Public Sector
Group Insurance Plan

ACTIVE EMPLOYEES

PSGIP Benefits Booklet

Published April 2025

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Public Sector Group Insurance Plan

Benefits Booklet

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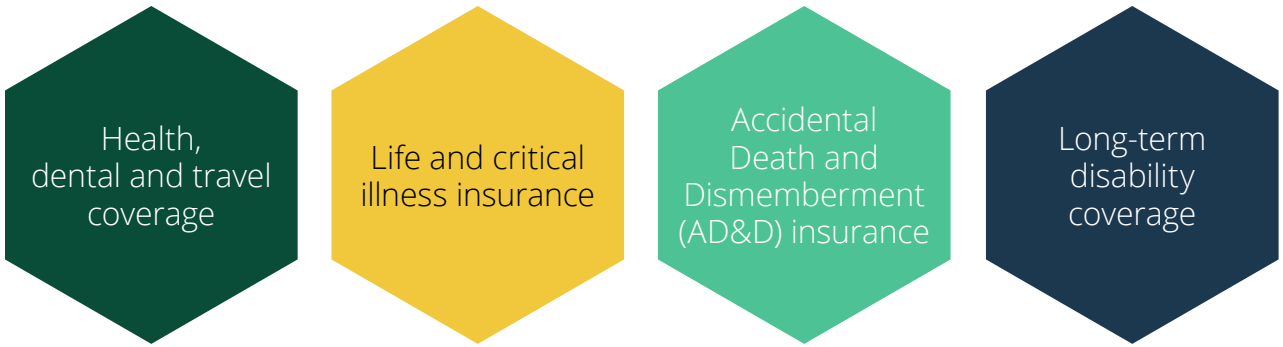
WELCOME

Welcome to Your Group Benefits Plan

This group benefits plan is designed to help protect you and your family throughout your career. It's important to get to know your benefits and to use them when needed.

This booklet has been developed to answer your questions about your group benefits. Simply browse through the various sections to see what the plan pays and what you need to do to claim benefits. This booklet also provides a detailed benefits summary, list of forms and other important resources, definitions and more.

We hope this booklet will help you better understand your benefits, which may include:



This member booklet summarizes the benefits and some provisions of your group benefits plan; it does not include all details, provisions, exclusions and limitations. Every effort has been made to ensure that the information is accurate. However, if there is any question as to the interpretation, all rights with respect to an insured person will be governed by the official group insurance policies. Benefits may be changed at any time.

Benefits At-a-Glance

OVERVIEW

The Benefits At-a-Glance summarizes the coverage available to you under the PSGIP. It does not describe all the benefit details. **Certain limitations and conditions apply.** See the exclusion sections for each benefit for more information. Coverage shown is per insured person and per calendar year, unless otherwise stated.

- Health
- Travel
- Dental
- Basic Life and AD&D Insurance
- Optional Life, AD&D and Critical Illness Insurance
- Long-Term Disability

HEALTH

Supplements your provincial health coverage.

Reimbursement*	
Prescription drugs (mandatory generic substitution)	• 80% of the first $150 per eligible drug expense, and 100% thereafter • $500 lifetime maximum for vaccines • $300 lifetime maximum for smoking cessation products (limited to 50% reimbursement) • $250 maximum per calendar year for sexual dysfunctions medications • Pay-direct drug card (reimbursement is processed at point-of-sale, where available)
Hospital accommodations	• 100% of the difference between a ward and semi-private room • 80% of the difference between a semi-private and private room
Paramedical practitioners	80% • Maximum 20 visits per practitioner (6 for social workers) per calendar year (excluding massage therapists) • $240 maximum per calendar year for massage therapists • $800 combined annual maximum for the following practitioners: acupuncturists, chiropodists (or podiatrists), chiropractors, clinical psychologists and registered counseling therapists, naturopaths, osteopaths, physiotherapists, social workers and speech therapists
Eye exams	80% • One eye exam every 2 calendar years (every calendar year for **children** age 18 and under)
Eye glasses or contact lenses	80% • $160 maximum once every 2 calendar years (every calendar year for children age 18 and under)

* Expenses are reimbursed based on Canada Life's assessment of **reasonable and customary** fees.

Reimbursement*	
Private-duty nursing	80% • $8,000 maximum per calendar year
Medical supplies and prosthetics	80%
Other eligible expenses	80% (except for ambulance services)
• **Accidental dental**	Treatment must be completed within 12 months of the accident
• **Ambulance services**	100% of the first $50 of eligible expenses per calendar year, and 80% thereafter
• **External insulin pumps**	1 pump every 5 calendar years, to a maximum of $5,200
• **Hearing aids**	$900 maximum per ear every 5 calendar years
• **Orthotics and orthopedic shoes**	$240 combined maximum every calendar year

* Expenses are reimbursed based on Canada Life's assessment of **reasonable and customary** fees.

TRAVEL

Supplements your provincial health coverage.

Reimbursement	100%
Emergency out-of-province/ country health care	$1 million maximum per emergency (must be covered under provincial plan)
Travel assistance	24/7 services 1 866 530-6024 (in Canada and the US) / Collect: (905) 816-1901

DENTAL

Provides coverage for a variety of dental procedures.

	Plan A	Plan B
Reimbursement		
Preventative services (e.g., oral exams, cleaning and scaling of teeth, fillings and x-rays)	80% Recall exams once every calendar year	80% Recall exams once every calendar year
Maintenance services (e.g., oral surgery and periodontic and endodontic care)	80%	80%
Major restorative services (e.g., dentures, crowns and bridges)	No coverage	50% $1,000 maximum per calendar year
Orthodontics (braces)	No coverage	50% $3,000 lifetime maximum
Dental fee guide	Current year fee guides for general practitioners and specialists (if applicable)	

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Provides financial security if you or a **dependent** dies or suffers a severe injury as a result of an accident.

	Basic Life	Basic AD&D
Coverage		
Full-time employees	3 X your annual **earnings** $300,000 maximum*	3 X your annual earnings $300,000 maximum
Part-time Civil Service employees	2 X your annual earnings $25,000 minimum and $175,000 maximum	2 X your annual earnings $25,000 minimum and $175,000 maximum
Part-time CUPE employees	$40,000	$40,000
Part-time UPSE employees, and excluded non-union and non-excluded employees	$40,000	$40,000
Part-time PEINU employees	$100,000	$100,000
Part-time UPSE employees covered before June 1, 1996	2 X employment guarantee $25,000 minimum and $175,000 maximum	2 X employment guarantee $25,000 minimum and $175,000 maximum
Part-time IUOE employees	$50,000	$50,000

* If you are a full-time **Civil Service employee** and you did not elect a benefit of 3 X annual **earnings** on December 1, 1996, coverage is equal to 2 X your annual earnings, to a maximum of $175,000.

If you are a full-time UPSE employee who did not elect coverage of 3 X annual earnings during June 1996, or a part-time UPSE employee who was covered before June 1, 1996, coverage is equal to 2 X employment guarantee, minimum of $25,000, to a maximum of $175,000.

	Basic Life	Basic AD&D
Coverage		
For your spouse	$4,000** (optional coverage)	—
For your children	$3,500 per **child** (optional coverage)	—

** Coverage is equal to $3,500 if you are a:

– full-time Health Sector UPSE employee who elected a benefit of 3 X annual **earnings** on June 1, 1996,

– permanent full-time UPSE employee who transferred from Civil Service to Health Sector on August 1, 1995 and remained an UPSE employee, and full-time Health Sector UPSE employee who did not elect a benefit of 3 X annual earnings on June 1, 1996, and

– permanent part-time UPSE employee who transferred from the Civil Service to the Health Sector on August 1, 1995 and remained an UPSE employee, and part-time UPSE employee covered prior to June 1, 1996. (Part-time UPSE employees covered prior to June 1, 1996 and subsequently transfer to full-time UPSE after June 1, 1996 remain at $3,500).

OPTIONAL LIFE, AD&D AND CRITICAL ILLNESS INSURANCE

Provides additional financial security to enhance your basic coverage.

	Optional Life	Optional AD&D	Optional Critical Illness
Coverage			
For you	$300,000 maximum (in units of $10,000)	$300,000 maximum (in units of $10,000)	$250,000 maximum (in units of $10,000)
For your spouse	$300,000 maximum (in units of $10,000)	50% of your optional AD&D coverage (60% if you have no **children**)	$250,000 maximum (in units of $10,000)
For your children	$10,000 per **child**	15% of your optional AD&D coverage if you have a **spouse** (20% otherwise) $20,000 maximum per child	Not available
Proof of good health	Required for amounts above $30,000	Not required	Required for amounts above $50,000

LONG-TERM DISABILITY

Provides important financial security in the event that your income is interrupted by an illness or injury and you are unable to work.

Benefits paid	70% of your monthly **earnings** (indexed annually)
Maximum	$6,000 per month (limited to 85% of your pre-disability income when all sources of income are combined)
Waiting period	4 months or when sick leave benefits with your employer expire, whichever is later
Duration of benefits	Until age 62, recovery or retirement, whichever occurs first, if your date of disability is on or after January 1, 2019
Benefits taxable	Yes

Plan Costs

YOUR COSTS

You and your employer share the cost of benefits, except for travel, basic life for dependents if you are a **Civil Service employee** and all optional benefits. These benefits are 100% paid by you.

The following are the costs you pay monthly and are valid for the benefit year (April 1, 2025 to March 31, 2026). These premiums are subject to change based on the annual renewal process.

Costs per Month		
Health	Single	$67.36
	Family	$156.97
Travel	Single	$2.12
	Family	$4.20
Dental	**Plan A**	
	Single	$19.06
	Family	$48.02
	Plan B	
	Single	$23.49
	Family	$57.35
Long-term disability		1.87% of your **earnings**
Basic life	Per $1,000 of coverage	$0.069

Costs per Month		
Basic life for your dependents	Health PEI (flat amount)	$0.39
	Civil Service (flat amount)	$0.78
Basic AD&D	Per $1,000 of coverage	$0.0103
Optional life	Employee and **spouse** (per $1,000 of coverage)	**Age**
		Under 35 $0.059 35-39 $0.069 40-44 $0.120 45-49 $0.202 50-54 $0.342 55-59 $0.581 60-64 $0.932
	Dependent **children** (flat amount)	$1.24
Optional AD&D	Single (per $1,000 of coverage)	$0.0204
	Family (per $1,000 of coverage)	$0.0376

Costs per Month			
Optional Critical Illness	Employee and **spouse** (per $1,000 of coverage)	**Male Non-Smoker**	
		Under 20	$0.051
		20-25	$0.061
		26-30	$0.092
		31-35	$0.132
		36-40	$0.214
		41-45	$0.305
		46-50	$0.458
		51-55	$0.763
		56-60	$1.343
		61-64	$2.146
		Male Smoker	
		Under 20	$0.061
		20-25	$0.071
		26-30	$0.112
		31-35	$0.203
		36-40	$0.346
		41-45	$0.610
		46-50	$1.068
		51-55	$1.953
		56-60	$3.408
		61-64	$5.259

Costs per Month			
Optional Critical Illness	Employee and **spouse** (per $1,000 of coverage)	**Female Non-Smoker**	
		Under 20	$0.051
		20-25	$0.061
		26-30	$0.092
		31-35	$0.132
		36-40	$0.203
		41-45	$0.315
		46-50	$0.437
		51-55	$0.641
		56-60	$0.977
		61-64	$1.424
		Female Smoker	
		Under 20	$0.061
		20-25	$0.071
		26-30	$0.112
		31-35	$0.193
		36-40	$0.305
		41-45	$0.509
		46-50	$0.783
		51-55	$1.221
		56-60	$2.004
		61-64	$3.031

Note: Some employee groups have different levels of cost sharing. For more information on the rates you pay, visit Johnson Inc.'s member website at **johnson-insurance.com/Members-Only/**.

EXAMPLE

Here's an example of how to calculate your costs. If you choose $100,000 (100 units of $1,000) of Optional AD&D insurance, your monthly cost will be calculated as follows:

Coverage	Cost
Single	100 x $0.0204 = **$2.04 per month**
Family	100 x $0.0376 = **$3.76 per month**

How Rates Are Determined

The insurer determines the rates for travel, disability, life, AD&D and optional critical illness insurance.

The rates for health and dental coverage, however, are based on a number of factors, including:

- the increasing cost of drugs,
- the introduction of new, expensive drugs,
- new medical technology, and
- changes in legislation that make private plans the first payers over the provincial health plan.

But there's another factor that has a significant impact on plan costs: your claims.

The more the plan is used, the more the plan will cost the following year. In fact, your plan essentially works like a bank account:

1. Your premiums are deposited into the plan's fund or account.
2. Whenever a claim is paid, the amount is withdrawn from the account.
3. As a result, the PSGIP Trustees must ensure there is enough money in the account to cover all the claims, as well as the expenses to administer the plan.

CONSUMER TIPS

Things You Can Do to Help Keep Plan Costs Down

Each plan member has a role to play in helping control expenses. After all, it's your plan and your money.

Keeping costs down is easier than you might think. Here are some useful consumer tips that contribute to the well-being of the plan and your wallet.

- When your doctor prescribes a medication, ask about less expensive therapeutic options.
- Compare prices. Not all pharmacies charge the same amount for prescription drugs. Shop around.
- Take your medication as directed. Ask your doctor or **pharmacist** the following questions:
  - Are there any side effects? If so, what do I do?
  - Will this drug have any effects on other drugs (prescription or over-the-counter drugs) that I am also taking?
  - Are there certain types of foods or drinks that I must avoid while taking this drug?
  - Are there alternatives to this drug or other solutions for my condition?
- Talk to your pharmacist, who can offer you free professional advice.
- Determine the right quantity of prescription drugs.
  - Consider a sample or trial prescription when you are trying a drug for the first time. That way, you will save money if you have to discontinue a drug because of an allergic reaction.
  - Ask for a larger supply if you are taking medication on an ongoing basis. As a result, you will save on the pharmacist's dispensing fees.
- Stay active and eat right. A healthy diet can also positively affect your overall health. Whatever form of exercise you enjoy, it will help you reduce the risk of heart disease and other serious health problems.
- In addition to exercise, you can get involved in hobbies, do volunteer work, take classes, and more.
- Staying active and involved in your community is also good for your mental health and overall well-being.

About the Plan

OVERVIEW

The Public Sector Group Insurance Plan (PSGIP) is designed to provide group insurance benefits to plan beneficiaries as determined by the parties (employers and unions).

It helps protect you for the times in your life when you need assistance covering health and dental expenses and provides financial protection in times of illness, injury or unexpected events.

The plan is guided by in the following principles:

- **Quality** – provides sound financial protection in times of need.
- **Comprehensive** – provides a wide range of benefits for both you and your family in times of illness, injury or unexpected events.
- **Convenient** – offers a practical drug card with many advantages – no need to pay the total cost of a drug up-front, no claim form to complete, and more.
- **Promotes responsibility** – it's your plan... and your money. As a result, you have a direct impact on both cost savings and increases.

PSGIP TRUSTEES

The plan is managed by the PSGIP Trustees, a group of member appointees consisting of:

- Chair – Bobby Kennedy (CUPE)
- Vice Chair – Pamela MacEachern (Employer)
- CUPE: Bobby Kennedy
- IUOE: Holly Brasky
- PEINU: Jennifer Doyle
- UPSE (Civil Service): Trevor MacKinnon
- UPSE (Health): Carolyn Knox
- Employer: Pamela MacEachern
- Employer: Erin Gauthier
- Employer: Lara MacMurdo
- Employer: Vacant
- Employer: Vacant

Trustees' Mission

To achieve the plan's objectives, the Trustees are committed to the following qualities:

Proactiveness

> Identify and analyse group insurance trends and best practices

> Make recommendations to optimize the plan's cost-effectiveness and long-term sustainability

Transparency

> Inform parties of all decisions

> Educate beneficiaries on the plan and their role

Integrity

> Adhere to the Trust document at all times

> Respect all legal documents and requirements

The PSGIP Trustees work diligently to ensure that the plan runs smoothly. They act solely in the best interests of the plan and its beneficiaries, in accordance with their mission statement and the Trust Document.

Activities of the PSGIP Trustees include:

- establishing and administering the fund,
- entering into all necessary contracts,
- establishing and administering reserve funds,
- appointing and monitoring the performance of the administrator, consultants, insurance carriers, etc.,
- investing funds and paying expenses,
- communicating regularly and openly with plan members and parties,
- reviewing requests from parties for additional or expanded services,
- making plan changes, where permitted, and
- adjusting rates as a result of plan experience.

The Trustees cannot make plan changes that result in material rate increases or add new benefits to the plan on a cost-shared basis. In addition, the Trustees require unanimous approval or direction from the parties to increase or enhance benefits.

THE FINE PRINT

This member booklet summarizes the benefits and some provisions of your group insurance plan. It does not include all details, provisions, exclusions and limitations. This booklet supersedes and replaces all previous communication material. It does not constitute the group insurance policies and is not a contract of insurance, nor does it create or confer any contractual or other rights. Benefits may be changed at any time. Every effort has been made to ensure that the information is accurate. However, if there is any question as to interpretation, all rights with respect to an insured person will be governed solely by the official group insurance policies.

You may obtain a copy of the official group insurance policies by writing to:

Public Sector Group Insurance Plan Trustees
c/o HR Atlantic
20 Great George Street, Unit 201
Charlottetown, PE C1A 4J6

References to external sites are provided for information purposes only. PSGIP, its insurers and any party involved in creating this PSGIP benefits booklet, are not responsible for the content of external sites, nor do they endorse any of the sites in any way. Also, external sites do not reflect your PSGIP coverage, nor are they part of your group insurance policies.

Eligibility

OVERVIEW

To participate in the PSGIP, you must reside in Canada and be an eligible **Civil Service** or **Health PEI** employee as described below.

Civil Service Employees	Health PEI Employees
Class 1 • Permanent full-time employees • Permanent part-time employees (including provisional and probationary employees) with a guarantee of at least 40% of the normal working hours for at least 6 months • Contract employees for whom benefit eligibility is specified in the employment contract	You are part of Health PEI if you belong to any of the following groups: • Prince Edward Island Nurses Union (PEINU) • International Union of Operating Engineers (IUOE) • Canadian Union of Public Employees (CUPE) • Prince Edward Island Union of Public Sector Employees (UPSE) • Excluded employees/physicians • Non-union, non-excluded employees You may join the PSGIP if you are: • a permanent full-time employee working at least 30 hours per week, • a permanent part-time employee who has completed the probationary period and is working less than the fully prescribed hours of work on a recurring and regularly scheduled basis, • a temporary UPSE, IUOE, PEINU or excluded employee hired for 12 months or more. **Note:** If you are a casual UPSE employee and you had coverage before August 1, 1995, you may continue your coverage in effect on August 1, 1995. However, you are not eligible for any additional benefits.
Class 2 • Permanent part-time employees (including provisional and probationary employees) with a guarantee of less than 40% of the normal working hours	
Class 4 • **Temporary employees** after 6 months of continuous employment	

Your **spouse** and **children** are also eligible for coverage provided they meet the official definitions of spouse and children.

Restriction for Family Members for Optional AD&D

No eligible individual may be covered more than once under the optional AD&D insurance policy. In other words, if you are covered as an employee or retiree, you cannot be covered as a **spouse** or dependent **child** of another employee or retiree who is also covered under the plan. In addition, only one spouse can choose coverage for dependent **children**. Your spouse and eligible children can only be insured if you are covered under the plan.

WHEN COVERAGE BEGINS

All coverage for you and your **dependents** will normally begin as soon as you are eligible, provided you enrol within 31 days (90 days for health, dental and Basic Dependent Life coverage) following the applicable eligibility date listed below.

If you are a late applicant (i.e. you don't enrol within 31 days (90 days for health, dental and Basic Dependent Life coverage) following your eligibility date), your coverage will come into effect on the first of the month after Johnson Inc. receives your application, or when the insurer approves your **proof of good health** (if required).

If you are not actively at work when your coverage is to begin, your coverage will only start when you return to active work with regular **earnings**.

Eligibility date	Health, Travel and Dental	Long-Term Disability	Basic Life and AD&D	Optional Life, AD&D* and Optional Critical Illness**
Civil Service – Class 1	First day of employment	First day of employment	First day of employment	First day of employment
Civil Service – Class 2	First day of employment	Not eligible	Not eligible	After 6 months of continuous employment
Civil Service – Class 4 (temporary)				
• working at least 40% of the normal weekly working hours	After 6 months of continuous employment	After 12 months of continuous employment	After 12 months of continuous employment	After 12 months of continuous employment
• working less than 40% of the normal weekly working hours	After 6 months of continuous employment	Not eligible	Not eligible	After 6 months of continuous employment

Eligibility date				
	Health, Travel and Dental	**Long-Term Disability**	**Basic Life and AD&D**	**Optional Life, AD&D* and Optional Critical Illness****
Health PEI	First day of the month following 1 month of continuous employment	First day of the month following 1 month of continuous employment	First day of the month following 1 month of continuous employment	First day of the month following 1 month of continuous employment

* For optional life insurance, if you apply for coverage within 31 days following your eligibility date, a portion of the coverage (up to $30,000 for yourself and your **spouse** and $10,000 for each **child**) will come into effect on the date Johnson Inc. receives your application. The difference, if any, will take effect once the insurer approves your **proof of good health**.

If you apply for any optional AD&D insurance, coverage will come into effect on the first of the month after Johnson Inc. receives your application.

** For optional critical illness insurance, if you apply for coverage within 31 days following your eligibility date, a portion of the coverage (up to $50,000 for yourself and spouse) will come into effect on the date Johnson Inc. receives your application. The difference, if any, will take effect once the insurer approves your proof of good health.

WHEN COVERAGE ENDS

Coverage ends for you and your **dependents** as follows:

Health, travel and dental	When you leave your employment* or retire*, whichever is earliest. If you had coverage as an active employee, you are eligible to join the Retiree plan at retirement.
Long-term disability	Age 62 less the qualifying period*, or when you leave your employment* or retire*, whichever is earliest.
Basic life for you	When you leave your employment* or retire*, whichever occurs first. When your coverage ends, you have 31 days to convert your coverage to an individual policy if you wish to do so.

Basic life for your dependents and Basic AD&D insurance	For **Civil Service**, when you leave your employment or retire, whichever occurs first. When your coverage ends, you have 31 days to convert your coverage to an individual policy if you wish to do so. Basic life for your dependents for Health PEI, age 65*, or when you leave your employment* or retire*, whichever occurs first. Basic AD&D for Health PEI, age 80*, or when you leave your employment* or retire*, whichever occurs first. When your Life and AD&D coverage ends, you have 31 days to convert that coverage to an individual policy if you wish to do so. Life insurance conversion applies to all or part of the life insurance where the person under this policy terminates on or before their 65th birthday. For Health PEI, age 65*, or when you leave your employment* or retire*, whichever occurs first. When your Basic AD&D coverage ends, you have 31 days to convert that coverage to an individual policy if you wish to do so.
Optional life and AD&D insurance	Age 65*, or when you leave your employment* or retire*, whichever occurs first. When your Optional Life coverage ends, you have 31 days to convert your coverage to an individual policy if you wish to do so.
Optional critical illness insurance	Age 65*, or when you leave your employment* or retire*, whichever occurs first.

* For **Health PEI employees**, the last day of the month following the date on which you are no longer an insurable employee.

Coverage can also end for the following reasons:

When your coverage ends	The earliest of: • the date* you no longer satisfy the definition of an eligible employee, • the date* you request termination of coverage (not applicable to basic life and AD&D and long-term disability coverage), • the date* your employer terminates your coverage, • the date this plan terminates or coverage for the group, division or class to which you belong is terminated, • the date you become a full-time member of the armed forces (not applicable to AD&D coverage), • the date you no longer pay the premium for your coverage, where applicable, • for contract employees only, the date your contract terminates, • your death (except for health, dental and travel for your **dependents**).
When your dependents' coverage ends	The earliest of: • the date your coverage ends, • the date this plan terminates, • the date you ask to end dependent coverage, • the date the dependent no longer satisfies the definition of dependent, • dependent coverage is terminated under the policies, • the date you no longer pay the premium for your dependent coverage.

* For **Health PEI employees**, the last day of the month following the date on which you are no longer an insurable employee.

Enrolling

ENROLLING FOR BENEFITS

When you are eligible to join the plan, you will be automatically enrolled in the mandatory benefits, but you will need to make a few selections and decide if you want to enrol for any optional benefits.

Automatically enrolled for:	**Enrolment deadlines**
✓ Basic life and AD&D insurance (if applicable) ✓ Long-term disability (if applicable)	Automatically enrolled as of your eligibility date
Enrolment decisions to make:	
✓ Health and dental coverage (for you and your family) ✓ Travel coverage (for you and your family) ✓ Dependent life insurance (for your family) ✓ Optional life insurance (for you, your **spouse** and your **children**) ✓ Optional AD&D insurance (for you and your family) ✓ Optional critical illness insurance (for you and your **spouse**)	Within 31 days (90 days for health, dental and Basic Dependent Life coverage) following your eligibility date

Important Enrolment Deadline

You must enrol within 31 days (90 days for health, dental and Basic Dependent Life coverage) of becoming eligible for benefits. Otherwise you will need to provide **proof of good health** to apply for some coverage and dental benefits will be limited. See the section **What Happens if I Don't Enrol in Time?** for more information.

How to Join the Plan

To join the plan, follow these simple steps:

Step 1: Johnson Inc. will enrol you for mandatory coverage and provide you with an Enrolment form for optional benefits and a Beneficiary Designation form.

Step 2: Complete and sign the form.

Step 3: Gather any supporting documents that may be required.

- If you are required to provide **proof of good health**, download the medical questionnaire, or request a copy from Johnson Inc. Depending on your responses, you may be required to undergo a medical examination.
- Proof of good health is required:

Optional life insurance	• For you and your **spouse**: – For amounts over $30,000 if you enrol within 31 days after your eligibility date, and – For all amounts if you enrol over 31 days after your eligibility date
Health	• For you and your family: – If you enrol over 90 days after your eligibility date, and – If you enrol over 31 days after a **life event**.

- If your **child** is disabled, you must provide satisfactory proof that they are incapable of self-support because of the disability.
- If your child is an overage student, you must provide confirmation of your child's continuing attendance at an accredited college or university for each year coverage is to be continued.
- Designate your beneficiaries on a Beneficiary Designation form

Step 4: Return the Enrolment form, Beneficiary Designation form and any supporting documents to Johnson Inc.

What Happens if I Don't Enrol in Time?

If you enrol after the 31-day deadline (after 90 days for health, dental and Basic Dependent Life coverage), two things will happen:

1. You will be required to submit **proof of good health** for all persons you wish to enrol, including yourself, for optional life and health coverage. This may not apply if you are adding a new **dependent** to your existing health, travel or dental coverage (e.g., you have a **child** or get married). Contact Johnson Inc. for details on adding dependents to your coverage.

   When proof of good health is required, coverage will only begin on the date the insurer approves the proof of good health, provided you are actively at work on that day.

2. Dental benefits will be limited to $100 during the first 12 months of coverage if you are a late applicant. After 12 months, the normal reimbursements applicable under the plan will apply. This provision does not apply if you damage your teeth in an accident.

What Happens if I Don't Enrol?

If you don't enrol, you will be covered for mandatory benefits only – basic life and AD&D insurance and long-term disability (if applicable). You can later enrol for other benefits, but you will be considered a late applicant. See the section **What Happens if I Don't Enrol in Time?** for more information.

ENROLLING FOR HOME AND AUTO INSURANCE

Johnson Inc. is the preferred home and auto insurance provider for PSGIP members.

PSGIP members can access exclusive offers and group rates for home and auto insurance provided through Johnson Inc. In addition to extensive coverage, premiums are payable through convenient payroll deductions.

For information on coverage, rates and enrolment, call 1 888 737-1689 or visit **johnson.ca**.

Health

OVERVIEW

Illness or injury can strike when you least expect it. When it does, you should be able to focus on getting better, not on how to pay your bills. That's why the plan offers you and your family health care coverage. It is designed to complement the provincial plan and help pay major health expenses.

For a summary of your health coverage, refer to the **Benefits At-a-Glance** section. There you will find information on reimbursement levels and applicable maximums.

Eligible expenses must be **reasonable and customary**, **medically necessary** and incurred while the individual was covered under the plan.

Payment will be based on reasonable and customary charges in the area in which the treatment is given as determined by the insurer adjudicating benefits. Limits may apply to specific services and supplies.

For a list of health plan exclusions, see the **Exclusions** section.

Item	Coverage
Prescription drugs (mandatory generic substitution)	80% reimbursement of the first $150 per eligible drug expense, and 100% thereafter
Hospital accommodations	100% reimbursement of the difference between a ward and semi-private room 80% between semi-private and private
Paramedical practitioners	80% reimbursement to specified annual maximums
Vision care	80% reimbursement to specified annual maximums
Medical services	80% reimbursement to specified annual maximums
Medical equipment and supplies	80% reimbursement to specified annual maximums

PRESCRIPTION DRUGS

Coverage is based on the lowest-cost generic equivalent of the prescribed brand name drug, unless your doctor provides medical evidence that the prescribed drug cannot be substituted.

Eligible drugs must be approved by the Canadian government for sale to the general public and have a Drug Identification Number (DIN). However, the plan may cover the **usual cost** of certain life-supporting, non-prescription drugs approved by Canada Life.

Prescription drugs can be prescribed by any of the following medical practitioners:

- **Physicians**
- **Dentists**
- **Nurse practitioners**
- **Pharmacists** (where allowed by law)

Coverage

- 80% of the first $150 per eligible drug expense, and 100% thereafter
- $500 lifetime maximum for preventative vaccines and toxoids
- 50% reimbursement of the usual cost of nicotine replacement products, subject to a lifetime maximum of $300 per person
- $250 maximum per calendar year for sexual dysfunction medications
- 100-day supply for therapeutic or maintenance drugs

Certain general exclusions also apply.

Remember to use your pay-direct drug card when filling a prescription to get your claim processed on the spot. You then only need to pay out-of-pocket what's not covered by the plan.

How Your Reimbursement Works

The plan will cover the **usual cost** of the lowest-cost generic drugs requiring a prescription. You will not pay more than $30 per eligible drug appearing on your prescription if you select the lowest-cost generic drug or a brand name drug without a generic equivalent.

You can select a brand name drug that has a generic equivalent, but you may pay more if there is no medical reason for choosing the brand name drug over the generic substitution.

EXAMPLES

These examples show how prescription drug costs are reimbursed.

	Example 1	Example 2
	$50 Prescription Cost (lowest-cost generic)	**$200 Prescription Cost (lowest-cost generic)**
The plan pays	80% of $50 = $40	80% of $150 = $120 100% of $50 = $50 $120 + $50 = $170
You pay	20% of $50 = $10	20% of $150 = $30

What is a Generic Drug?

Generic drugs are like brand name drugs in dose, strength, and how they are taken. They have the same active ingredients and are equally safe and effective. The only difference in composition is their inactive ingredients – the binders, fillers, and dyes used to give the drugs their shape and colour. These differences have no effect on the drugs' active ingredients or how it works.

Generic drugs are less expensive than brand name drugs because the generic drug manufacturers do not have to recoup research and development costs incurred by brand name manufacturers after the patent protection expires. As result, these savings can be passed on to consumers and group benefit plans.

By law these generic drugs are considered interchangeable with brand name drugs and **pharmacists** are allowed to substitute for the generic option when you have a prescription filled. Generic drugs are regulated by Health Canada and undergo constant testing to ensure they meet strict requirements.

What if the Lowest-Cost Generic Equivalent Doesn't Work for Me?

If there is a medical reason why you cannot take the generic equivalent of the brand name drug, you can still request that the brand name drug be covered by the plan. You and your doctor must complete Canada Life's *Request for Brand Name Drug Coverage* form (available on **canadalife.com** or by contacting Johnson Inc. at (902) 628-3537).

Send the completed form to Canada Life at the address indicated on the form. Canada Life will assess your request and send you a letter letting you know if the request for brand name drug coverage is approved.

Pay-Direct Drug Card

For your convenience, the plan provides you with a pay-direct drug card, which you can use to pay for prescription drugs, diabetic supplies, and certain over-the-counter, life-supporting drugs that have been prescribed for you and approved for reimbursement by Canada Life.

Claims are processed immediately, so you only have to pay your co-pay amount. That means you have no claims to submit and you won't be waiting for reimbursement.

What the Plan Does Not Cover

- Alcohol
- Bandages
- Blood glucose monitors, dextrometers
- Contraceptives other than contraceptive drugs and products containing a contraceptive drug
- Cosmetic items
- Cotton
- Disinfectants
- Fertility drugs
- Food substitutes, infant food or formula
- Hair growth stimulants
- Homeopathic medicines
- Non-disposable insulin injectors
- Products that can be bought without a prescription, unless the policyholder approves them
- Spring-loaded devices used to hold lancets
- Sunscreens
- Vitamins (except injectible), minerals, dietary supplements

HOSPITAL ACCOMMODATIONS

The plan covers the **usual cost** of **hospital** accommodation in Canada:

- 100% of the difference in cost between a ward and a semi-private room, and
- 80% of the difference in cost between a semi-private and private room.

If you are medically required to be admitted into a private room, the provincial plan will cover the cost at 100%.

The plan also pays 100%, up to $1,000 per hospital admission, of the usual cost of **medically necessary** ancillary hospital services if you are admitted as an inpatient to a general hospital in another province and a government health plan does not fully cover the cost. Ancillary hospital services include items such as drugs or recovery room expenses that were not picked up by the provincial plan.

If you are an out-patient, the plan pays the usual cost of out-patient services and supplies from a hospital or a surgical supply company.

PARAMEDICAL PRACTITIONERS

The plan covers the **usual cost** of paramedical services, provided your paramedical practitioner is registered in the province where the service is given. The practitioner cannot be a member of your **immediate family** or someone who lives with you.

The following list of practitioners are covered under the plan, up to the limits specified in the **Benefits At-a-Glance** section:

- Acupuncturists
- Chiropodists or podiatrists*
- Chiropractors*
- Clinical psychologists and registered counseling therapists
- Massage therapists (your massage therapist must be registered with the Massage Therapy Association)
- Naturopaths
- Osteopaths*
- Registered physiotherapists
- Social workers (provided you have a written referral from the Prince Edward Island Government Employee Assistance Program)
- Speech therapists

* Laboratory tests and X-rays are covered if they are recommended by a licensed chiropractor, osteopath or podiatrist.

VISION CARE

The plan covers the **usual cost** of eligible vision care as follows (general exclusions apply):

Eligible Expenses	Special Notes
Eye exams (including eye refractions)	• 80% reimbursement • For persons over age 18: once every 2 calendar years • For **children** age 18 and under: once every calendar year A registered, licensed optometrist or ophthalmologist must perform the eye exam.
Eye glasses or contact lenses	• 80% reimbursement, to a maximum of $160 every 2 calendar years (every calendar year for children age 18 and under) • Includes coverage for prescription sunglasses and safety glasses An ophthalmologist or optometrist must prescribe the contact lenses or eye glasses to correct vision.
Contact lenses for certain conditions	• If you suffer from ulcerated keratitis, severe corneal scarring, keratoconus (conical cornea) or aphakia: reimbursed up to $160 in any period of 2 calendar years A licensed ophthalmologist must prescribe the contact lenses. The plan will pay for these contact lenses only if your sight can be improved to at least the 20/40 level by contact lenses, but it cannot be improved to that level with eye glasses.

MEDICAL SERVICES

The plan covers the **usual cost** of eligible medical services as follows (general exclusions apply):

Eligible Expenses	Special Notes
Accidental dental treatment	The plan covers the usual cost of repairing or replacing any healthy, natural teeth that have been damaged or lost due to a sudden impact. To be reimbursed, you must complete treatment within 12 months of the impact, unless treatment has to be postponed because of your age. Reimbursement will be based on the least expensive treatment that is adequate to correct the damage and on the current dental fee guide. No implants, treatments related to implants, or treatments to correct existing problems are covered by this part of the plan.
Ambulance services	If you are in an accident or become critically ill, the plan will cover the usual cost of a licensed ambulance or other emergency service to transport you to the nearest **hospital** that is able to give the necessary emergency treatment. This also covers travel between hospitals. Reimbursed at 100% of the first $50 of eligible expenses per calendar year, and 80% thereafter. Can be reimbursed up to $240 in any calendar year for the travel expenses of an accompanying registered nurse, when **medically necessary** and approved by the plan. The nurse cannot be a relative. If a licensed ambulance does not provide transportation for someone to accompany you, the plan may cover the cost of a person to accompany you, if it is medically necessary.

Eligible Expenses	Special Notes
Private-duty nursing	The plan will cover the **usual cost** of private nursing care at your home or in the **hospital**, up to $8,000 per covered person each calendar year, provided all of the following conditions are met: • your doctor has determined, in writing, that it is **medically necessary**, • Canada Life has approved the service beforehand, • nursing care is provided within Canada by a registered nurse, registered nursing assistant, or registered practical nurse, • the person providing nursing care does not normally live with you or is not a member of your **immediate family**, • if nursing care is provided in a hospital, the person is not an employee of the hospital, • the nursing care professional provides skilled care that only they can provide, and • the nursing care is not provided in a nursing home, rest home, home for the aged, or any facility that provides similar care.

MEDICAL EQUIPMENT AND SUPPLIES

The plan covers the **usual cost** of eligible medical equipment and supplies as follows (general exclusions apply):

Eligible Expenses	Special Notes
Apnea monitor	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.

Eligible Expenses	Special Notes
Artificial limbs/eyes and other prosthetic devices	Covered if non-myoelectric and approved by Canada Life **Important notes:** • Talk to Canada Life before making your purchase, as the cost varies greatly. Canada Life will let you know how much the plan will pay based on the least expensive device that is medically adequate. • Replacements are covered if they are due to a pathological change. • The plan pays for repairs and/or adjustments up to $40 in any calendar year, including the cost of repairs and/or adjustments to walkers and braces.
Asthma nebulizer	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.
Breast prosthesis after mastectomy	Including replacement(s) every 2 calendar years
Breathing appliances	Reimbursed up to $240 every 5 calendar years Examples of breathing appliances: respirators, compressors, and inhalers (including Maxi-Mist, Medi-Mist, Shucho Mist, and Pulmo Aids)
Casts	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.
Certain diagnostic tests, radium treatments, and X-rays	–

Eligible Expenses	Special Notes
Compressors	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.
Crutches and canes	–
Custom-made foot orthotics	Expenses are reimbursed up to $240 per calendar year (including custom-made orthopedic shoes and any modifications) • Must be prescribed by a **physician**, podiatrist or chiropodist as being necessary after a biomechanical examination, and • Must be required for regular daily living activities, and not just for sports or recreation.
Custom-made orthopedic shoes, including modifications	Expenses are reimbursed up to $240 per calendar year (including custom-made foot orthotics) • Must be prescribed by a physician, podiatrist or chiropodist, and • No other method, such as orthotics and/or off-the-shelf orthopedic shoes, can correct the problem.
Diabetic supplies	You can use your drug card to cover these expenses Examples of diabetic supplies: disposable needles, syringes, lancets and testing materials for monitoring diabetes
Hearing aids and repairs	Reimbursed up to $900 per ear every 5 calendar years Batteries are not covered.

Eligible Expenses	Special Notes
Hospital beds	Reimbursement based on: • the cost of rental or purchase, whichever is more economical, • Canada Life's approval before the purchase is made, and • the least expensive device that is medically adequate. Spare parts or alternative supplies are not covered.
Insulin pumps	Covered once every 5 years, to a maximum reimbursement of $5,200
Ostomy supplies	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.
Oxygen	–
Oxygen equipment	Covered if approved by Canada Life To determine the eligible reimbursement amount, submit a pre-approval to Canada Life.
Stump socks	–
Surgical bras	–
Surgical stockings	Up to 2 pairs each calendar year
Temporary therapeutic equipment	Reimbursement based on: • the cost of rental or purchase, whichever is more economical, • Canada Life's approval before the purchase is made, and • the least expensive device that is medically adequate. Spare parts or alternative supplies are not covered.

Eligible Expenses	Special Notes
Walkers and braces	Covered if approved by Canada Life **Important notes:** • Talk to Canada Life before making your purchase, as the cost varies greatly. Canada Life will let you know how much the plan will pay based on the least expensive device that is medically adequate. • Replacements are covered if they are due to a pathological change. • The plan pays for repairs and/or adjustments up to $40 in any calendar year, including the cost of repairs and/or adjustments to standard non-myoelectric artificial limbs/eyes and other approved prosthetic devices.
Wheelchairs (standard manual or electric)	Reimbursement based on: • the cost of rental or purchase, whichever is more economical, • Canada Life's approval before the purchase is made, and • the least expensive device that is medically adequate. Spare parts or alternative supplies are not covered.
Wigs	Covered following chemotherapy or radiation treatment, to a $250 lifetime maximum

What the Plan Does Not Cover

The plan does not cover the following items or any other item not listed as an eligible expense, even when prescribed by a **physician**:

- Air conditioners or purifiers
- Blood pressure kits
- Breast pumps
- Cataract contact lenses
- Craftmatic, Ultramatic, or other lifestyle beds
- Exercise equipment, machines, or programs
- Grab bars
- Holter monitor
- Home or car modifications (e.g., ramps or lifts)
- Hoyer lift
- Humidifiers
- Mattresses, except for standard mattresses with approved **hospital** beds
- Obus formes or orthopaedic pillows
- Raised toilet seats
- TENS units
- Transfer bench
- Trapeze

EXCLUSIONS

The following list of exclusions applies to the health and travel plans:

- Any service for which reimbursement is prevented by law,
- Cosmetic treatments,
- Health care services or supplies required as a result of any of the following:
  - committing a criminal offense or provoking an assault,
  - intentionally self-inflicted injury,
  - participation in a riot or civil disturbance, or
  - war, rebellion, or hostilities of any kind, whether you are a participant or not,
- Health care services or supplies required solely for recreation or sports purposes,
- Health care services or supplies that you are eligible to claim under any workers' compensation legislation in your province of residence,
- "In vitro" or "in vivo" procedures, or any other infertility procedures, unless otherwise specifically covered in this plan,
- Services or supplies for which you would normally not be charged,
- Services required by a court, your employer, a school, or anyone other than your **physician** (for example, if your employer requires a doctor's note or a court requires that you receive psychological treatment), or
- Treatment to correct temporomandibular joint dysfunction (joint of the jaw).

Travel

OVERVIEW

If you suddenly and unexpectedly become ill or injured while outside your province of residence and you require immediate medical treatment, the plan will cover all eligible expenses, up to specified limits. You must be eligible for benefits under a government health plan in Canada to qualify for emergency out-of-province/country coverage or travel assistance coverage.

For a summary of your travel coverage, refer to the **Benefits At-a-Glance** section. There you will find information on reimbursement levels and applicable maximums.

Eligible expenses must be **reasonable and customary**, **medically necessary** and incurred while the individual was covered under the plan.

Payment will be based on reasonable and customary charges in the area in which the treatment is given as determined by the insurer adjudicating benefits. Limits may apply to specific services and supplies.

For a list of travel plan exclusions, see the **Exclusions** section.

Item	Coverage
Out-of-country emergency coverage	100% reimbursement, to a maximum of $1 million per emergency above what your provincial health plan pays **Note:** Certain expenses, such as prescription drugs, are covered to the same extent as they would be in Canada.
Out-of-province referrals	100% reimbursement for the difference between: • the actual cost, and • the amount available under the provincial plan, provided the provincial plan is first payer.

WHAT'S COVERED

Eligible Expenses	Special Notes
Hospitalization	Hospital room at the ward rate Hospital services and supplies also covered
Living expenses for a companion travelling with the patient, to stay with the patient beyond the original return date	Reimbursed up to $150 a day, for a total reimbursement of $1,500 Includes cost of accommodation, meals, telephone and taxi or rental cars The travel assistance provider must approve the charges beforehand.
Medical evacuation home or transportation to another medical facility	Economy airfare for transportation home
Physician services	–
Referrals to physicians or medical facilities, if necessary	The travel assistance provider is not responsible for the actions or advice of any persons that you are referred to.
Return home airfare (economy class) for a travel companion	For a companion who is travelling with the patient and who has forfeited their ticket because of a delay caused by the insured person's illness, injury, or death The travel assistance provider must approve the charges beforehand.
Return home airfare (economy class) for each child	For each child left alone because of the insured person's illness, injury, or death The travel assistance provider will also arrange for a qualified attendant to accompany the children, if necessary. The travel assistance provider must approve the charges beforehand.
Return of deceased	Reimbursed up to $3,500

Eligible Expenses	Special Notes
Return of vehicle (to insured person's home or the nearest rental agency)	Reimbursed up to $1,000 The travel assistance provider must approve the charges beforehand.
Round-trip economy airfare for a visiting family member	Provided the insured person is travelling alone and must be hospitalized for more than 10 days The travel assistance provider must approve the charges beforehand.
Wheelchairs, prescription drugs, crutches, and other eligible expenses under the plan's health coverage	Covered to the same extent as they would be in Canada
Non-medical services	• Multilingual assistance by telephone, 24 hours a day, 365 days a year, to obtain aid, assistance, and exchange information relating to the covered services, • Arrangements for direct payment, wherever possible, for **physician**s' services, hospitalization and other insured services, • Communication with the physician who is treating the insured person to get an understanding of the situation and monitor the condition, • Telephone interpretation services in most major languages, • The sending and receiving of urgent messages, • Help to locate Embassy or Consulate services, and • Help to locate lost documents or luggage.
Out-of-province referrals	The plan covers the **usual cost** of treatment, in relation to referrals for treatment in Canada and the United States only. If treatment is available in your home province, the plan will not cover the referral expenses. A physician in your home province must give a written referral for treatment that is not performed in that province. Canada Life must approve the referral beforehand.

What the Plan Does Not Cover

Your travel coverage does not pay for any expenses incurred directly or indirectly as a result of:

- your pregnancy, if expenses are incurred outside Canada within nine weeks of your expected delivery date,
- the birth of a **child** born outside of Canada within nine weeks of the expected delivery date, or after the expected delivery date,
- an accident that occurred while you were operating a vehicle, vessel, or aircraft, if you:
  - were impaired by drugs or alcohol, or
  - had a blood-alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood,
- abuse of illegal substances.

The plan also does not provide coverage as described in this section:

- for emergency treatment while travelling for health reasons,
- once emergency treatment for a condition is completed, for any ongoing treatment related to that condition, and
- for medical emergencies in your home province.

General exclusions also apply. See the **Exclusions** section for more information.

TRAVEL ADVICE

Things to Keep in Mind Before You Travel

Out-of-country emergency coverage provides protection for certain medical expenses incurred by you and your eligible **dependents** as a result of a medical emergency that occurs while traveling outside Canada, typically when travelling for business, vacation or education purposes.

A medical emergency is:

- a sudden and unexpected injury,
- the onset of a condition not previously known or identified prior to departure from Canada, or
- an unexpected episode of a condition known or identified prior to departure from Canada.

An unexpected episode means it would not have been reasonable to expect the episode to occur while travelling outside Canada. If a person was suffering from symptoms before departure from Canada, Canada Life may request medical documentation to determine whether, in the circumstances, it could have reasonably been anticipated that the person may require medical treatment while outside Canada.

For pregnant travellers, this means that any pregnancy-related expenses incurred outside Canada may not be covered if, for example, they are incurred:

- on or after day one of the person's 35th week of pregnancy, or
- at any time prior to the 35th week of pregnancy and the person's Canadian **physician** considers the pregnancy to be high risk.

Planning a Vacation?

If you're planning a get-a-way, be sure to check if the country you're visiting requires proof of travel health insurance. If proof is required, contact Johnson Inc. at 1 800 371-9516 to have confirmation of your emergency travel insurance sent to you by mail, email or fax. In some countries, such as Cuba, proof of coverage can be shown in the form of a proof of coverage letter and/or your provincial health card.

If you do not have the appropriate proof of coverage when you enter a country, you may be required to purchase additional coverage on the spot.

When travelling, it is recommended to have the following information with you:

- wallet ID card,
- provincial health card,
- a valid passport, and
- coverage confirmation letter (provided by Johnson Inc.).

What to Do in the Event of an Emergency

In the event of an emergency where you become ill or are injured outside your home province or Canada, call the travel assistance provider **as soon as possible**. You can find the contact number on your travel assistance card, which you should always keep on you while you are traveling.

If you or your representative does not call the travel assistance provider right away, your benefits may be reduced by 40% of covered expenses, with a maximum reimbursement of $25,000.

Calling immediately will enable the travel assistance provider to co-ordinate payment directly with the **hospital** and/or medical provider involved, only if the travel assistance provider obtains your approval to co-ordinate payment with the provincial health plan.

Following Doctors' Orders

If your **physician** or the Travel Assistance Centre recommends that you return to your home province and you choose not to go, your emergency coverage and travel assistance coverage will end.

If your physician or the Travel Assistance Centre recommends that you be moved to another facility and you choose not to go, your benefits will be reduced by 40% of covered expenses, with a maximum reimbursement of $25,000.

EXCLUSIONS

The same list of exclusions as describe under the health plan, also apply to the travel benefit. See the health **Exclusions** section for details.

Dental

OVERVIEW

The dental plan offers you and your family the choice between two plan options:

Plan A	Plan B
• Preventative services • Maintenance services	• Preventative services • Maintenance services • Major restorative services • Orthodontics (braces)

For a summary of your dental coverage, refer to the **Benefits At-a-Glance** section. There you will find information on reimbursement levels and applicable maximums.

Eligible dental expenses are those that a **dentist**, doctor, or denturist (provided the work is within the scope of the denturist's license and they are registered with the Council of the Denturist Society of PEI) considers necessary.

Expenses are based on the Dental Association Suggested Schedule of Fees for General Practitioners or the Dental Specialist Fee Guide, if applicable, for the current year.

It is entirely up to you and your dentist to decide which treatment method to use – alternative or otherwise. However, reimbursement will be based on the least expensive treatment method that will provide a professionally adequate result.

We encourage you to get approval for unusual or large dental expenses beforehand to make sure the plan covers them.

For a list of dental plan exclusions, see the **Exclusions** section.

Plan A	Plan B
• 80% reimbursement for preventative and maintenance services	• 80% reimbursement for preventative and maintenance services • 50% reimbursement for major restorative services, to a maximum of $1,000 per calendar year • 50% reimbursement for orthodontics (braces), to a lifetime maximum of $3,000

Submitting a Treatment Plan for Expensive Dental Treatment

If your dental treatment will cost more than $500, Canada Life recommends that you contact them before you incur the expense, to determine how much the plan will pay and how much you will pay. Here's what you need to do:

1. For pre-determination of benefits, send Canada Life a detailed description of the treatment plan and its cost. Your **dentist** can provide this information for you and send it on your behalf.
2. You may also be asked to supply a fully completed written estimate, plus pre-operative X-rays, diagnostic casts, and laboratory reports.

PREVENTATIVE SERVICES – PLANS A AND B

The plan covers the **usual cost** of eligible preventive services as follows, subject to general exclusions:

Eligible Expense	Description	Special Notes
Anaesthesia	From sedatives to total loss of consciousness	During a surgical dental procedure
Bite adjustment/ equilibration	A procedure to correct the bite problem between the upper and lower teeth when they are in contact	8 units every calendar year
Cavity prevention	Fluoride	Once every calendar year
	Oral hygiene instruction and re-instruction – One-on-one instruction by the **dentist** or oral hygienist on how to brush and floss	
	Pit and fissure sealants – Coating put on top of any pits or cracks in teeth to prevent cavities from forming	Unlimited
	Polishing/cleaning of tooth	1 treatment every calendar year
	Recall package – Polishing, recall scaling, recall examinations, and fluoride	Once every calendar year
	Recall scaling	1 treatment every calendar year as part of the recall package
Examinations	Analysis of primary and permanent teeth	Once every calendar year
	Consultation to discuss a serious dental problem and to agree on a treatment plan	Unlimited
	Emergency examinations	Unlimited
	Initial or complete examination	Once per dentist
	Recall examinations	Once every calendar year

Eligible Expense	Description	Special Notes
Fillings	Amalgam fillings – Silver fillings that are used to restore teeth	
	Composite fillings – White fillings that are used to restore teeth	
	Pre-fabricated posts – Pre-made posts used for additional support to the tooth after root canal treatment	
	Retentive pins – Pins used to make sure that a restoration or filling stays in place	
	Sedative fillings for caries, trauma and pain control – Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anaesthesia to reduce pain before a permanent filling is installed.	
	Stainless steel, plastic and polycarbonate caps – Caps that are installed to cover the whole tooth	
	Veneer applications – White facings placed on a tooth's surface	Veneers that are done for cosmetic purposes are not covered.
Finishing restorations	Polishing of a filling previously placed in the mouth	Unlimited
Interproximal discing	Removal of a thin slice of tooth enamel to make more room for the teeth that are slightly crowded	Unlimited

Eligible Expense	Description	Special Notes
Minor oral surgery	Extractions Removal of a tooth, including an impacted tooth	Unlimited
	Residual root removal Removal of tooth roots left behind when a tooth is pulled out	
Mouth guards	A soft, flexible, plastic protective appliance worn to protect upper and lower teeth during contact sports	1 every calendar year
Recontouring of teeth	Procedure to correct the bite between opposing teeth by shaping or grinding the enamel surfaces	For functional purposes only Unlimited
Space maintainers and related maintenance	An appliance that a **dentist** uses to maintain a space where a tooth has been removed	Unlimited

Eligible Expense	Description	Special Notes
Tests and other diagnostic services	Bacteriological analysis of the saliva – To determine the susceptibility of cavities	Unlimited
	Biopsy of oral tissue	Unlimited
	Cytological tests	
	Diagnostic casts and models of the upper and lower teeth – For diagnostic ability or for construction of impression trays and temporary bridges and partial dentures	Unlimited
	Diagnostic cast interpretation – Diagnosis of dental condition by studying impressions or casts of a person's mouth	Unlimited
	Diagnostic photographs – Intra and extra oral photographs of the teeth, mouth and jaw that aid in the diagnostic determination of dental treatment	Unlimited
	Histological tests	
	Laboratory reports and interpretation	Unlimited
	Microbiological tests	
	Pulp vitality test – To determine if the pulp (the soft tissue inside a tooth) is healthy	

Eligible Expense	Description	Special Notes
X-rays	Bitewing films – To detect decay in molar teeth	Up to 4 per calendar year
	Cephalometric films – X-rays of the facial and skull profile for orthodontic purposes	Up to 5 every 2 calendar years
	Extra-oral films – X-rays taken outside of the oral cavity	Up to 4 per calendar year
	Facial and sialographic films – Intra-oral X-rays of the salivary glands that assist with the diagnosis of duct stones	Unlimited
	Full mouth or panoramic films	1 series per calendar year
	Hand and wrist X-rays	
	Occlusal films – X-rays of the chewing surface of the teeth to show the fit between the upper and lower teeth when they are in contact	Up to 4 per calendar year
	Panorex films – One view of the entire mouth	Once every calendar year
	Radiopaque dyes – Dyes that can be seen on an X-ray and are used to determine decay in teeth, or gum pockets around abscessed teeth	Unlimited
	Single films	Unlimited
	TMJ films (films relating to temporomandibular joint dysfunction)	Up to 4 per calendar year

MAINTENANCE SERVICES – PLANS A AND B

The plan covers the **usual cost** of eligible maintenance services as follows, subject to general exclusions:

Eligible Expense	Description	Special Notes
Alveoloplasty	Remodelling, removing or reducing bone	
Appliances and related adjustments	Myofacial pain syndrome appliances – Worn to manage pain in the facial area caused by internal and external forces on the teeth due to muscle contractions from abnormal forces or stress	Appliances once per arch every 2 calendar years, unlimited adjustments and repairs
	Periodontal appliances – Making the impression and inserting the appliances	Appliances once per arch every 2 calendar years, unlimited adjustments and repairs
	TMJ appliances – Worn to manage temporomandibular joint pain and discomfort	Cost of making the impression and inserting the appliance once per arch every 2 calendar years, unlimited adjustments and repairs
Gingivoplasty	Remodelling gums	Unlimited

Eligible Expense	Description	Special Notes
Maintenance of existing dentures	Adjustments (including remount and occlusal equilibration)	Unlimited, provided adjustments made more than 3 months after the new dentures were inserted
	Custom-stained denture bases	Must be provided in a **dentist**'s office
	Prophylaxis and polishing – Procedure to clean and polish dentures, can be done in an office or in a lab	Unlimited
	Rebasing – Fitting dentures with a new base	Once per arch every 2 calendar years
	Rebuilding of worn acrylic teeth	Must be provided in a dentist's office
	Relining – Adding material so that the dentures fit properly	Once per arch every 2 calendar years
	Remake – Remaking a new partial denture using the patient's existing framework	Once per arch every 2 calendar years
	Repairs – Fixing broken or damaged dentures	Unlimited
	Resetting of teeth	Unlimited
	Resilient liner	Unlimited
	Tissue conditioning – Applying a conditioner to the alveolar ridge that ensures a proper denture fit	Unlimited
Major oral surgery	Surgery – May include local anaesthesia, appropriate X-rays, surgery and follow-up care	Unlimited, provided the surgery is not for cosmetic purposes and not part of any implant or part of any orthognathic surgery, remodelling or repositioning of the lower jaw

Eligible Expense	Description	Special Notes
Major oral surgery	Antral surgery – Surgical removal of a tooth that has been forced up into a sinus cavity	
	Fractures – Treatment of fractures of the upper or lower alveolar bone, which holds the teeth in the sockets	
	Frenectomy – Surgery on the frenum (a thin tissue that connects the lips to the gums and the tongue to the floor of the mouth)	
	Hemorrhage control – Treatment to stop bleeding resulting from an extraction or trauma	
	Post-surgical care – Treatment given by the **dentist** after surgery until healing is complete	
	Sialolithotomy – Partial removal of the salivary duct	
	Stomatoplasty – Remodelling the floor of the mouth	
	Surgical enucleation – Surgical removal of teeth prior to eruption	
	Surgical excision – Removal of cysts or a foreign body	
	Surgical incision – Incision made to an infected area usually to allow drainage	
	Surgical exposure – Surgical incision to expose teeth that will not erupt or come on time	
	Surgical repositioning – Surgical procedure to reposition teeth due to growth abnormalities or trauma, resulting in the correct alignment of the upper and lower jaws	

Eligible Expense	Description	Special Notes
Major oral surgery	Transplantation of erupted or non-erupted teeth – Placement of teeth to another area of the mouth because of the early removal of the pre-existing teeth due to decay or trauma	
	Vestibuloplasty – Ridge reconstruction	
Repairs to existing major restorative work	Repairs to existing crowns, inlays, onlays, and bridgework, porcelain staining of fabricated crown, and removal and/or recementation of crowns, inlays, onlays, and bridgework	Unlimited
Treatment of gum disease	Desensitization – Applying fluoride to reduce sensitivity	May include local anaesthesia, surgical dressing, sutures and follow-up care for 1 month, post-treatment evaluation not covered
	Displacement dressing – Placing a medicated pack on inflamed gums to move gums away from the calculus (deposits on teeth that irritate gums)	
	Flap surgery – The opening made for bone removal	
	Gingival curettage – Scraping out damaged tissue inside the gums	
	Gingivectomy – Removing damaged gum tissue	

Eligible Expense	Description	Special Notes
Treatment of gum disease	Periodontal scaling and/or root planing (tartar removal) – Scaling: removing calcium deposits on teeth, root planing: smoothing rough tooth surfaces and removing any calcium deposits	
	Tissue graft – The transfer of healthy gums to an area where the gums have receded	
Treatment of roots	Apexification – Closing the root of a tooth with hard tissue	
	Apicoectomy – Surgical removal of a root end after root canal therapy	
	Bleaching endodontically treated tooth – The whitening of a tooth internally through the root canal opening of a tooth	
	Endosseous intracoronal – Implants for root stabilization, codes 34461, 34462 and 34471	
	Hemisection – The removal of a portion of the root(s) and the crown of a tooth but leaving the other root(s) in place	
	Intentional removal, apical filling and reimplantation – The intentional removal of a healthy tooth and implanting it (e.g., a third molar is removed and used to replace a missing first molar)	

Eligible Expense	Description	Special Notes
Treatment of roots	Pulpectomy – The removal of tissue from the pulp chamber	
	Pulpotomy – The removal of dental pulp from the crown portion of the tooth	
	Retrofilling – Filling done through the root end	
	Root amputation – Root(s) from a tooth removed because of infection The crown and at least one root remain so that the tooth does not have to be removed.	
	Root canal therapy	

MAJOR RESTORATIVE SERVICES – PLAN B ONLY

If you chose Plan B with basic and major care, the plan covers the **usual cost** of eligible major restorative services as follows, subject to general exclusions, to a maximum reimbursement of $1,000 per calendar year:

Eligible Expense	Description	Special Notes
Bridges	Bridges	Crown lengthening (subgingival preparation) before tooth preparation is not covered. Charges for replacing an existing bridge will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below: • it has been more than 5 calendar years since the last bridge was inserted, or • it has been less than 5 calendar years since the last bridge was inserted and the existing bridge can no longer be worn. Canada Life must approve this.

Eligible Expense	Description	Special Notes
Bridges	Pontics – Artificial teeth that replace missing teeth	Covered only if it has been more than 5 calendar years since the last pontic was installed in that space
	Posts in retainers/abutments – Posts and cores used for additional support to the retainer/abutment	Covered only if it has been more than 5 calendar years since the last installation to that tooth
	Retainers/abutments – The tooth beside the missing tooth that will be used to support the bridge	Preparation of the tooth is covered only if it has been more than 5 calendar years since the last preparations were made to that tooth
Caps and tooth coverings	Build-up/fillings – Restoring a tooth prior to capping for better adaptation of the cap	
	Crowns – A cap that covers the whole tooth	
	Inlay/onlay restorations – Metal, composite, or porcelain casts placed on the surface of the tooth	
	Posts and cores – Laboratory-processed posts and cores used for additional support to the tooth after root canal therapy	
	Retentive pins in inlays, onlays and crowns – Pins used to make sure that the inlays, onlays or crowns stay in place	
	Veneer applications (laboratory processed) – White facings put on a tooth's surface	Veneer applications that are done for cosmetic purposes are not covered

Eligible Expense	Description	Special Notes
Dentures	Acrylic dentures – Dentures with an acrylic denture base	Covered only if it has been more than 5 calendar years since the last acrylic dentures were inserted
	Complete dentures – Dentures that replace either all of the top teeth or all of the bottom teeth	Charges for replacing an existing denture will only be paid if such replacement is for an equivalent denture and meets one of the conditions shown below: • it has been more than 5 calendar years since the last complete dentures were inserted, or • it has been less than 5 calendar years since the last complete dentures were inserted and the existing dentures can no longer be worn. Canada Life must approve this.
	Gnathological dentures – Placed to realign the upper and lower jaws following surgical procedures for jaw correction	Covered only if it has been more than 5 calendar years since the last dentures were inserted

Eligible Expense	Description	Special Notes
Dentures	Overdentures – Placed over a few remaining teeth that have had root canal treatment, and adapted to assist with the stabilization of the denture	
	Partial dentures – Partial dentures replacing one or more top or bottom teeth The partial dentures may be acrylic (plastic), metal or chrome base that can have acrylic, wire or chrome clasps (which hold on to the teeth).	Covered only if it has been more than 5 calendar years since the last partial dentures were inserted or additional teeth have been extracted
	Transitional dentures – Temporary dentures used for healing purposes due to the extraction of one or more teeth	Covered for one complete upper denture and one complete lower denture in 5 calendar years

ORTHODONTICS – PLAN B ONLY

If you chose the basic/major care option, the plan covers the **usual cost** of eligible orthodontic procedures to correct crooked or misaligned teeth (e.g. braces), to a lifetime maximum of $3,000. This includes all dental treatment needed to correct the problem, such as:

- examinations,
- X-rays, models,
- photographs, reports,
- surgical exposure of teeth,
- appliances, and
- adjustments.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment is covered as if it were an orthodontic service.

EXCLUSIONS

- Any dental charges not included in the Dental Association Suggested Schedule of Fees for General Practitioners or the Dental Specialist Fee Guide
- Dental services or supplies that you are eligible to claim under any workers' compensation legislation
- Any endodontic treatment that was started before the effective date of coverage
- Any treatment related to orthognathic surgery
- Charges for appointments that are not kept
- Charges for completing claim forms
- Cosmetic procedures
- Crown lengthening (subgingival preparation) before tooth preparation
- Experimental treatment or testing
- Procedures or supplies used in vertical dimension corrections (changing the height of teeth) or to correct attrition problems (worn-down teeth)
- Replacement of dental appliances, including dentures, that are lost, misplaced, or stolen
- Treatment to correct temporomandibular joint dysfunction, except for temporomandibular joint dysfunction appliances

In addition to the above, the plan does not cover the following major dental coverage:

- Crowns, bridges, or dentures for which tooth preparations were started before the effective date of coverage
- Implanting fabricated teeth or any major surgery resulting from implanting fabricated teeth

Life and Accident

OVERVIEW

A financial safety net is important when you have loved ones who depend on you for financial security. The plan helps provide that safety net in the event of your death or a serious injury. Financial protection is also offered in the event your **spouse** or **child** dies.

For a summary of your life and AD&D coverage, refer to the **Benefits At-a-Glance** section. There you will find information on benefits payable in the event of a death or serious injury.

For a list of life and AD&D exclusions, see the **Exclusions** section.

Life Insurance	**Basic Life**	**Optional Life**
	• For you (mandatory) • For your **spouse** (optional) • For your **children** (optional)	• For you (optional) • For your spouse (optional) • For your children (optional)
AD&D Insurance	**Basic AD&D**	**Optional AD&D**
	• For you (mandatory)	• For you (optional) • For your spouse (optional) • For your children (optional)

LIFE INSURANCE

The plan provides a basic life insurance benefit for you, your **spouse** and **children**. If you wish to increase your coverage for you, your spouse or **child**, you can purchase optional life insurance as well.

For a summary of your life insurance coverage, refer to the **Benefits At-a-Glance** section.

Basic life insurance is not available if you are a **Civil Service** – Class 2 employee or a Civil Service – Class 4 **temporary employee** working less than 40% of the normal weekly working hours.

Basic and Optional Life Insurance for You

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

Designating a beneficiary – and keeping your beneficiary designation up to date – ensures that your intended beneficiaries are well-protected. To designate or update your beneficiary, complete the Beneficiary Designation form (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516) and return it to Johnson Inc.

Basic and Optional Life Insurance for Your Dependents

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

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Along with basic life insurance protection, the plan automatically provides you with basic AD&D insurance – an extra measure of protection against a number of losses. If you wish to increase your coverage, or obtain coverage for your **spouse** or **child**, you can purchase optional AD&D insurance as well.

For a summary of your AD&D insurance coverage, refer to the **Benefits At-a-Glance** section.

Basic AD&D insurance is not available if you are a **Civil Service** – Class 2 employee or a Civil Service – Class 4 **temporary employee** working less than 40% of the normal weekly working hours.

Basic and Optional AD&D Insurance for You

In the event of a covered loss (other than loss of life), the benefit will be paid to you. In the event of your death, the benefit amount is payable to your designated beneficiary, or to your estate if your beneficiary has died before you or you haven't designated a beneficiary.

Designating a beneficiary – and keeping your beneficiary designation up to date – ensures that your intended beneficiaries are well-protected. To designate or update your beneficiary, completed the Beneficiary Designation form (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516) and return it to Johnson Inc.

Optional AD&D Insurance for Your Dependents

You, your **spouse** and **child** can only be covered once under the plan. For example, if your spouse is also covered under the PSGIP, they cannot choose family coverage if you have also chosen family coverage.

In the event of a covered loss, including loss of life, the benefit will be paid to you.

WHAT'S COVERED

If an injury results in a loss or loss of use of a limb as specified in the table below, within one year from the date of the accident, you will receive a percentage of the benefit amount you have in place for both basic and optional coverage. However, not more than one (the largest) of such benefits will be paid with respect to injuries resulting from one accident.

Covered Loss	Percentage Payable
• Life	100%
• Hemiplegia (paralysis of one arm and one leg on the same side of the body) • Paraplegia (paralysis of both lower limbs) • Quadriplegia (paralysis of all four limbs) • Use of both hands, both feet, or both arms	200%
• Entire sight in both eyes • One hand and one foot • One hand or foot and entire sight in one eye • Speech and hearing in both ears • Brain death	100%
• Use of one leg or one arm	75%
• Use of one hand or one foot • Entire sight in one eye • Speech or hearing in both ears	66 2/3%
• Hearing in one ear	50%
• Thumb and index finger of the same hand • Four fingers of the same hand	33 1/3%
• All toes of one foot	25%

For benefits to be payable, the loss of use must:

- be total and irrecoverable,
- continue for 12 consecutive months, and
- be determined by the insurer to be permanent.

EXAMPLE: HOW COVERAGE WORKS

Let's assume that you have basic AD&D coverage of $90,000 and optional AD&D coverage of $100,000. If you were to lose an arm, you would receive 75% of your coverage, as follows:

Basic coverage	75% x $90,000 = $67,500
Optional coverage	75% x $100,000 = $75,000
Total benefits	**= $142,500**

Now let's assume that your optional AD&D coverage of $100,000 is family level. If your **spouse** were to lose an arm, you would receive 75% of your optional coverage, as follows:

Had you lost your arm	75% x $100,000 = **$75,000**
If your spouse were to lose an arm	If you have dependent **children**: 50% x $75,000 = **$37,500** If you do not have dependent children: 60% x $75,000 = **$45,000**

ADDITIONAL BENEFITS

Basic Coverage	
Bereavement	If injuries covered under this plan result in your death within 365 days from the date of the accident, the plan will pay the reasonable and necessary expenses actually incurred by your **spouse** and dependent **children** for up to six sessions of grief counselling by a **professional counsellor**. The maximum reimbursement is $1,000 for all sessions combined.
Cosmetic disfigurement	This coverage does not apply to business travel policies. If you suffer a third-degree burn in a non-occupational accident, the plan will pay a percentage of your basic accidental death coverage, depending on the area of the body that was burned, as follows:

Body part	(A) Area classification	(B) Maximum allowable % for burned area	(C) Maximum % of your basic accidental death coverage payable
Face, neck, head	11	9%	99%
Hand and forearm	5	4.5%	22.5%
Either upper arm	3	4.5%	13.5%
Torso (front or back)	2	18%	36%
Either thigh	1	9%	9%
Either lower leg (below knee)	3	9%	27%

Basic Coverage	
Cosmetic disfigurement	The maximum benefit payable (C) is determined by multiplying the area classification (A) by the maximum allowable percentage for the burned area (B). In the event of a 50% surface burn, the maximum allowable percentage for the burned area (B) is reduced by 50%. **Note:** This table only represents the maximum percentage of your basic accidental death coverage payable for any one accident. If you suffer burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.
Day care	In the event of your accidental death, the plan pays for reasonable and necessary day care expenses incurred for each dependent **child** under age 12 who is: • enrolled in a licensed day care facility at the time of your accident, or • enrolled in a licensed day care facility within 365 days of the date of your accident. Benefits are payable for up to four consecutive years, to an annual maximum of 5% of your coverage or $5,000, whichever is lower. In this case, the dependent child must: • be your legitimate or illegitimate child, adopted child, stepchild, or any child who is in a parent-child relationship with you, • be 12 years old or under, and • depend on you for maintenance and support. If you do not have eligible dependent **children** at the time of your death, your beneficiary will receive an additional benefit of $1,500 under this benefit or the special education benefit, but not both. The insurer will require satisfactory proof that the child is enrolled in a licensed day care facility.

Basic Coverage	
Disappearance	If your body has not been found within one year of the disappearance, stranding, sinking or wrecking of the vehicle in which you were an occupant at the time of the accident, it will be assumed that you have died. The plan will then pay benefits.
Family transportation	If you suffer an accidental injury and are hospitalized outside Canada or at least 150 km from your principal place of residence, the plan will pay up to $15,000 for transportation costs to have a member of your **immediate family** visit you. Your attending **physician**, however, must require your family member's presence in writing. Transportation must be by the most direct route by a licensed common carrier.
Home and vehicle alteration	If you receive benefits for a covered loss and must use a wheelchair, the plan will pay up to the greater of $15,000 and 10% of your basic accidental death coverage to a maximum of $50,000, for both of the following combined: • the one-time cost of alterations to your home so it is wheelchair accessible and habitable, and • the one-time cost of alterations to your vehicle so it is accessible and you can drive it. For benefits to be paid: • expenses must be incurred within 365 days of the accident that resulted in the covered loss, • home alterations must be made by someone experienced in such matters who is recommended by a recognized organization providing support and assistance to wheelchair users, and • vehicle alterations must be made by someone experienced in such matters and approved by provincial licensing authorities.

Basic Coverage	
Identification	If you pass away accidentally at least 150 km away from your normal place of residence and the police or a similar government requests that a member of the **immediate family** identify the body, the plan will reimburse the reasonable expenses actually incurred by such member for: • transportation by the most direct route or town where the body is located, and • hotel accommodation in that city or town, subject to a maximum duration of three days. The maximum amount payable for all of these expenses combined is $15,000. Reimbursement is subject to the subsequent payment of the basic accidental death benefit following the identification of the body as the insured person. The plan does not cover board or other ordinary living, travelling or clothing expenses. Also, transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire. These benefits are limited to only one policy should this benefit be contained in two or more policies issued to the policyholder by the insurer.
In-hospital confinement monthly income	If an accident leads to your hospitalization for at least seven consecutive days and you are under the care of a legally qualified and registered **physician** or surgeon (other than yourself), the plan will pay a monthly benefit of 1% of your coverage, up to $2,500 per month. For hospitalization of less than one month, the plan will pay 1/30 of the monthly benefit per day. Benefits cannot exceed 365 days for any covered accident.
Permanent and total disability	If you suffer an injury that results in **permanently and totally disability** (after 365 days from the date of an accident) the plan pays a benefit equal to your coverage amount, less any benefit payment already made under the plan as a result of the same accident. A continuous total disability must begin within 30 days of the accident that led to a covered loss, and means your complete inability during the first year to perform the substantial and material duties of your occupation.

Basic Coverage	
Rehabilitation	If you are entitled to benefits for eligible losses, the plan will pay up to $15,000 of reasonable and necessary expenses for special training to be qualified for an occupation in which you would not have engaged in had the accident not occurred. Expenses must be incurred within two years of the accident. No benefits are payable for ordinary living, travelling or clothing expenses.
Repatriation	In the event of your accidental death outside Canada or over 50 km from your principal place of residence, the plan will pay up to $15,000 for the preparation and transportation of your body to such place. Your death must occur within 365 days of the accident.
Seat-belt benefit	If you suffer a covered loss while wearing a properly fastened seat belt in a private passenger car, station wagon, van, or jeep-type automobile at the time of the accident, the plan will pay 10% of the amount that would otherwise be payable for the covered loss. The official accident report must certify that you or your covered **dependents** were wearing seat belts at the time of the accident.
Special education benefit	In the event of your accidental death, the plan will pay a benefit to any dependent **child** who, on the date of the accident that led to your death: • is enrolled full-time in any post-secondary institution beyond the 12th or 13th grade level, or • was at the 12th or 13th grade level and subsequently enrols as a full-time student in any post-secondary institution within 365 days of the accident that led to your death. The benefit is equal to 5% of your coverage amount, to a maximum of $5,000 per year. This benefit is payable for a maximum of four consecutive annual payments, provided your dependent child remains full-time in a post-secondary institute. If no dependent child qualifies at the time of the accident, the plan will pay an additional benefit of $1,500 to your designated beneficiary under this benefit or the day care benefit, but not both.

Basic Coverage	
Spousal occupational training	In the event of your accidental death, the plan will pay up to $15,000 for any occupational training expenses incurred by your **spouse** to gain active employment in a field for which they were not previously qualified. The expenses must be incurred within three years of the date of the accident.
Waiver of premium	If you become **totally disabled** before age 65 and provide annual satisfactory evidence of your total disability, you will not have to pay your premium for coverage. This waiver will last until your return to active employment with your employer, your 65th birthday, or coverage is terminated.

Optional Coverage	
Bereavement	If injuries covered under this plan result in your death within 365 days from the date of the accident, the plan will pay the reasonable and necessary expenses actually incurred by your **spouse** and dependent **children** for up to six sessions of grief counselling by a **professional counsellor**. The maximum reimbursement is $1,000 for all sessions combined.
Comatose benefit	If you become comatose as a result of an accident, the plan will pay a monthly benefit equal to 1% of your optional coverage for accidental death, until the earliest of: • 100-month period, • your death, and • the date you are deemed to be out of the coma. This benefit will be reduced by any optional benefit already paid by the plan for your accidental loss if you become comatose within 365 days of the accident and remain comatose for 31 consecutive days.

Optional Coverage

Common disaster

If you and your covered **spouse** die within one year from injuries resulting from the same accident, or separate accidents occurring within the same 24-hour period, your spouse's coverage will be increased to equal your optional coverage, up to $200,000.

Benefits will be payable to and divided equally among your surviving dependent **children**.

Cosmetic disfigurement

This coverage does not apply to business travel policies. If you suffer a third-degree burn in a non-occupational accident, the plan will pay a percentage of your basic accidental death coverage, depending on the area of the body that was burned, as follows:

Body part	(A) Area classification	(B) Maximum allowable % for burned area	(C) Maximum % of your basic accidental death coverage payable
Face, neck, head	11	9%	99%
Hand and forearm	5	4.5%	22.5%
Either upper arm	3	4.5%	13.5%
Torso (front or back)	2	18%	36%
Either thigh	1	9%	9%
Either lower leg (below knee)	3	9%	27%

The maximum benefit payable (C) is determined by multiplying the area classification (A) by the maximum allowable percentage for the burned area (B). In the event of a 50% surface burn, the maximum allowable percentage for the burned area (B) is reduced by 50%.

Note: that this table only represents the maximum percentage of your basic accidental death coverage payable for any one accident. If you suffer burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Optional Coverage		
Escalation benefit	After you have been covered under the plan for 12 months, your coverage is increased each year by 1% for a maximum of five years.	
Extended family benefit	If your family is covered when you suffer an accidental death, coverage may continue for your **spouse** and dependent **children** for a maximum of six months, provided premiums are paid.	
Special benefit for dependent children	**Injury**	**Benefit**
	• Loss of two hands • Loss of two arms • Loss of two legs • Loss of two feet • Loss of one hand and one foot • Loss of entire sight in both eyes • Loss of speech and hearing • Quadriplegia	4 x what the plan would have paid for your **child**'s accidental death
	• Loss of one arm or one leg • Loss of speech or hearing • Paraplegia • Hemiplegia	2 x what the plan would have paid for your child's accidental death
	• Loss of life • Loss of one hand or foot	1 x what the plan would have paid for your child's accidental death
	The maximum benefit payable is $100,000.	

Optional Coverage	
Homemaker weekly indemnity	If your **spouse** suffers a covered loss and becomes disabled and is prevented from performing any and all of the regular household and/or childcare duties, the plan will pay $150 per week (from the second day of the disability) for the duration of the disability, to a maximum of 26 weeks. Your spouse must: • become disabled within 30 days of the accident, • be unemployed and not in receipt of employment insurance benefits at the time of the covered loss, and • be under the regular care and attendance of a **physician** during the disability.
Identification	If you pass away accidentally at least 150 km away from your normal place of residence and the police or a similar government requests that a member of the **immediate family** identify the body, the plan will reimburse the reasonable expenses actually incurred by such member for: • transportation by the most direct route or town where the body is located, and • hotel accommodation in that city or town, subject to a maximum duration of three days. The maximum amount payable for all of these expenses combined is $15,000. Reimbursement is subject to the subsequent payment of the basic accidental death benefit following the identification of the body as the insured person. The plan does not cover board or other ordinary living, travelling or clothing expenses. Also, transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire. These benefits are limited to only one policy should this benefit be contained in two or more policies issued to the policyholder by the insurer.

EXCLUSIONS

Optional Life Insurance

No benefit will be payable if death results, directly or indirectly, from suicide while sane or insane, for any amount of insurance that has been in effect for less than two years.

This exception applies separately to the initial amount of insurance and any subsequent increase in coverage elected for employee or spousal coverage.

Basic and Optional AD&D Insurances

This coverage does not provide benefits for losses resulting from:

- suicide or attempted suicide,
- self-inflicted injuries,
- war, declared or undeclared,
- full-time service in any military organization,
- flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration,
- flying as pilot or crew member in any aircraft or device for aerial navigation, or
- full-time, active duty in the armed forces of any country or international authority.

Disability

OVERVIEW

Long-term disability benefits provide financial help should you become disabled for an extended period of time. If you are eligible for benefits, you will receive a percentage of your income while you are on long-term disability leave.

For step-by-step instructions, see the guide How to apply for long-term disability benefits (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537).

For a summary of your long-term disability coverage, refer to the **Benefits At-a-Glance** section. There you will find information on benefits payable in the event you become disabled.

For a list of long-term disability exclusions, see the **Exclusions** section.

Long-term disability is not available if you are a **Civil Service** – Class 2 employee working less than 40% of the normal weekly working hours or a Civil Service – Class 4 **temporary employee** working less than 40% of the normal weekly working hours.

Long-term disability	70% of your monthly **earnings**, to a maximum benefit of $6,000 per month

LONG-TERM DISABILITY

The plan will pay monthly long-term disability (LTD) benefits to you if you are considered **totally disabled**. These benefits are taxable.

Your benefit amount will increase annually to take into account the rising cost of living. Although a disability can put your life on hold, the cost of living keeps on growing. That's why the PSGIP currently increases benefits on January 1 of each year after your first full calendar year of total disability. This increase is equal to the annual increase in the Consumer Price Index, to a maximum of 3% per year.

If you become disabled as a result of an accident, you may also be eligible for a permanent total disability benefit under your AD&D insurance. See the **AD&D insurance** section for more information.

Your Benefits and Pension During Periods of Disability

The continuation of your benefits while on long-term disability leave depends on the benefit and your employment group. Certain benefits could be continued without premium payments. Johnson Inc. will provide you with details at the time of your application for coverage.

While you are receiving long-term disability benefits, an additional percentage of your **earnings** will be paid on your behalf to cover your contributions to the pension plan – the Civil Service Superannuation Fund.

When Will Benefits Begin?

LTD benefits will begin after the qualifying period has been satisfied, which is the later of:

- the date your accumulated sick leave credits have expired, or
- four months of continuous total disability.

You must, however, still be **totally disabled** at that time.

When Will Benefits End?

LTD benefits continue until the earliest of the following dates:

- when you cease to be disabled,
- when you fail to submit to a requested physical examination and/or mental evaluation,
- when you fail to provide satisfactory written proof of continuance of disability,
- when you are no longer receiving regular and ongoing care of a **physician**,
- when you refuse to enter into (or stop participating in) any rehabilitation program that the insurer considers to be appropriate,
- for approved claims that:
  - Begin on or after January 1, 2019: when you reach age 62 (if your sick leave benefits end after your 61st birthday, monthly income payments will continue beyond age 62 until a total of 12 monthly payments have been made or your disability ceases),
  - Began between February 1, 1998 and December 31, 2018: when you reach age 60 (if your sick leave benefits end after your 59th birthday, monthly income payments will continue beyond age 60 until a total of 12 monthly payments have been made or your disability ceases),
  - Began before February 1, 1998: when you reach age 65,
- when you are incarcerated in a prison or mental institution by authority of a criminal court,
- when you refuse to complete and return a Reimbursement Agreement/Direction form, provided by Canada Life, or comply with the terms of a signed Reimbursement Agreement/Direction form, when requested, in accordance with the provisions under third-party liability, or
- when you die.

Note: LTD benefits may extend beyond your termination date provided you became disabled while you were still insured. Benefits will continue to be paid according to the contract provisions regardless of the subsequent termination of the group policy. Canada Life reserves the right to request proof of the continuance of **total disability** and to have you submit to an examination by Canada Life's medical advisors when requested.

In the Case of a Reoccurring Disability

If the second disability is...	The second disability will be considered...
Related to the first disability and recurs within 6 months	A continuation of the first disability and LTD benefits will immediately become payable in the same amount
Related to the first disability and recurs after 6 months, or is not related to the first disability	A new disability, which means you will receive LTD benefits after your accumulated sick leave credits have expired or 4 months of continuous **total disability**, whichever is later

Rehabilitative Programs

If you have been disabled for the waiting period or longer and engaged in a rehabilitative program approved by the insurer, you will continue to receive LTD benefits.

However, the monthly LTD benefit will be reduced by 50% of the amount, if any, of remuneration you earn for the work performed during the rehabilitation period. This reduction applies provided that, while on rehabilitative employment, your income from all sources outlined in the **Other Sources of Income** section is not greater than 100% of **earnings** before your disability.

LTD benefits will end when your rehabilitative income equals 75% or more of the current monthly earnings for your normal occupation.

This rehabilitative income will continue until the earliest of the following dates:

- the date your rehabilitative employment ends,
- no later than 24 months after the rehabilitative employment began,
- the date the rehabilitative employment is no longer approved, or
- your 60th birthday.

Other Sources of Income

LTD benefits are designed to give you a reasonable level of income without equalling or exceeding your normal pay. For this reason, the benefit you receive from the plan will be reduced by income from any of the following sources:

- disability benefits payable under the Canada or Quebec Pension Plan (C/QPP), excluding C/QPP benefits for **dependents**,
- **earnings** or payments from any employer,
- disability benefits payable under any other group, association or franchise insurance plan,
- disability and income replacement benefits payable under any government plan (excluding employment insurance (EI) benefits),
- retirement benefits provided by an employer,
- income replacement indemnity payable under any automobile insurance plan, and
- earnings recovered through a legally enforceable cause of action against some other person or corporation.

There is a further reduction of your benefit if the total of the long-term disability benefit, the income from all sources outlined above and the public pension plan benefits payable to you on behalf of another member of your family exceeds 85% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Should you not be eligible for LTD benefits due to this benefit integration, contributions to your employer's pension plan will still be made on your behalf.

Note: Your monthly LTD benefit will not be reduced by disability benefits payable under the C/QPP until your C/QPP benefits are determined. However, when you submit your LTD claim, you must sign an agreement to reimburse the insurer. Otherwise, C/QPP benefits that have not been determined by the time your benefit is payable will be estimated and deducted from your monthly benefit. Adjustments to correct such payments will be made after the award has been determined.

Third-Party Liability

If you have a cause of action against a third party for income lost as a result of your disability, the LTD will be payable as specified. However, before payments begin, you must complete a Reimbursement Agreement/Direction form, provided by Canada Life, agreeing to reimburse the insurer. The amount to be reimbursed will not exceed the amount of LTD benefits paid by the insurer. Full details concerning terms and calculation of reimbursement are as set out in the agreement.

EXCLUSIONS

No LTD benefit will be payable for any period of **total disability**:

- during which you are not under the care of a doctor,
- during the time you are on a maternity leave agreed upon by you and your employer,
- during which you fail to undergo medical, psychiatric, psychological, educational and/or vocational exams by examiners selected by the insurer,
- during which you are incarcerated in a prison or mental institution by authority of a criminal court,
- as a result of drug or alcohol use or the use of any hallucinogen unless in an approved rehabilitation program or due to an organic disease,
- resulting from intentionally self-inflicted injuries or attempted suicide while sane or insane,
- resulting from war, declared or undeclared, insurrection, rebellion, participation in a riot, or active duty in the armed forces of any country,
- resulting from the commission of or an attempt to commit a criminal offense,
- due to a condition for which you were treated or attended by a **physician**, or for which prescription drugs or medicines were taken within a six-month period prior to the effective date of your insurance. This limitation will not apply after you have performed all the duties of your regular occupation on a regularly scheduled basis for a 24-month period after your effective date, or
- for any period in which you are entitled to benefits under any *Workers' Compensation Act*.

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

Optional Critical Illness Insurance

OVERVIEW

Critical Illness Insurance is designed to offer you financial security when illness puts savings and assets at risk. It can provide peace of mind and financial support during a difficult time and designed to help alleviate the financial burden that can come with a serious illness, allowing you to focus on your health and recovery. You can choose to buy Optional Critical Illness Insurance coverage for yourself or your spouse.

For a summary of your Optional Critical Illness coverage, refer to the **Benefits At-a-Glance** section.

Critical Illness Insurance	Basic Critical Illness	Optional Critical Illness
	• Not available	• For you (optional) • For your spouse (optional)

OPTIONAL CRITICAL ILLNESS

If a person is diagnosed with a critical illness while they are insured, Canada Life will pay a lump sum benefit to the employee. If there is a specified survival period for a covered condition, Canada Life will not pay the benefit until the end of the survival period. No benefit is payable if the person dies or experiences **irreversible** cessation of all functions of the brain during the survival period.

Optional Critical Illness Insurance for You and Your Spouse

You and your spouse can apply for coverage in units of $10,000 up to a maximum of $250,000.

What's Covered

Under Optional Critical Illness coverage, the following conditions are considered a critical illness if they meet the defined criteria and have been diagnosed by a **specialist**.

Covered Illness	Conditions
Heart attack*	Refers to the death of heart muscle caused by a blockage in blood flow. To be considered a heart attack, there must be a rise and fall of biochemical cardiac markers at levels that are diagnostic of myocardial infarction. Additionally, at least one of the following conditions must be met: a) The presence of heart attack symptoms. b) New electrocardiogram (ECG) changes that are consistent with a heart attack. c) The development of new Q waves during or immediately after an intra-arterial cardiac procedure, such as coronary angiography or coronary angioplasty. The benefit becomes payable after a survival period of 30 days following the date of diagnosis

Covered Illness	Conditions
Stroke*	Refers to an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source. To be considered a stroke, the following conditions must be met: a) There must be an acute onset of new neurological symptoms. b) There must be new objective neurological deficits observed during a clinical examination. These symptoms and deficits must persist for more than 30 days following the date of the condition. Diagnostic imaging testing must also corroborate these new symptoms and deficits. The benefit becomes payable after a survival period of 30 days following the date of diagnosis.
Coronary artery bypass surgery*	Refers to undergoing heart surgery to correct the narrowing or blockage of one or more coronary arteries using bypass graft(s). The surgery must be deemed medically necessary by a specialist. The benefit becomes payable after a survival period of 30 days following the date of surgery.
Cancer (life threatening)*	Refers to a tumor characterized by the uncontrolled growth and spread of malignant cells, as well as the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.
Kidney failure	Refers to chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Covered Illness	Conditions
Blindness	Refers to the total and irreversible oss of vision in both eyes. This loss of vision is evidenced by either of the following conditions: a) The corrected visual acuity is 20/200 or less in both eyes. b) The field of vision is less than 20 degrees in both eyes.
Major organ transplant	Refers to the irreversible failure of a vital organ, including the heart, both lungs, liver, both kidneys, or bone marrow. The transplantation procedure must be deemed 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. The benefit is limited to these specific organs.
Dementia, including Alzheimer's disease*	Dementia, including Alzheimer's disease, refers to a progressive deterioration of memory and at least one of the following areas of cognitive function: aphasia (speech disorder), apraxia (difficulty performing familiar tasks), agnosia (difficulty recognizing objects), or disturbance in executive functioning (difficulty with abstract thinking, planning, initiating, sequencing, monitoring, and stopping complex behavior) that affects daily life. To qualify, the person must exhibit dementia of at least moderate severity, as evidenced by a Mini Mental State Exam score of 20/30 or less, or an equivalent score on another generally accepted test of cognitive function. There must also be evidence of progressive deterioration in cognitive and daily functioning over a period of at least six months, either through serial cognitive tests or historical documentation.

Covered Illness	Conditions
Parkinson's disease and specific atypical Parkinsonian disorders*	Refers to a permanent neurologic condition characterized by bradykinesia (slowness of movement) and at least one of muscular rigidity or rest tremor. The person must exhibit objective signs of progressive deterioration in function for at least one year, and their treating neurologist must have recommended dopaminergic medication or an equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders include progressive supranuclear palsy, corticobasal degeneration, and multiple system atrophy. Medical information about the diagnosis and related signs, symptoms, or investigations must be reported to Canada Life within six months of the diagnosis. Failure to provide this information within the specified period may result in the denial of any claim related to Parkinson's Disease, Specified Atypical Parkinsonian Disorders, or any critical illness caused by these conditions or their treatment.
Paralysis	Refers to 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	Refers to a condition that can be confirmed by specific criteria: a) Two or more separate clinical attacks, supported by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination. b) Well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination. c) A single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination that have developed at intervals of at least one month apart.

Covered Illness	Conditions
Deafness	Refers to the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3000 hertz.
Loss of speech*	Refers to the complete and permanent loss of the ability to speak due to physical injury or disease for a period of at least 180 days.
Coma*	Refers to 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.
Severe burns	Refers to third degree burns over at least 20% of the body surface.
Aortic surgery*	Refers to the surgical procedure of removing and replacing a diseased part of the aorta with a graft. The aorta refers to the main artery in the body, including the thoracic and abdominal sections, but not its branches. The surgery must be deemed medically necessary by a specialist. The benefit is payable after a survival period of 30 days following the date of surgery.
Benign brain tumour*	Refers to a non-malignant tumour located in the cranial vault, limited to the brain, meninges, cranial nerves, or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.
Heart valve replacement or repair*	Refers to the surgical procedure of replacing a heart valve with either a natural or mechanical valve or repairing defects or abnormalities in a heart valve. The surgery must be deemed medically necessary by a specialist. The benefit is payable after a survival period of 30 days following the date of surgery.

Covered Illness	Conditions
Loss of independent existence	Refers to the complete inability to perform at least two out of six activities of daily living for a continuous period of at least 90 days, with no reasonable chance of recovery. The six activities of daily living are: a) Bathing - the ability to wash oneself in a bathtub, shower, or by sponge bath, with or without the use of assistive devices. b) Dressing - the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances, with or without the use of assistive devices. c) Toileting - the ability to get on and off the toilet and maintain personal hygiene, with or without the use of assistive devices. d) Bladder and bowel continence - the ability to manage bowel and bladder function in a way that maintains a reasonable level of hygiene, with or without the use of protective undergarments or surgical appliances. e) Transferring - the ability to move in and out of a bed, chair, or wheelchair, with or without the use of assistive devices. f) Feeding - the ability to consume prepared food or drink, with or without the use of assistive devices.
Loss of limbs	Refers to 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	Refers to one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions

Covered Illness	Conditions
Occupational HIV infection*	Refers to the infection with Human Immunodeficiency Virus (HIV) that occurs as a result of accidental injury during the person's normal occupation, which exposed them to HIV-contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the person's effective date of insurance or the effective date of an increase in coverage. To receive payment under this condition, the following requirements must be met: a) The accidental injury must be reported to Canada Life within 14 days of the incident. b) A serum HIV test must be taken within 14 days of the accidental injury, and the result must be negative. c) A serum HIV test must be taken between 90 and 180 days after the accidental injury, and the result must be positive. d) All HIV tests must be conducted by a licensed laboratory in Canada or the United States. e) The accidental injury must be reported, investigated, and documented in accordance with current Canadian or United States workplace guidelines.

Covered Illness	Conditions
Bacterial meningitis*	Refers to 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.
Aplastic anemia	Refers to 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: a) marrow stimulating agents; b) immunosuppressive agents; or c) bone marrow transplantation.

*See the **exclusions & limitations** page for details on exceptions to benefit provisions

EXCLUSIONS & LIMITATIONS

Coverage that has not been medically underwritten is subject to a pre-existing condition limitation, which applies during the first 2 years of coverage. Conditions for which the person obtained medical care in the 24 months before becoming insured may be excluded.

No benefits will be paid for:

1. a critical illness that is directly or indirectly related to a condition for which the person obtained medical care within 24 months before he became insured. Medical care is considered to be obtained when they consult a health care professional, use medication on the advice of a doctor, or receive other medical services or supplies, whether or not a specific diagnosis is made.

   This exclusion does not apply:

   a) if the illness is diagnosed after they have been continuously insured for 24 months; or
   b) to amounts of insurance which are subject to the underwriting provision.

2. a critical illness resulting directly or indirectly from or associated with any of the following:

   a) 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;

   b) war, insurrection, or voluntary participation in a riot;

   c) participation in a criminal offence or provoking an assault;

   d) 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; or

   e) an accident occurring while the person was operating a motorized vehicle if their blood alcohol level was higher than 80 milligrams of alcohol per 100 millilitres of blood

Benefits under this policy will be paid only after Canada Life has received satisfactory proof that payment is due.

The claimant must provide information required to prove his entitlement to benefits and must also authorize Canada Life to obtain information from other sources for this purpose.

Canada Life will not be liable for benefits for which proof is submitted more than 3 months after the earlier of:

1. the end of the critical illness survival period, where applicable; and
2. the date this policy terminates.

For most diagnoses, you must survive for at least 30 days from the date of diagnosis. The survival period is 90 days for paralysis and loss of independent existence.

Please see the table below for details on exclusions to covered illnesses:

Covered Illness	Exclusions
Heart attack	No benefits will be paid if there are elevated biochemical cardiac markers after an intra-arterial cardiac procedure without the presence of new Q waves. Additionally, ECG changes suggesting a prior myocardial infarction that do not meet the definition of a heart attack as described above will not be eligible for benefits.
Stroke	No benefits will be paid for transient ischaemic attacks or intracerebral vascular events caused by trauma. Lacunar infarcts that do not have the specified neurological symptoms and deficits persisting for more than 30 days do not meet the definition of a stroke.
Coronary artery bypass surgery	No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

Covered Illness	Exclusions
Cancer (life threatening)	No benefits will be paid for lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), tumours classified as Ta, any non-melanoma skin cancer, without lymph node or distant metastasis. Additionally, certain criteria must be met for specific types of cancer, such as melanoma skin cancer, prostate cancer, papillary thyroid cancer, follicular thyroid cancer, chronic lymphocytic leukemia, malignant gastrointestinal stromal tumors (GIST), and malignant carcinoid tumors. There is a cancer exclusion period. No benefits will be paid if, within the first 90 days following the late of the effective date of insurance or an increase, the person has signs, symptoms, investigations leading to a cancer diagnosis, or a diagnosis of cancer (covered or excluded under the policy). Medical information about the diagnosis and any related signs, symptoms, or investigations must be reported to Canada Life within six months of the diagnosis. Failure to provide this information within the specified period may result in the denial of any claim related to cancer or any critical illness caused by cancer or its treatment.
Dementia, including Alzheimer's disease	No benefits will be paid for affective or schizophrenic disorders, or delirium.

Covered Illness	Exclusions
Parkinson's disease and specific atypical Parkinsonian disorders	There is an exception to the benefit provision, as no benefits will be paid for any other type of parkinsonism. There is also a Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period. No benefits will be paid if, within the first year following thelater of the effective date of insurance or an increase, the person has signs, symptoms, investigations leading to a diagnosis of Parkinson's Disease, Specified Atypical Parkinsonian Disorders, or any other type of parkinsonism, or receives a diagnosis of any of these conditions. Medical information about the diagnosis and related signs, symptoms, or investigations must be reported to Canada Life within six months of the diagnosis. Failure to provide this information within the specified period may result in the denial of any claim related to Parkinson's Disease, Specified Atypical Parkinsonian Disorders, or any critical illness caused by these conditions or their treatment.
Loss of speech	No benefits will be paid under this condition for all psychiatric related causes.
Coma	No benefits will be paid for a medically induced coma.
Aortic surgery	No benefits will be paid for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures, or non-surgical procedures.

Covered Illness	Exclusions
Benign brain tumour	No benefits will be paid for pituitary adenomas that are less than 10 mm in size. There is also a benign brain tumour exclusion period. No benefits will be paid if, within the first 90 days following the later of the effective date of insurance or an increase, the person has signs, symptoms, or investigations leading to a diagnosis of a benign brain tumour (whether covered or excluded under the policy), or receives a diagnosis of a benign brain tumour. Medical information about the diagnosis and related signs, symptoms, or investigations must be reported to Canada Life within six months of the diagnosis. Failure to provide this information within the specified period may result in the denial of any claim related to a benign brain tumour or any critical illness caused by a benign brain tumour or its treatment.
Heart valve replacement or repair	No benefits will be paid for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures, or non-surgical procedures.
Occupational HIV infection	No benefits will be paid if: a) The person has chosen not to take any available licensed vaccine for HIV protection. b) A licensed cure for HIV infection becomes available before the accidental injury. It is important to note that non-accidental injuries, such as sexual transmission or intravenous (IV) drug use, do not meet the definition of Occupational HIV Infection.
Bacterial meningitis	No benefits will be paid under this condition for viral meningitis

Life Events and Making Changes

OVERVIEW

If you experience a **life event**, you have 31 days to make changes to your health, travel and dental coverage. You may also change your optional life insurance, AD&D insurance, and optional critical illness insurance at any time. Here are the changes you can make:

Important Deadline

You have 31 days following a life event to make changes to your health, travel and dental coverage; otherwise, you will need to provide **proof of good health** for health coverage and dental benefits will be limited. See the section **What Happens if I Don't Enrol in Time?** for more information.

Health coverage	You may change from single to family coverage, and vice versa, or add new **dependents**. **Proof of good health** may be required.
Dental coverage	You may change from single to family coverage, and vice versa, or add new dependents. If you choose Plan A, you can change to Plan B at any time. Once you choose Plan B, you cannot change back to Plan A afterward.
Travel coverage	You may change from single to family coverage, and vice versa.
Optional life insurance	You may change your level of coverage (for yourself and for your dependents) any time. You must provide proof of good health if you wish to increase your coverage.
Optional AD&D insurance	You may change your level of coverage at any time.
Optional critical illness insurance	You may change your level of coverage (for yourself and for your spouse) any time. You must provide proof of good health if you wish to increase your coverage.

CHANGE IN MARITAL STATUS

If you get married or start a common-law relationship, you have 31 days to enrol your new **spouse** in the benefits plan, provided your spouse meets the definition of spouse. If you apply for coverage after the 31-day limit, your spouse will need to provide **proof of good health**.

You can only cover one spouse at a time, so if you have a former spouse, you will need to remove their coverage.

If you get divorced or separated, you can continue to cover your former spouse under your health, dental and travel benefits, if you wish, but you may cover only one spouse. If your spouse is still covered under another group insurance plan, you may still coordinate benefits for your **children**'s covered expenses between your plan and your former spouse's plan.

What to Do

To add a new **spouse**:

1. Complete the Enrolment form. You can get a paper copy by contacting **Johnson Inc.**
2. Gather any supporting documents that may be required, such as a **proof of good health** medical questionnaire:
   - If you enrol your spouse within 31 days of the **life event**, you must submit proof of good health if you wish to purchase over $30,000 of optional life insurance for your spouse.
   - If you enrol your spouse within 31 days of the **life event**, you must submit proof of good health if you wish to purchase over $50,000 of optional critical illness for your spouse.
   - If you enrol your spouse in the PSGIP over 31 days after the life event, you must provide proof of good health for all coverage.
   - Depending on the responses in the proof of good health medical questionnaire, your spouse may be required to undergo a medical examination.
3. Return the form and any supporting documents to Johnson Inc.
4. Coverage will take effect once Canada Life approves the proof of good health, if any.

To remove a former spouse:

1. Notify Johnson Inc., in writing, of the change in your marital status.
2. Specify that you wish to terminate coverage for your former spouse.

DEPENDENT CHILDREN

If you welcome a new **child** into your home, either by birth or adoption, you have 31 days to enrol your new child in the plan, provided they meet the definition of child. Coverage for new borns begins at birth or on the date coverage would otherwise begin, whichever is later.

If your child is an overage student, meaning that they are over age 21, but under age 26, you can continue their benefits coverage, provided they are enrolled in full-time studies at an accredited learning institution. You can also continue coverage for overage children if they are physically or mentally disabled.

What to Do

To enrol a new child in the plan:

1. Complete the Enrolment form. You can get a paper copy by contacting Johnson Inc.
2. Gather any supporting documents that may be required, such as a **proof of good health** medical questionnaire (available on **canadalife.com** or by contacting Johnson Inc. at (902) 628-3537).
   - If you are applying to cover the child more than 31 days after having them, you must submit proof of good health. Depending on your responses, your child may be required to undergo a medical examination.
3. Return the form and any supporting documents to Johnson Inc.
4. Coverage will take effect as of birth, or once Canada Life approves the proof of good health, if any.

To declare an overage student

1. Notify Johnson Inc. when your child's dependent status changes. Each fall you must provide proof of full-time attendance at an accredited learning institution to confirm your child's continuing studies.

LEAVE OF ABSENCE OR LAYOFF

If you take an approved leave of absence (with or without pay), such as maternity or parental leave, or are on a layoff, all PSGIP coverage, except LTD, will continue.

With the exception of Optional Critical Illness and LTD, coverage can continue for up to 18 months (24 months for **Civil Service employees** employees on a leave of absence) following the month in which your leave or layoff began. You must pay the applicable premiums to maintain coverage.

Optional Critical Illness may continue for a maximum of six months.

LTD coverage may be continued for a maximum of:

- 3 months, if you are on a layoff or an unpaid leave of absence,
- until the end of the leave, if you are on maternity or parental leave, or
- 18 months for **Health PEI employees** and 24 months for Civil Service employees if you are on a paid leave of absence.

If you take an approved educational leave, benefits will be based on your actual salary. During a period of deferred salary leave, your benefits can be continued. Check with your supervisor or human resources manager for details.

What to Do

Johnson Inc. will contact you regarding your benefits arrangements and premium payments. If you have not been contacted by Johnson Inc. soon after your leave begins, call them directly at (902) 628-3537 or 1 800 371-9516.

DISABILITY

The continuation of your benefits while on LTD leave depends on the benefit and your employment group. Certain benefits could be continued without premium payments. Johnson Inc. will provide you with details at that time.

While you are receiving LTD benefits, an additional percentage of your **earnings** will be paid on your behalf to cover your contributions to the pension plan – the Civil Service Superannuation Fund.

What to Do

Notify **Johnson Inc.** of your disability no later than eight weeks before your qualifying period ends, even if you are applying for workers' compensation benefits. A Johnson Inc. representative will then send you the information and forms you need to apply for LTD benefits and premium waiver. Johnson Inc. will help guide you through the disability process and can help you gather other information needed by Canada Life, the insurance company that handles disability claims.

For more information on applying for LTD benefits, see the **Disability** section and the guide How to apply for long-term disability benefits (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537).

LOSS OF SPOUSAL COVERAGE

If you did not choose PSGIP's health, dental or travel coverage because you were covered under your **spouse**'s plan, you may join the PSGIP if your spouse's coverage ends. You have 31 days following the end of your spouse's coverage to enrol without having to provide **proof of good health**.

What to Do

1. Complete the Enrolment form. You can get a paper copy by contacting **Johnson Inc.**
2. Gather any supporting documents that may be required:
   - If you choose family coverage and have an overage student **dependent** (age 21 to 26), you must provide confirmation of your **child**'s continuing attendance at an accredited college or university each year for continued coverage.
   - If your child is disabled and over age 21, you must provide satisfactory proof that they are incapable of self-support because of the disability.
   - If you enrol in the PSGIP over 31 days after your eligibility date, you must provide **proof of good health** for health coverage.
   - Depending on responses in the proof of good health medical questionnaire, you or your **spouse** may be required to undergo a medical examination.
3. Return the form and any supporting documents to Johnson Inc.
4. Coverage will take effect once Canada Life approves the application and proof of good health, if any.

LEAVING YOUR EMPLOYMENT

If you leave your employment, your PSGIP coverage will end on your termination date. However, if you are a **Health PEI employee**, all coverage (except for LTD) will end on the first day of the month following your termination of employment.

If your employment ends for reasons other than retirement and you are age 50 or over, you may be eligible for certain retiree benefits (years of service may apply). For details, contact **Johnson Inc.** at (902) 628-3537 or 1 800 371-9516.

Converting Your Coverage

If you are under age 65, you have 31 days to convert your basic and optional life and AD&D coverage to individual policies, without providing **proof of good health**, when you leave your employment. After 31 days, you will no longer be eligible to convert your coverage. For details, contact Johnson Inc. at (902) 628-3537 or 1 800 371-9516.

In Cases of LTD Payments

LTD benefits will extend beyond your termination date provided you became disabled while you were still insured. LTD benefits will continue to be paid according to the contract provisions regardless of the subsequent termination of the group policy.

Canada Life reserves the right to request that you provide proof of the continuance of your **total disability**, and submit to an examination by Canada Life's medical advisors when requested.

What to Do

1. If you have any outstanding claims for eligible health and dental expenses, Canada Life must receive your health or dental claim within 90 days after your termination date for your claim to be processed.
2. If you wish to convert your life insurance and AD&D insurance to individual policies, call Johnson Inc. at (902) 628-3537 or 1 800 371-9516. Johnson Inc. will send your request to the insurer on your behalf. The insurer will then send you an information package, including premium rates for individual insurance policies. Remember, you have 31 days to submit your application for conversion.
3. Also call Johnson Inc. for coverage details should your employment end for reasons other than retirement and you are age 50 or over.

WORKING PAST AGE 65

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

Health	You become eligible for the Seniors' Drug Cost Assistance Program (DCAP) at age 65. As an active employee, the PSGIP will continue to be the first payer on drug claims, but you can submit any amounts not covered under the PSGIP to the DCAP for possible reimbursement.
Travel	At age 70, your travel coverage moves under the PSGIP retiree plan, where there are some limitations, such as: • coverage is limited to the first 180 days of your trip, and • pre-existing medical conditions must be stable prior to travelling.
Basic AD&D and basic life for your dependents (for Health PEI only)	Coverage ends at age 65. When you reach age 65, you have 31 days to convert your Basic AD&D coverage to an individual policy, to a maximum of $200,000 when combined with any Optional AD&D coverage, without providing **proof of good health**.
Optional life, optional AD&D and optional critical illness	Coverage ends at age 65. When you reach age 65, you have 31 days on or before your 65th birthday to convert your Optional AD&D coverage to an individual policy, to a maximum of $200,000 when combined with any Basic AD&D coverage, without providing proof of good health.

What to Do

Contact **Johnson Inc.** to inform them that you have reached age 65 and to inquire about converting your coverage.

RETIREMENT

When you retire, you have the option to join the Retiree Public Sector Group Insurance Plan (PSGIP). Membership in the plan is voluntary and is 100% retiree-paid.

As you prepare for retirement, there are a few important things you need to know about the retiree plan, like the coverage it offers, how it differs from your current coverage, the rules for joining and associated costs.

The best place to start is to view the **Retirement Planning video**.

You can find more information and details in the **Retiree Benefits Guide**.

Inside the **Retiree Benefits Guide**, you'll find:

- **A benefits at-a-glance overview** of the options available for health, travel and dental coverage, as well as life and accident insurance options during your retirement,
- **Benefit rules during retirement** outlining the restrictions and limitations for enrolling in the retiree health, dental and travel plans, opting out and the rules for rejoining at a later date,
- **A comparison** of the differences between active and retiree coverage,
- **A list of thing to consider** when choosing your health care option,
- **A cost estimate example** to help you understand your health care needs and determine which health option will work best for you,
- **Information on life and accident insurance options** at retirement, including conversion to an individual policy,
- **A Retiree Checklist** to review and assist as you prepare for retirement, and
- **Contact information** for Johnson Inc. if you have questions or need more information.

To better understand the costs of the various plan options under the retiree plan, view the current **Retiree Benefits Rate Sheet**. Rates are reviewed on an annual basis and are subject to change.

Summary of Coverage Changes at Retirement

Here is a snapshot of what will happen to your benefits when you retire.

Health benefits	Your current coverage will end. However, if you had coverage as an active employee, you may choose one of four coverage options available to retirees and their **dependents**. You will receive details upon retirement. **Note:** If you were in the health plan for active employees upon your retirement, you will have 31 days following your retirement date to elect an option without having to provide **proof of good health**. You will have an opportunity to change your health plan option on April 1 of each year during your retirement.
Dental benefits	If you had coverage as an active employee, you may continue your dental coverage for you and your **dependents** upon retirement. If you have Plan B as an active employee, you may reduce your coverage to Plan A upon retirement. You will have an opportunity to change your dental plan option on April 1 of each year during your retirement.
Disability benefits	Coverage will end at retirement or age 62, less the waiting period, whichever is earlier.
Travel benefits	If you had coverage as an active employee, you may continue your travel coverage for you and your **dependents** upon retirement.

Death benefits	**Your coverage** Your current basic coverage will end. If you retire at or after age 55 with 10 years of service as a **Civil Service employee** or with two years of service as a **Health PEI employee**, you are automatically covered for $5,000 of retiree life insurance. **Note:** If you hold two positions at any time, one with Civil Service and one with Health PEI, your retiree life insurance is limited to $5,000. If you are a Civil Service employee, you will be covered throughout retirement for basic AD&D insurance of $5,000, at no cost to you. You may also maintain any optional life and AD&D coverage until age 65. You can convert your current coverage to individual policies if you retire prior to age 65. **Your family's coverage** Your family's current basic life and AD&D coverage will continue at no cost. If you retire from the **Health PEI**, this coverage will end on the first day of the month following your 65th birthday. You may also maintain your family's optional life and AD&D coverage until you reach age 65. You can convert your family's current coverage to individual policies if you retire prior to age 65.

If you choose to end your health, dental or travel coverage at retirement because you are covered under your **spouse**'s plan, you may re-join the PSGIP if coverage under your spouse's plan ends, provided you apply for coverage within 31 days of your spouse loosing coverage.

What to Do

1. When you know your retirement date, call Johnson Inc. at (902) 628-3537 or 1 800 371-9516. Johnson Inc. will provide you with all the details you need about the coverage available to you and to your family during retirement.
2. If you have any outstanding claims for eligible health and dental expenses, you have 90 days after your termination date to submit a health or dental claim to Canada Life.
3. When you retire, visit the PSGIP Retiree benefits website at **mybenefitplan.ca** or consult the PSGIP Retiree Benefits Booklet for ongoing information about your plan.

DEATH

If You Pass Away

If you pass away, your beneficiary will receive the following death benefits:

- Basic life insurance + optional life insurance (if you purchased optional coverage)

Plus, if the death was as a result of an accident

- Basic AD&D insurance + optional AD&D insurance (if you purchased optional coverage)

Basic life insurance and AD&D insurance are not available if you are a **Civil Service** – Class 2 employee working less than 40% of the normal weekly working hours or a Civil Service – Class 4 **temporary employee** working less than 40% of the normal weekly working hours.

BENEFITS COVERAGE FOR YOUR FAMILY

Your **dependents**' health, dental and travel coverage will continue, provided they pay the cost of coverage. Your surviving **spouse** has 31 days after your death to choose to continue coverage.

Coverage for your eligible dependents will continue until the earliest of the following dates:

- the date your surviving spouse passes away,
- the date your dependents no longer meet the definition of eligible dependents, and
- the date this plan terminates or this coverage has ended.

For life and AD&D coverage, your eligible dependents can convert their coverage (if applicable) into individual policies. If an application for conversion is made within 31 days of your death, no proof of insurability will be required. Your dependents can apply for conversion by calling Johnson Inc. at (902) 628-3537 or 1 800 371-9516.

WHAT TO DO

If you pass away, someone will need to inform Johnson Inc. of your death. A representative will then provide the necessary information and documentation.

If Your Spouse or Child Passes Away

If your spouse or **child** passes away, you will receive the following death benefits:

- Basic life insurance + optional life insurance (if you purchased optional coverage)

Plus, if the death was as a result of an accident

- Optional AD&D insurance (if you purchased optional coverage)

WHAT TO DO

If your spouse or child passes away, you need to inform Johnson Inc. of your dependent's death. A representative will then provide the necessary information and documentation.

Health, Travel and Dental Claims

HEALTH, TRAVEL AND DENTAL

You have two main options for submitting most of your health, travel and dental claims – online and paper claim form.

Deadline for Submitting Claims

You must submit your claim and receipts within the following deadlines or they will not be reimbursed:

Online claims	Within 6 months after incurring the expense
Paper claims	Within 12 months after incurring the expense

Online Claims

If you register for Canada Life's My Canada Life at Work online secure site and for direct deposit, you will be able to submit a number of health and dental claims online and receive your reimbursement faster. To register, go to **www.mycanadalifeatwork.com**. Then follow the links to register.

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

Get your claims reimbursed faster when you submit your claims online and enrol for direct deposit. Be sure to sign up for Canada Life's My Canada Life at Work.

Paper Claims

To submit a paper claim, complete the appropriate form (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537):

- Health Benefits Claim form,
- Statement of Claim Out-of-Country Expenses form, or
- Dental Benefits Claim form.

You can access the forms online or request paper copies of the form from Johnson Inc.

To avoid any delays in processing your health or dental claim, be sure that all sections of your claim form are complete and that your receipts are attached.

Remember, always provide your group policy number (56530) and your identification number, which can be found on your pay-direct drug card.

It is important to indicate if you have benefits under another plan, such as your **spouse**'s plan. If this information is not included, your claim cannot be processed.

Staple receipts and any other required documentation to your claim form before mailing. For drugs, be sure to include the pharmacy receipt. Don't forget to keep a copy for your records.

Direct Deposit

You can have Canada Life deposit your claim reimbursements directly into your bank account. It's a fast and convenient way to receive your health and dental reimbursements.

To sign up for direct deposit, go to **www.mycanadalifeatwork.com** and follow the steps online. Alternatively, you can contact Canada Life directly and a representative will talk you through the steps for signing up. Canada Life will not take banking information over the telephone. You will need to submit this information by mail.

The initial set-up takes one to two weeks. Afterward, deposits should take only one to two days.

Helpful Tips for Submitting Claims

The steps for making a claim will depend on the eligible expense you are claiming. See the expense below for specific instructions.

If you have a question about a health claim, contact Canada Life at 1 800 957-9777.

Prescription drugs	**Paying with Your Pay-Direct Drug Card** • Give your pay-direct drug card to the **pharmacist**. • The pharmacist will enter the data on your card and your prescription into their system. • Within seconds, this data is electronically processed, and the system will indicate your portion of the cost. • You pay for only your portion of the cost. • Your claim is submitted automatically, which means you do not need to submit a claim form to Canada Life. • If you also have coverage under your **spouse**'s plan, you may use your drug card for that plan too. **If You Don't Have Your Pay-Direct Drug Card** • Pay the total cost up-front and ask for a receipt. • Complete an online claim or submit a paper claim form to Canada Life. **Note:** Your receipt must show the prescription number and the name of the drug or the Drug Identification Number (DIN).

Paramedical practitioners **Vision care** **Out-patient services and supplies** **Ambulance services**	• Pay the total cost up-front and ask for a receipt. • Complete an online claim or submit a paper claim form to Canada Life.
Hospital accommodations	• You have no claim form to complete. Simply provide the plan's policy number and your certificate number, which you can obtain from your pay-direct drug card or from Johnson Inc. • The **hospital** will invoice Canada Life directly. • If you have chosen a private room, the hospital will bill you directly for the portion of your expenses not covered by the plan.
Private-duty nursing	• Obtain written confirmation from your doctor that the service is **medically necessary**. • Obtain approval from Canada Life prior to receiving any private nursing care. • Once you are receiving nursing care, you must obtain a claim form from Canada Life specifically for this purpose. • Complete the claim form and submit it to Canada Life.
Medical equipment and supplies	• Where applicable, before you incur an expense, ask Canada Life to approve the expense. • Pay the total cost up-front and ask for a receipt. • Complete an online claim or submit a paper claim form to Canada Life. **Note:** For diabetic supplies, you can simply use your pay-direct drug card.

Accidental dental treatment	• Submit a treatment plan within 180 days of the impact for treatments scheduled to occur more than 180 days following the impact. • Pay the total cost up-front and ask for a receipt. • Complete a claim form. Indicate on the form that the expense is the result of an accident. Canada Life will require details of the accident and possibly X-rays. • Submit the claim form and your receipt to Canada Life.
Travel	• When you travel, be sure to carry your travel assistance card at all times. • If you become ill or injured, you or your representative should immediately call the number on the card. • If a medical provider or **hospital** bills you directly, send the bill along with your claim form to: Assistance Centre – Claims Department P.O. Box 97, Station A Mississauga, ON L5A 2Y9 • You must submit your claim form within 12 months after incurring the expense. • If you have any claim questions or require an out-of-country claim form, please call the Canada Life Customer Care Centre toll free at 1 800 957-9777. **Claims for Referrals** Before you incur eligible expenses, you must provide Canada Life with: • Full details from the **physician** regarding the treatment, and • A statement from the provincial health plan that describes what it will cover. After you have incurred an eligible expense and the provincial plan has already paid its portion, complete an online claim or submit a paper claim form for the unpaid portion to Canada Life.

Dental	• Ask your **dentist** if they can bill Canada Life directly. • If your dentist bills Canada Life directly: – Pay only your portion of the cost. You have no claim form to submit. • If your dentist does NOT bill Canada Life directly: – Pay the total cost up-front and ask for a receipt. – Complete an online claim or submit a paper claim form to Canada Life. • For orthodontic treatments, obtain a treatment plan from your dentist and submit it to Canada Life. The plan will pay 50% of the eligible expense up to the maximum, as follows: 30% of the cost at the beginning of the treatment, excluding the diagnostic fee, and the rest on a monthly or quarterly basis depending on how the dentist bills for the services or how you submit receipts. No advance payments will be made.

COORDINATION OF BENEFITS

If you and your **spouse** both have family coverage, you may submit your claims to both plans and get reimbursed for up to 100% of your covered expenses.

The steps to follow will depend on who incurred the expenses:

Your expenses	The PSGIP is the first payer.
Your spouse's expenses	Your **spouse**'s plan is the first payer.
Your children's expenses	Submit a claim to the plan of the parent whose birthday falls first in the calendar year. For example, if your birthday is March 11 and your spouse's birthday is July 8, submit claims for your **children**'s expenses to the PSGIP first, and then to your spouse's plan. **Be sure to keep copies of your receipts.**

Coordination of Benefits with Pay-Direct Drug Cards

If you and your **spouse** both have family coverage and your spouse has a drug card under their plan, the **pharmacist** can use your PSGIP drug card to electronically process claims under both your plan and your spouse's plan, right on the spot.

Life, Accident and Disability

LIFE AND AD&D CLAIMS

If You Pass Away

- Someone must inform Johnson Inc. of your death by calling (902) 628-3537 or 1 800 371-9516. A representative will then provide the necessary information and documentation.
- To submit a claim, your beneficiary must complete the applicable claim form and submit it along with proof of death as soon as possible. Johnson Inc. will advise you of all documents that must be submitted. There are important deadlines to be aware of to ensure continuation of coverage for your **dependents**.

If Your Spouse or Child Passes Away

- Inform Johnson Inc. at (902) 628-3537 of your dependent's death. A representative will then provide the necessary information and documentation.

If You or Your Dependents Suffer a Loss, Other Than Loss of Life, as a Result of an Accident

- Report the claim by calling Johnson Inc. at (902) 628-3537 or, if you are outside the Charlottetown area, 1 800 371-9516. Johnson Inc. will provide you with a claim form and a list of any other required documents.
- Complete and return the claim forms and supporting documents to Johnson Inc. within 30 days of the accident. Your claim will still be valid if it is not reasonably possible for you to provide the written notice or proof within the 30-day deadline. However, you must provide notice or proof no later than one year after the accident.

DISABILITY CLAIMS

Before your sick leave benefits end, call Johnson Inc. at (902) 628-3537 or 1 800 371-9516 to notify them of your disability, even if you are applying for workers' compensation benefits. Be sure to mention the policy number (165211). A representative will then send you the necessary information and forms required to file long-term disability premium waiver and AD&D benefits (where applicable).

- Complete the forms. Your attending **physician** must also complete a portion of the forms.
- Return the completed forms to Johnson Inc. within six months from the end of the qualifying period.

For more detailed step-by-step instructions, see the guide How to apply for long-term disability benefits (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516).

Note: Canada Life reserves the right to request proof of the continuance of **total disability**, and to have you submit to an examination by Canada Life's medical advisors when requested.

OPTIONAL CRITICAL ILLNESS CLAIMS

If You or Your Spouse is Diagnosed with a Serious Illness

- You may contact Johnson Inc. by calling (902) 628-3537 or 1 800 371-9516. A representative can then provide the necessary information and documentation.
- To submit a claim, you or your spouse must complete and submit the applicable claim forms and, such as the physician's report, claimant statement and employer statement, as soon as possible. Johnson Inc. will advise you of all documents that must be submitted **LINK**.

Forms and Documents

You can print hard copies of all forms and documents from the benefits website at mybenefitplan.ca or contact Johnson Inc. at (902) 628-3537 or 1 800 371-9516 to request copies.

FORMS

To enrol for benefits or make a change, such as adding a new dependent	· Enrolment form · Beneficiary Designation form · Medical questionnaire
To submit a health claim	· Health Benefits Claim form
To submit a dental claim	· Dental Benefits Claim form
To submit an out-of-country expense claim	· Statement of Claim Out-of-Country Expenses form
To request coverage for a brand name drug	· Canada Life Request for Brand Name Drug Coverage form
To submit a complaint to the PSGIP Trustees	· PSGIP Complaint form

DOCUMENTS

For quick reference of your benefits coverage	· Benefits At-a-Glance
If you need a print copy of your benefits coverage	· PSGIP: Active Employee Booklet
For information about your travel coverage	· TravelAssist brochure
For information about confidential services and support resources	· Employee Assistance Program – gov.pe.ca/psc/eap/
For information on benefits during retirement	· Retiree Benefits Guide
For information on how to apply for LTD benefits	· How to apply for long-term disability benefits

Contacts

JOHNSON INC.

Johnson Inc. is your benefits resource and the plan administrator of all your benefits. This means that with respect to your benefits they:

- determine your eligibility for coverage,
- answer your questions,
- keep your records, and
- make sure you receive all necessary documents.

Keep Your Personal Information Up-to-Date

Don't forget to contact Johnson Inc. if you have a change in your personal information, such as an address or to add or remove a dependent.

They handle claims for disability, AD&D and death benefits. When you call, be sure to specify the applicable policy number:

- Basic life, dependent life and disability: 165211
- Optional life: 159864
- Basic AD&D: AB10232401
- Optional AD&D: OE10232401
- Optional critical illness: 162666GOCI

When to Contact Johnson Inc.

For information about coverage or to make changes **To claim disability, AD&D, optional critical illness or death benefits** (Does not include inquiries related to claim reimbursements, which should be directed to Canada Life)	**Johnson Inc.** (902) 628-3537 – Charlottetown area 1 800 371-9516 – Toll free 8:30 a.m. – 4:30 p.m., Monday to Friday Johnson Inc. (to mail) PO Box 4319 STN A Toronto, ON M5W 3G5 Johnson Inc. (to walk-in/visit) 201 Buchanan Drive (Buchanan Plaza) Charlottetown, PEI C1E 2E4 PEI@johnson.ca johnson-insurance.com/Members-Only/ (go to the "Members Only" section)
For questions about group home and auto insurance or to enrol for these plans	**Johnson Inc.** Home and Auto – 24/7 Claims Service 1 888 737-1689 johnson.ca

Although Johnson Inc. is the plan administrator, Canada Life insures benefits in the event of disability or natural death, and Chubb Life Insurance Company of Canada (Chubb) insures benefits in the event of a serious accidental injury or accidental death.

CANADA LIFE

Canada Life is the plan's insurer and claim adjudicator for health and dental benefits.

When you call, be sure to specify the policy number (56530).

When to Contact Canada Life

For questions about health and dental claims	**Canada Life** 1 800 957-9777 8:30 a.m. – 4:30 p.m., Monday to Friday For online claims and benefits information, visit the Canada Life member website. Select "GroupNet for Plan Members" from the left menu to login. canadalife.com To submit a paper claim form: Canada Life 47C Beach Grove Road Charlottetown, PEI C1E 1K5

Canada Life Online

Managing your health and dental claims is easy when you are registered on Canada Life's GroupNet for Plan Members' online secure site – **canadalife.com**. Once you've registered you can:

- arrange for direct deposit for claims reimbursement,
- submit many of your claims online,
- track your claims and review your claims history,
- get access to personalized information about your coverage,
- get personalized claim forms for paper claim submissions,
- view your benefits booklet and a benefits summary,
- print a copy of your benefits card, and
- access extensive health and wellness content.

CANADA LIFE MOBILE APP

Download Canada Life's free Canada Life Mobile app and access the convenience of My Canada Life at Work from your smartphone, including submitting many of your claims online and accessing personalized coverage and claims information right from your phone.

ASSURED ASSISTANCE INC. – TRAVEL ASSISTANCE PROVIDER

Assured Assistance Inc. is the plan's travel assistance provider.

When you call, be sure to specify the policy number (335336).

When to Contact Assured Assistance Inc.

For questions about claims and coverage information	**Assured Assistance Inc.** In the event of an emergency: Toll free: 1 866 530-6024, from Canada or the United States Collect: (905) 816-1901 For general inquiries regarding claims or coverage: Toll free: 1 800 957-9777 (Canada Life) To submit a claim form: Assured Assistance Inc. Assistance Centre – Claims Department P.O. Box 97, Station A Mississauga, ON L5A 2Y9

EMPLOYEE ASSISTANCE PROGRAM

The **Employee Assistance Program (EAP)** is designed to help employees experiencing personal problems, which may affect job performance. EAP helps employees solve problems as early as possible before they seriously affect self, family, and work performance.

For information about confidential services and support resources	**Employee Assistance Program (EAP)** Toll free: 1 800 239-3826. gov.pe.ca/psc/eap/

TRUSTEES

To contact the PSGIP Trustees	**Public Sector Group Insurance Plan** (902) 626-2500 psgiptrustees@hratlantic.ca 20 Great George Street, Unit 201 Charlottetown, PE C1A 4J6 Feedback on the service provided or your experience accessing the service can be directed to the Trustees at the address or phone number listed above. For more information about the Trustees, see the PSGIP Trustees section.

Glossary

Brain death	Irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain, even though the heart is still beating.
Child/children	Your natural, legally adopted, step or other eligible child* who meets all of the following requirements: • unmarried, • not cohabiting in a conjugal relationship with another individual, • totally dependent on you for support and maintenance, • one of the following ages: – under age 21, – under age 26 if a full-time student at an accredited post-secondary institution**, – of any age if physically or mentally disabled, but otherwise qualifies under this definition, provided they became disabled while covered by the plan and you provide satisfactory proof that your child is incapable of self-support as a result of the disability***, • living in Canada, unless a full-time student elsewhere, and • not in the armed forces (except for optional and dependent life insurance coverage). * The plan can also include the natural or legally adopted child of your common-law spouse and another person, a child who resides with you and is not eligible for publicly provided benefits substantially equivalent to those provided under the plan and in respect of whom you have legal custody or guardianship, and any child who lives with you and is totally dependent on you and/or your spouse for support. Totally dependent means that no support or maintenance of a financial nature is paid or payable on account of this child by an individual other than yourself and/or your spouse and no other individual receives (or would be eligible to receive if application were made) publicly funded benefits or tax credits on account of this child. ** Confirmation of enrolment as a full-time student must be provided. *** Proof of your child's continuing disability and incapability of self-support may be required from time to time. Coverage may be terminated if the child becomes capable of self-support.

GLOSSARY

Civil Service employees	**Class 1**	• Permanent full-time employees • Permanent part-time employees (including provisional and probationary employees) with a guarantee of at least 40% of the normal working hours for at least 6 months • Contract employees for whom benefit eligibility is specified in the employment contract
	Class 2	• Permanent part-time employees (including provisional and probationary employees) with a guarantee of less than 40% of the normal working hours
	Class 4	• Temporary employees after 6 months of continuous employment
Dentist	A doctor of dental surgery or a doctor of dental medicine licensed to practice and prescribe in the area where services are rendered.	
Dependents	Your eligible spouse and children.	
Earnings	For permanent employees, earnings will be based on gross earnings, excluding bonuses, overtime and commissions. For permanent part-time CUPE Health PEI, UPSE Health PEI and UPSE Civil Service employees, earnings for LTD benefits will be based on regular earnings for the previous calendar year. However, earnings will never be less than the employment guarantee. For long-term disability benefits for any other permanent part-time Health PEI IUOE or PEINU employees, and life insurance benefits for permanent part-time or temporary part-time Civil Service employees, earnings will be based on guaranteed earnings.	

GLOSSARY

Health PEI employees	You are part of Health PEI if you belong to any of the following groups: • Canadian Union of Public Employees (CUPE) • Excluded employees/physicians • International Union of Operating Engineers (IUOE) • Non-union, non-excluded employees • Prince Edward Island Nurses Union (PEINU) • Prince Edward Island Union of Public Sector Employees (UPSE) You may join the PSGIP if you are: • a permanent full-time employee working at least 30 hours per week, • a permanent part-time employee working less than the fully prescribed hours of work on a recurring and regularly scheduled basis, • a temporary UPSE, IUOE, PEINU or excluded employee hired for 12 months or more. **Note:** If you are a casual UPSE employee and you had coverage before August 1, 1995, you may continue your coverage in effect on August 1, 1995. However, you are not eligible for any additional benefits.

GLOSSARY

Hospital	A facility that is licensed to provide active treatment for sick or injured patients. It does not include rehabilitation hospital, mental institution, convalescent hospital or home, an institution used primarily for treatment of a specific illness or disease, a nursing home, a chronic care facility, a home for the aged, a rest home or any other facility that provides similar care. Beds set aside for chronic care in a hospital are not covered. **Regarding accidental injury or death benefits** For in-hospital confinement monthly income, hospital means a legally constituted establishment that meets all of the following conditions: • operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients, • provides 24-hour 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, and • is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.
Immediate family	"Immediate family" refers to a spouse (or common-law spouse), parents, grandparents, children over age 18, brothers or sisters.
Irreversible	Irreversible means the condition cannot be improved by medical or surgical treatment at the time of diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the health of the person.

GLOSSARY

Life event	Qualifying life event includes: • A change in your marital status, either a marriage or common-law relationship, or a divorce or separation, • The birth or adoption of a child, • The death of a dependent, or • The loss of benefits coverage under a spousal program. If you experience a life event, you have 31 days to register the event and make your benefit changes.
Medically necessary	A service or supply provided or prescribed by a health care professional to prevent, diagnose, or treat an injury, disease, or disability that is: • consistent with the treatment of symptom(s) or diagnosed injury, disease, or disability, • not primarily prescribed or provided for convenience, • the most appropriate, safe, and cost-effective service or supply, and • generally recognized as accepted medical practice. When the plan refers to a health care professional, it means a person who is legally licensed to practice their profession where services are rendered, and includes physicians, pharmacists, dentists, and other professionals as approved by the plan.
Nurse practitioner	A nurse practitioner of medicine who is legally licensed to prescribe drugs and administer medical treatment within the scope of their license.

GLOSSARY

Permanently and totally disabled	Under AD&D insurance coverage, permanent and total disabled means that after 365 days from the date of an accident you are completely and irreversibly unable to perform at least two of the six Activities of Daily Living without assistance from another person, as deemed by a Physician and as supported by objective medical evidence. Activities of Daily Living mean the following: 1) Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. 2) Dressing: Putting on and taking off all items of clothing and any required braces, fasteners or artificial limbs. 3) Transferring: Moving into or out of a bed, chair or wheelchair. 4) Toileting: Getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene. 5) Continence: Ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag). 6) Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table).
Pharmacist	A pharmacist who is legally licensed to prescribe drugs within the scope of their license.
Physician	A doctor of medicine who is legally licensed to prescribe drugs, administer medical treatment, and perform surgery within the scope of their license.
Professional counsellor	A therapist or counsellor who is licensed, registered or certified to provide the applicable treatment or counselling.
Proof of good health	Medical questionnaire that you must complete to show the status of your health. Depending on your answers, Canada Life can require a medical examination and any other information.

GLOSSARY

Reasonable and customary	Canada Life reimburses expenses based on Reasonable and Customary charges. Generally this is the lowest of the following: • Representative pricing in the area where the treatment is provided. • Prices shown in the applicable professional association fee guide and the maximum prices established by law.
Specialist	A specialist is a licensed and certified medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed. Specialists include, but are not limited to, cardiologists, neurologists, nephrologists, oncologists, ophthalmologists, burn specialists and internists. The specialist must not be the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.
Spouse	The person to whom you are legally married, or the person of the same or opposite sex with whom you have been living in a common-law relationship for at least 12 months. **Note:** • Your spouse must live in Canada, unless they are a full-time student elsewhere. • The plan does not cover any spouse in the armed forces (except for optional and dependent life insurance coverage). • The plan covers only one spouse at a time.

GLOSSARY

Temporary employee	An employee in the unclassified division engaged to perform specific duties for a specified time period because of: • a leave of absence of a classified employee through sickness, accident, vacation or other approved leave of absence, • a vacancy in a classified position while an employing authority is determining whether or not a position is to be filled, or • the initiation of a special project including an extra workload. **Note:** If you are a temporary employee and you have a break in service greater than 28 days, you must fulfil a new waiting period.
Totally disabled/ total disability	Under LTD coverage, totally disabled means: During the qualifying period and the following 24 months of disability, illness or injury must render you physically or mentally incapable of performing the essential duties of your normal occupation. If during this period another occupation becomes available for which you are qualified, and you are mentally and physically able to perform the essential duties of this job, you must accept it. Otherwise, benefits will end. After the qualifying period and the following 24 months of disability, illness or injury must render you physically or mentally incapable of being gainfully employed for: • any occupation for which you are or may become qualified by education, training or experience, and • any occupation that pays 75% or more of the current monthly earnings for your normal occupation.

GLOSSARY

Usual cost	The usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy. The plan will only cover: • the amount that is usually charged for the service or supplies in the area in which the charge is made, • services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of the Canadian health care, • services and supplies that the plan is legally allowed by the government to cover. The plan will not cover services or supplies that are covered by the government plan in the insured person's home province, • charges for services and supplies that are incurred while the person is insured, • charges for services and supplies for the least expensive treatment that is medically adequate.