellor means a therapist or counsellor who is licensed, registered, or certified to provide such treatment.

In-Hospital Confinement Monthly Income

In the event you or your dependent sustain an injury which results in a payment being made under the schedule of losses of this policy, excluding the Loss of Life Benefit, and are confined to a hospital as an in-patient under the care of a legally qualified and registered physician or surgeon other than yourself, Chubb Life will pay for each full month, one percent of the Insured's Principal Sum, subject to a maximum benefit of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the first full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

Hospital as used herein means a legally constituted establishment which meets all the following requirements:

- Operates primarily for the reception, care, and treatment of sick, ailing, or injured persons as in-patients
- Provides 24-hour-a-day nursing service by registered or graduate nurses
- Has a staff of one or more licensed physicians available at all times
- Provides organized facilities for diagnosis and surgical facilities
- Is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts

In-patient means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If you or your dependent suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following list, subject to a maximum benefit payable of $25,000:

- Face, Neck, Head (100%).
- Hand and Forearm (25%).
- Either Upper Arm (15%).
- Torso (Front or Back) (35%).
- Either Thigh (10%).
- Either Lower Leg (Below Knee) (25%).

In the event of a burn to 50% of the surface, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If you or your dependent suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event you or your dependent sustain an injury which results in a payment being made under the schedule of losses, your benefit amount will be increased by 10%, to a maximum of $25,000, if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. You or your dependent must provide proof you were wearing a seat belt as part of the written proof of loss.

Vehicle means a private passenger car, station wagon, van, or jeep-type automobile. **Seat belt** means those belts that form a restraint.

Identification Benefit

In the event accidental Loss of Life is sustained by you or your dependent not less than 150 km from your normal place of residence and identification of the body by a Member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such Member for:

- Transportation by the most direct route to the city or town where the body is located.
- Hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured. The maximum amount payable is $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling, or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described herein shall be covered to the extent of the benefits afforded you.

If the body of you or your dependent has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that you or your dependent died due to bodily injuries sustained in an accident covered under this Plan.

The following benefits are applicable to the Optional AD&D insurance only

Common Disaster Benefit (only applicable in the case of Spousal Coverage)

If as a result of a common accident you and your spouse should both lose your lives within one year of such common accident, your spouse's loss of life benefit shall be increased to equal 100% of your (Member) benefit amount.

The benefit will be payable to and equally divided among your surviving children, or, in the case of any surviving child who is a minor or otherwise not competent to give valid release, Chubb Life may pay such benefit to the guardian, trustee or other person deemed by Chubb Life to be equitably entitled to receive such benefit. Any payment made by Chubb Life in good faith pursuant to this provision shall fully discharge Chubb Life to the extent of such payment.

Common accident means the same accident or separate accidents occurring within the same 24-hour period.

Surviving children means your dependent children as defined in the definition of eligible dependents applicable to the policy provided such children survive both you and your spouse by at least 24 hours.

Extended Family Benefit (only applicable in the case of Spousal Coverage)

If an Insured Member, who had insured his spouse, suffers loss of life in a covered accident, coverage may be extended for the spouse for a maximum of six months if premiums are paid.

Benefits will not be paid for:

The following exclusions are applicable to both Basic and Optional AD&D insurance coverage. The Plan does not cover any loss, which is the result of:

- Intentionally self-inflicted injuries, suicide, or any attempt thereat, while sane or insane.
- Declared or undeclared war or any act thereof.
- Losses occurring while the insured person is serving on full-time active duty in the armed forces of any country or international authority (any premium paid to be returned by Chubb Life pro-rata for any such period of full-time active duty).
- Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the Description of Hazards section of the Accidental Death & Dismemberment portion of the policy.
- Travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a Member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography of exploration.
- This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

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OPTIONAL CRITICAL ILLNESS INSURANCE

Your Plan includes access to Optional Critical Illness coverage for you and your spouse.

The following is a summary of your Critical Illness coverage.

Member Optional Critical Illness insurance	• Available in $10,000 units to a maximum of $250,000 • Subject to approval of evidence of insurability, except for the first $50,000 if it is applied for within the first 31 days of eligibility
Spousal Optional Critical Illness insurance	• Available in $10,000 units to a maximum of $250,000 • Subject to approval of evidence of insurability, except for the first $50,000 if it is applied for within the first 31 days of eligibility

What is covered under Critical Illness

While you're insured, if you or your spouse is diagnosed with one of the illnesses defined below, Canada Life will pay you the Optional Critical Illness insurance benefit.

Where a survival period is specified for a condition below, Canada Life will not pay the benefit until the end of the survival period. If your benefit is $10,000 or more, Canada Life will also make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for this optional benefit, you may be required to provide proof of insurability subject to approval by 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.

Your Optional Critical Illness insurance will not continue past the end of the day before the date you reach age 65. Spousal coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever is earlier.

Covered illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a specialist as defined by the policy.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

The diagnosis must be supported by objective medical evidence.

Heart attack

Heart attack means the death of heart muscle due to obstruction of blood flow, which results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- Heart attack symptoms.
- New electrocardiogram (ECG) changes consistent with a heart attack Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

No benefits will be paid for:

- Elevated biochemical cardiac markers after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves.
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart attack definition as described above.

Stroke

Stroke means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, persisting for more than 30 days following the date of the condition, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination.

These new symptoms and deficits must be corroborated by diagnostic imaging testing

The benefit is payable after a survival period of 30 days following the date of diagnosis.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not qualify as a stroke.

No benefits will be paid for:

- Transient ischaemic attacks.
- Intracerebral vascular events due to trauma.

Coronary artery bypass surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

The benefit is payable after a survival period of 30 days following the date of surgery.

No benefits will be paid for:

- Angioplasty.
- Intra-arterial procedures.
- Percutaneous trans-catheter procedures.
- Non-surgical procedures.

Cancer (life-threatening)

Cancer (life-threatening) means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

No benefits will be for:

- Lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta.
- Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis.
- Any non-melanoma skin cancer, without lymph node or distant metastasis.
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis.
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.
- Chronic lymphocytic leukemia classified less than Rai stage 1.
- Malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

The term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer exclusion period:

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- Signs, symptoms, or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made.
- A diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

Kidney failure

Kidney failure means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Blindness

Blindness means the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes.
- The field of vision being less than 20 degrees in both eyes.

Major organ transplant

Major organ transplant means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary.

To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney, or bone marrow.

Dementia, including Alzheimer's disease

Dementia, including Alzheimer's disease, means dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech).
- Apraxia (difficulty performing familiar tasks).
- Agnosia (difficulty recognizing objects).
- Disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function.
- Evidence of progressive deterioration in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

No benefits will be paid for:

- Affective or schizophrenic disorders.
- Delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Parkinson's disease and specified atypical parkinsonian disorders

Parkinson's disease means primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

- Muscular rigidity.
- Rest tremor.

The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders means progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

No benefits will be paid for:

- Any other type of parkinsonism.

Exclusion period:

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- Signs, symptoms, or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder, or any other type of parkinsonism, regardless of when the diagnosis is made.
- A diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder, or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis.

If this information is not provided within this period, Canada Life has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or, any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

Paralysis

Paralysis means total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Multiple sclerosis

Multiple sclerosis means at least one of the following:

- Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the

nervous system, showing multiple lesions of demyelination.

- Well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination.
- A single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Deafness

Deafness means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Loss of speech

Loss of speech means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

No benefits will be paid for

- All psychiatric related causes.

Coma

Coma means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

No benefits will be paid for:

- A medically induced coma.

Severe burns

Severe burns means third degree burns over at least 20% of the body surface.

Aortic surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

The benefit is payable after a survival period of 30 days following the date of surgery.

No benefits will be paid for:

- Angioplasty.
- Intra-arterial procedures.
- Percutaneous trans-catheter procedures.
- Non-surgical procedures.

Benign brain tumour

Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

No benefits will be paid for:

- Pituitary adenomas less than 10 mm.

Exclusion period:

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- Signs, symptoms, or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made.
- A diagnosis of benign brain tumour (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Heart valve replacement or repair

Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

The benefit is payable after a survival period of 30 days following the date of surgery.

No benefits will be paid for:

- Angioplasty.
- Intra-arterial procedures.
- Percutaneous trans-catheter procedures.
- Non-surgical procedures.

Loss of independent existence

Loss of independent existence means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices.
- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices.

- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring – the ability to move in and out of a bed, chair, or wheelchair, with or without the aid of assistive devices.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of limbs

Loss of limbs means the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

Motor neuron disease

Motor neuron disease means one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease).
- Primary lateral sclerosis.
- Progressive spinal muscular atrophy.
- Progressive bulbar palsy.
- Pseudo bulbar palsy.

Occupational HIV infection

Occupational HIV infection means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred following the later of the person’s effective date of insurance or, for an increase, the effective date of the increase.

Payment under this condition requires satisfaction of all the following:

- The accidental injury must be reported to Canada Life within 14 days of the accidental injury.
- A serum HIV test must be taken within 14 days of the accidental injury, and the result must be negative.
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive.
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States.
- The accidental injury must have been reported, investigated, and documented in accordance with current Canadian or United States workplace guidelines.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV infection.

No benefits will be paid if:

- The person has elected not to take any available licensed vaccine offering protection against HIV.
- A licensed cure for HIV infection has become available prior to the accidental injury.

Bacterial meningitis

Bacterial meningitis means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

No benefits will be paid for:

- Viral meningitis.

Aplastic anaemia

Aplastic anaemia means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents.
- Immunosuppressive agents.
- Bone marrow transplantation.

General Critical Illness Insurance Limitations

No benefits will be paid for a critical illness resulting directly or indirectly from or associated with any of the following:

- Intentionally self-inflicted injury or attempt at suicide, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions.
- War, insurrection, or voluntary participation in a riot.
- Participation in a criminal offence or provoking an assault.
- Use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician.
- Operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.
- Death or irreversible cessation of all functions of the brain which occurs during the benefit payment waiting period.

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DESIGNATING A BENEFICIARY

You will need to complete two beneficiary forms: one for Life insurance and Critical Illness (with Canada Life) and one for AD&D (with Chubb).

Please note, if you are appointing a minor (under age 18) as a beneficiary, then you will also need to complete the section on Trustee designation on these forms.

You can find the appropriate beneficiary designation forms on Cowan's Member Access site.

Why does it matter?

Submitting these forms will enable the insurance company to pay the benefits to your beneficiaries without the delay of settling your estate. It also ensures that your estate won't be reduced by additional probate fees, and that the insurance money is provided to your beneficiaries tax-free.

If Cowan does not have signed beneficiary designation forms on file for you:

- Benefits will be paid to your estate and not directly to your desired beneficiaries; and
- Payment could be delayed under the rules and laws governing estates.

You may want to consider obtaining legal advice for more information on the implications of having your estate as your beneficiary.

Can I designate more than one beneficiary for a particular benefit?

Yes. You can also choose different beneficiaries for Life insurance, Critical Illness, and for AD&D, based on your estate planning needs.

Beneficiary designations must be completed in ink and in the appropriate section, specifying your beneficiaries' first and last names, along with the percentage allocated to each person. If you need to make changes, please strike through and initial the change – corrective liquid (e.g., white-out) is not permitted.

How can I confirm my beneficiaries on file?

You can view your designated beneficiaries by logging on to Cowan's Member Access site. Keep in mind, if you experience a life event (e.g., getting married, having a baby, etc.) – or you simply want to change your beneficiaries – you can submit new beneficiary designation forms at any time.

Revocable versus irrevocable beneficiary: What's the difference?

A revocable beneficiary can be changed by the Plan Member without the beneficiary's signature, while an irrevocable beneficiary requires the beneficiary to sign off on any changes.

If you want to designate an irrevocable beneficiary for Life insurance, you will have to fill out an additional Canada Life form. If you want to designate an irrevocable beneficiary for AD&D, just write "irrevocable" on the Chubb form and initial it.

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GENERAL INFORMATION

Benefit providers

Coverage	Insurer/Provider/Administrator	Policy Number
Health, Dental, HCSA	• Canada Life Assurance Company (Canada Life)	• Administrative Services Only (ASO) policy 50230
Global Medical Assistance	• Canada Life	• Insured policy 172530
Life insurance: **Basic Life, Optional Life**	• Canada Life • Basic Life waiver of premium is self-insured through ONE-T/FENSÉO for disabilities on or after September 1, 2020. Canada Life insures the Basic Life waiver of premium for all disabilities prior to that date	• Insured policies 172530 and 172531
Optional Critical Illness	• Canada Life	• Insured policy 172531GOCI
Accident insurance: **Basic AD&D, Optional AD&D**	• Chubb Life Insurance Company of Canada (Chubb Life)	• Insured policies AB10519401 and OE10519401
Cowan Insurance Group	• Third Party Administrator	
Cubic Health	• Manage Prior Authorization for specialty drugs used to treat complex diseases through the FACET program	

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Submitting claims

To ensure that your eligible claims are reimbursed, you must submit them for reimbursement within the required timeframe or the payment of your claim may be denied.

Claim	Submission Period	Provider
Health and Dental	• You can submit claims online for Prescription Drugs, Paramedical Services, Vision Care, and Dental claims. Visit My Canada Life at Work. • Online claims must be submitted no later than six months after you incur the expense • For claims submission online, you must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request • Paper claims must be submitted no later than 15 months after you incur the expense • Get personalized forms: My Canada Life at Work • Forms: Dental M445D, Health M635D	Canada Life
HCSA	• You can submit HCSA claims online via My Canada Life at Work • Claims must be submitted no later than 90 calendar days after the end of the Benefit Plan Year in which the expenses are incurred	Canada Life
Life insurance	• You can call Cowan at 1-888-330-4010 for information and help in completing Life insurance claims • Claims must be submitted no later than 15 months after you incur the expense	Canada Life

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Claim	Submission Period	Provider
Critical Illness	• You can call Cowan at 1-888-330-4010 for information and help in completing Critical Illness insurance claims • Claims should be submitted as soon as possible, but no later than six months after the earlier of: the end of the critical illness survival period (where applicable) or the date the Plan ends	Canada Life
AD&D	• You can call Cowan at 1-888-330-4010 for information and help in completing Accident insurance claims • Notice of claim to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period • Subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period. Otherwise, provide notice or proof as soon as reasonably possible • In no event will Chubb Life accept notice of claim beyond one year	Chubb Life
Waiver of Premium	• You must apply for waiver of premium benefits within 12 months of becoming eligible • If you believe you may be eligible, contact Cowan at 1-888-330-4010 or one-t@cowangroup.ca	• The Basic Life waiver of premium coverage is self-insured with ONE-/FENSÉO and Cowan will determine your qualification. Note: for any disabilities prior to September 1, 2020 Canada Life will determine your qualification for Basic Life waiver of premium • Canada Life will determine your qualification for Optional Life waiver of premium • Chubb Life determines your qualification for AD&D waiver of premium

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Coordination of benefits

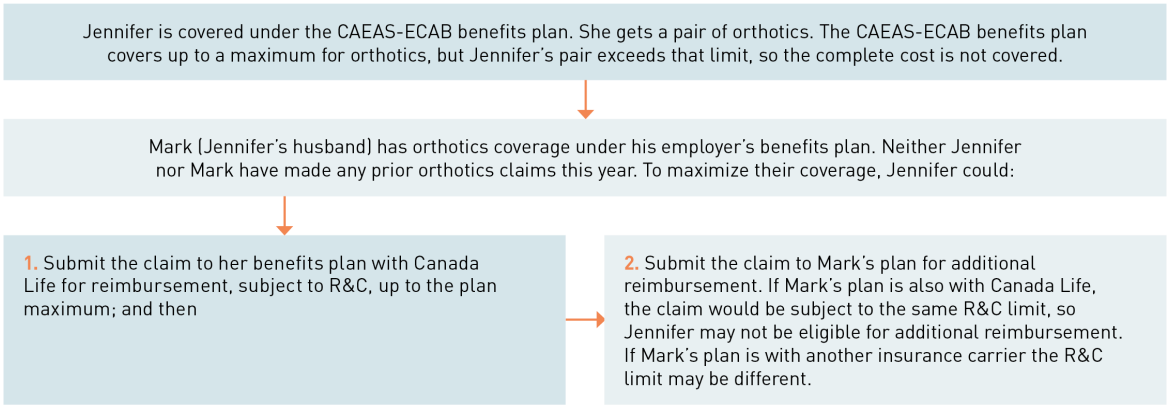
If both you and your spouse have benefits plans, you can coordinate your benefits – even if you are both Members of the CAEAS-ECAB Plan – to ensure you're getting the most from your coverage.

Coordination of benefits (COB) simply means submitting a claim to your Plan first, and then to your spouse's plan. If your spouse is the claimant, then he/she must first submit the claim to his/her plan and then to yours. If the claim is for a dependent child and both parents have benefits coverage, then the claim can be submitted:

1. To the plan of the parent with the earlier birthdate (month/day) in the calendar year; then
2. To the other parent's plan. (If both parents have the same birth date, then priority is based on the alphabetical order of the parents' first names.)

It's important to remember, however, that claims are subject to R&C limits. Coordinating benefits will increase your overall reimbursement, but due to R&C limits, your claim may not be reimbursed at 100%.

How coordination of benefits (COB) works



Additional claiming details

For **Drug claims**, your Plan sponsor will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents.

Checks done include

- Drug interaction.
- Therapeutic duplication.
- Duration of therapy.

These checks allow the pharmacist to react prior to the drug being dispensed. Depending on the outcome

of the checks, the pharmacist may refuse to dispense the prescribed drug.

For **Out of Country claims**, (including those for GMA expenses) they should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your provincial or territorial medical plan has very strict time limitations.

Access GroupNet for Plan Members to obtain a personalized claim form (form M5432, Statement of Claim Out-of-Country Expenses form). You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form.

The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

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

Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Canada Life.

Where Quebec law applies, any death benefits will be paid within 30 days of Canada Life receiving the required proof of your claim. All other benefits will be paid within 60 days of Canada Life receiving proof of your claim.

Date of Incurral

- For purposes of all calculations made under the Health benefit provision, expenses for services and supplies are considered to be incurred when the person receives them.
- For purposes of all calculations made under the Dental benefit provision, expenses other than orthodontic expenses are considered to be incurred when treatment is completed.
- Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment.

Liability for Benefits

The Trustees of ONE-T have entered into an agreement with The Canada Life Assurance Company whereby the Health (other than GMA) and Dental benefits outlined in this booklet are uninsured and The Trustees of ONE-T has liability for them. Also, the Basic Life waiver of premium coverage is self-insured with ONE-T/FENSÉO for any disabilities from September 1, 2020. Any Basic Life waiver of premium attributable to disabilities prior to this date is insured with Canada Life.

This means that the Health (other than GMA), Dental and Basic Life waiver of premium benefits are:

- An unsecured financial obligation and are payable from The Trustees of ONE-T's net income, retained earnings or other financial resources; and
- Not underwritten by a licensed insurer or regulated insurer. All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts The Trustees of ONE-T 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.

For any insured benefits, the role of your Plan sponsor is limited to providing you with information and not advice.

Legal Action

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

For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

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

Appeals to Canada Life

Insured benefits: You have the right to appeal a denial by Canada Life 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 by Canada Life 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.

If you believe you have a reason to appeal, first contact Canada Life. If the issue isn't resolved, your complaint will be escalated for further review. When you need to submit your appeal in writing, it will be addressed to the Ombudsman, whose mailing address can be found on the last page of this booklet.

Appeals of Prior Authorization Drug Benefit claim decisions should be made directly through Cubic's FACET Prior Authorization Program. For an appeal to be considered, there must be a material change to the medical information that was provided in the initial claim submission that warrants reconsideration, or there must be medical evidence of a change in the underlying medication condition from the point of initial submission of the Prior Authorization claim request.

Appeals will not be considered by the Plan for Ineligible Drug Benefits.

Appeals to ONE-T

If, after moving through the appeals process(es) with our providers, you are not fully satisfied, you can submit an appeal to ONE-T.

For example,

- For an appeal related to the reimbursement of a claim, you would already have submitted your initial request for reconsideration through Canada Life's appeal process;
- For Drug Prior Authorization appeals, you would already have directed your initial request for reconsideration to Cubic;

- For appeals related to eligibility, you would already have directed your request for reconsideration to Cowan.

Only *after* you have completed the steps above can you submit an appeal to ONE-T. Full details of this policy and the claims appeal form can be found on the ONE-T website.

Benefit Limitation for Overpayment

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

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

Protecting Your Personal Information

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. In doing so, Canada Life limits 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.

The Trustees of ONE-T has an agreement with Canada Life in which The Trustees of ONE-T has financial responsibility for some or all the benefits in the Plan and Canada Life processes claims on The Trustees of ONE-T's behalf. Both parties may exchange personal information with your health care providers, your Plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the Plan.

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

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office. For a copy of the Privacy Guidelines, or if you have questions about 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.

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GLOSSARY

Benefit Plan Year

The Benefit Plan Year begins on September 1st of each year and ends on August 31st of the following year.

Coordination of benefits (COB)

Coordination of benefits (COB) means submitting a claim to your Plan first, and then to your spouse's plan to cover any amount not covered in full by the CAEAS-ECAB Plan.

Deductible

A deductible is a specific amount of money you or your dependent have to pay before the insurance company will reimburse you.

Dental fee guide

This is the schedule of fees outlining the typical cost of dental services provided by general practitioners, as published by the dental association in your province of residence.

Dependent

An eligible dependent is someone who resides in Canada and is your spouse, whether married legal or common-law.

Your unmarried children are also considered dependents, if they are under age 21, or under age 26 if they are full-time students. Eligible children must reside in Canada or ordinarily reside in Canada but are temporarily studying outside of Canada.

Also, children who can't support themselves because of a physical or mental disorder are considered dependents and are covered without age limit if the disorder begins before they turn 21, or while they are students under 26, and the disorder has been continuous since that time.

Evidence of insurability

Proof of good health satisfactory to the insurer.

FTE

FTE stands for full-time equivalent and is the basis for calculating the amount of funding we receive to help pay for your benefits. Full-time employees have an FTE of 1 and have a cost sharing of 5% of the costs of benefits. Part-time employees have an FTE of less than 1, and the calculation of their cost share is based on the percentage of hours worked.

Health Care Spending Account (HCSA)

A Health Care Spending Account (HCSA) is an account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. These credits may be used to supplement your benefits coverage.

Hospital

A hospital is an institution that:

- Is legally termed a hospital.
- Is open at all times.
- Offers in-patient accommodation.
- Has a staff of one or more physicians available at all times.
- Continuously provides 24-hour nursing by registered nurses.

Nursing care

The Plan covers home nursing care provided in Canada. Nursing care is care that:

- Requires the skills and training of a registered nurse/registered practical nurse/licenced practical nurse.
- Is provided by a professional nurse who is not a Member of the patient's family.
- Coverage is limited to the number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be recognized in determining the level of skill needed.

Nursing home

A nursing home is an institution or part of an institution that:

- Offers in-patient accommodation.
- Has a staff of one or more physicians available at all times.
- Continuously provides 24-hour medical care by or under the supervision of professional nurses.

Facilities established primarily as residences for senior citizens, or which provide personal rather than medical care are not included.

Out-of-pocket maximum

The portion of eligible expenses you pay is considered out-of-pocket expenses. Once you reach the out-of-pocket maximum, reimbursement goes to 100% for eligible expenses, until you reach the coverage limits. An out-of-pocket maximum is applied to in-province expenses for drugs listed in the Liste de médicaments published by the Régie de l'assurance-maladie du Québec if you live in Quebec (provincial formulary drug expenses). The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec.

Plan sponsor

The Plan sponsor means Trustees of ONE-T/FENSEO.

Employer

Employer means a participating employer that is a part to ONE-T/FENSEO, the Ontario Non-union Education Trust; and has agreed to make contributions to the Plan Sponsor for Member coverage under this Plan.

Prior Authorization

Prior Authorization is a process that is intended to help ensure you or your dependent have met the eligibility criteria developed and maintained by Cubic Health Inc. for the drug or drug supply you are trying to get coverage for.

Reasonable and customary (R&C)

Reasonable and customary (R&C) limits are the normal range of fees for services and supplies in a given geographical area. All services and supplies, including but not limited to drugs and drug supplies, covered under the CAEAS-ECAB Plan must represent reasonable treatment – meaning they must be accepted by the Canadian medical profession, proven to be effective, and of a form, intensity, frequency, and duration that is essential to diagnose or manage a disease or injury. Some paramedical practitioners and medical service providers – such as massage therapists or physiotherapists – charge higher rates, which drive higher plan costs. R&C limits are important to ensure claims to our Plan are not excessive and will also help reduce the likelihood of benefits fraud.

Spouse

Your spouse is either a person to whom you are legally married, or your common-law partner (of either sex) who is living with you and has been living with you in a conjugal relationship for a period of at least 12 months, or your common-law partner with no minimum cohabitation period if you are both the parents of a natural or adopted child.

Waiver of premium

A benefit applied for, which if approved, means Canada Life (and/ or Chubb) will waive the premium you pay for Life Insurance or AD&D Insurance for you, or for your dependents, while you are on an approved long term disability. The extent of this benefit may be dependent upon the date at which you become disabled. To ensure your application will be considered, you must apply for this benefit, within the specified time frames. Refer to the relevant section within Life Insurance and AD&D Insurance for additional details.

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HAVE QUESTIONS OR NEED HELP?

Who to contact	
General benefits information	• www.one-t.ca

Coverage and claims questions	• Canada Life:
	  • for assistance with your medical and dental coverage, please call 1-866-800-8086, or via My Canada Life at Work
	  • for assistance with your Health Care Spending Account, please call 1-877-883-7072, or via My Canada Life at Work

Enrollment and eligibility questions	• Cowan at 1-888-330-4010 or one-t@cowangroup.ca
Personal benefits statement	• Cowan website
Complaints and concerns (Canada Life)	• By phone at 1-866-292-7825 • By fax at 1-855-317-9241 • By email to ombudsman@canadalife.com • By mail to: Ombudsman 255 Dufferin Avenue London, ON N6A 4K1 • Additional information on how to submit a complaint can be found at www.canadalife.com/complaints

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