Public Sector
Group Insurance Plan

RETIREES

PSGIP Benefits Booklet

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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.

If you are a retiree of CUPE Locals 1145, 1770, 1775 and 3620, City of Charlottetown, Innovation PEI, Island Waste Management Corporation (IWMC) or WCB of PEI, coverage is available for health, travel and dental benefits only.

- Health
- Travel
- Dental
- Basic Life and AD&D Insurance
- Optional Life and AD&D Insurance

HEALTH

Supplements your provincial health coverage.

Reimbursement*	Option 1	Option 2	Option 3	Option 4
Prescription drugs (mandatory generic substitution)	• 80% of the first $150 per eligible drug expense, and 100% thereafter	• You pay an annual** deductible before drug coverage begins: $300 single $600 family*** • 80% of the first $150 per eligible drug expense, and 100% thereafter	• You pay the first $50 per eligible drug expense, and 100% thereafter	• Coverage for vaccines only: 80%, to a $500 lifetime maximum per person
	Reimbursement is based on your prescription drug coverage option: • $500 lifetime maximum per person for vaccines • $300 lifetime maximum for smoking cessation products (limited to 50% reimbursement) • $250 maximum per calendar year for sexual dysfunction medications • Pay-direct drug card (reimbursement is processed at point-of-sale, where available)			

Reimbursement*	Option 1	Option 2	Option 3	Option 4
Hospital accommodations	• No private or semi-private coverage under Options 1, 2 & 3 • Ward coverage provided under the provincial plan			• 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% • 20-visit maximum per calendar year for physiotherapist • $240 maximum per calendar year for massage therapists and occupational therapists • $12 per visit, to a maximum of 20 visits per practitioner per calendar year for chiropodists or podiatrists (plus cost of laboratory tests and x-rays), chiropractors and osteopaths			
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% • $80 maximum once every 2 calendar years (every calendar year for children age 18 and under)			

Reimbursement*	Option 1	Option 2	Option 3	Option 4
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.

** Benefit year is from April 1 to March 31

*** $600 family refers to $300 for yourself and another $300 for all of your eligible **dependents** combined

TRAVEL

Supplements your provincial health coverage.

Reimbursement	100%
Emergency out-of-province/ country health care	$1 million maximum per emergency Coverage for the first 180 days of a trip Medical conditions must be **stable** (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 5 months	80% Recall exams once every 5 months
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% $500 maximum per calendar year
Dental fee guide	Current year fee guides for general practitioners	

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (for retirees of Civil Service and Health PEI only)

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

	Retiree Life and Basic Dependent Life*	Basic AD&D**
Coverage		
Retirees of Civil Service	$5,000 (retired at or after age 55 with 10 years of service and eligible for a pension)	$5,000 (retired at or after age 55 with 2 years of service)
Retirees of Health PEI	$5,000 (retired at or after age 55 with 2 years of service)	–
For your spouse* **	$4,000**** (optional coverage)	–
For your children	$3,500**** per child (optional coverage)	–

* If you retired from the Civil Service before June 1, 1997, with a pension from the Pension Plan, and you pass away before age 65, you are covered for your basic life insurance in effect prior to your retirement.

** If you retired from the Civil Service before June 1, 1997, coverage for basic AD&D insurance is equal to 2 X your pre-retirement earnings, up to age 65 ($5,000 afterward).

*** Coverage is equal to $3,500 if you were a permanent, full-time UPSE employee who transferred from the Civil Service to the Health Sector on August 1, 1995, and remained an UPSE employee.

**** If you retired from Health PEI, this basic coverage will end on the first day of the month following your 65th birthday. If you retired from the Civil Service, it will continue for life.

OPTIONAL LIFE AND AD&D INSURANCE (for retirees of Civil Service and Health PEI only)

Provides additional financial security to enhance your basic coverage.

	Optional Life	Optional AD&D
Coverage		
For you	Your amount in effect before retirement, up to a maximum of $300,000	Your amount in effect before retirement, up to a maximum of $300,000
For your spouse	Your **spouse**'s amount in effect before retirement, up to a maximum of $300,000	50% of your optional AD&D coverage (60% if you have no children)
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
Termination of coverage	Age 65	Age 65

Plan Costs

YOUR COSTS

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

		Retirees Under Age 65	Retirees Over Age 65
Health	**Option 1**		
	Single	$296.40	$238.67
	Family	$631.25	$508.19
	Option 2		
	Single	$254.11	$185.88
	Family	$547.05	$396.00
	Option 3		
	Single	$179.28	$143.49
	Family	$381.75	$305.63
	Option 4		
	Single	$33.86	$33.86
	Family	$72.18	$72.18

Costs per Month

		All Retirees	
Travel	Single	$13.80	
	Family	$27.62	
Dental	**Plan A**		
	Single	$34.48	
	Family	$78.01	
	Plan B		
	Single	$38.33	
	Family	$86.73	
Basic life for your dependents	Flat amount	$0.78	
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	

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, life and AD&D 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, with the guidance of the Retiree Sub-Committee, review plan provisions annually and consider changes to the plan based on member requests and cost implications. The final decision on any plan changes rests with the Trustees.

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:

- have been participating in the benefits plan as an active employee when you retire,
- have retired from an employer participating in the PSGIP,
- meet the appropriate age and years of service criteria for your employer group, and
- have coverage under the government health plan in your province of residence.

A summary of eligibility and coverage is outlined below.

Retirees of Civil Service	Retirees of Health PEI
If you retired at or after age 55 with 10 years of service and you are eligible for a pension, you are eligible for: • Health • Travel • Dental • Retiree life • Basic AD&D (for life) • Basic life for your **dependents** (for life) • Optional life for you and your family (to age 65) • Optional AD&D for your family (to age 65)	If you retired at or after age 55 with at least 2 years of service, you are eligible for: • Health • Travel • Dental • Retiree life • Basic life for your dependents (to age 65) • Optional life for you and your family (to age 65) • Optional AD&D for your family (to age 65)
If you retired at or after age 55 with less than 10 years of service or are terminated with or without cause at or after age 50 with 10 years of service, you are eligible for: • Health • Travel • Dental	If you retired at or after age 55 with less than 2 years of service or are terminated with or without cause at or after age 50 with 10 years of service, you are eligible for: • Health • Travel • Dental

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

A summary of eligibility and coverage is outlined below.

Retirees of CUPE Local 1145, 1770, 1775 or 3260, the City of Charlottetown, Innovation PEI, IWMC and WCB of PEI

You are eligible for:

- Health
- Travel
- Dental

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** begins on your retirement date. However, if you are a member of Health PEI and you retire early, your coverage will begin the first of the month following your retirement date. Until then, you will be covered as an active employee.

If you are a late applicant (i.e. you don't enrol at retirement), 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).

WHEN COVERAGE ENDS

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

Health, travel and dental	Continues for life
Retiree life, basic dependent life and basic AD&D insurance (Civil Service and Health PEI retirees only)	Civil Service retirees – Continues for life Health PEI retirees – Retiree life continues for life, basic dependent life ends on the first day of the month following your 65th birthday (no coverage for basic AD&D)
Optional life and optional AD&D insurance (Civil Service and Health PEI retirees only)	Civil Service retirees – Age 65 Health PEI retirees – First day of the month following your 65th birthday

Coverage can also end for the following reasons:

When your coverage ends	The earliest of: • the date you request termination of coverage (or, for Health PEI retirees, the first day of the month following the date you request termination of coverage), • the date the applicable policy terminates, and • the date you become a full-time member of the armed forces.
When your dependents' coverage ends	The earliest of: • the date your coverage ends, • the date the applicable policy terminates, • the date you ask to end dependent coverage, and • the date the dependent no longer satisfies the definition of dependent.

Enrolling

ENROLLING FOR BENEFITS

When you are eligible to join the plan, you will need to make a few decisions about what coverage you want to enrol for and the level of coverage you need.

Important Enrolment Deadline

If you don't enrol for benefits at retirement, or waive benefits coverage, you have 12 months from your date of retirement to enrol for coverage; however, 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 at Retirement?** for more information.

Automatically enrolled for:	Enrolment deadline
✓ Retiree life – $5,000 (Civil Service and Health PEI only) ✓ Basic AD&D insurance – $5,000 (Civil Service only)	Automatically enrolled when you retire

Enrolment decisions to make:	Enrolment deadline
Health, travel and dental: ✓ Choose the health care option that best meets your needs ✓ Decide if you want travel coverage ✓ Choose the dental care option that best meets your needs **Life and accident:** If you are under age 65, decide if you wish to convert your current coverage (within 31 days of retirement only) to individual policies for: ✓ Basic life insurance ✓ Basic life dependent insurance (for **spouse**) ✓ Basic accident insurance ✓ Optional employee life insurance ✓ Optional spousal life insurance ✓ Optional accident insurance If you retired from the Civil Service or Health PEI, determine if you wish to maintain your current coverage for: ✓ Basic dependent life insurance (coverage ends at age 65, unless you retired from the Civil Service, then coverage will continue for life) ✓ Optional employee life insurance (coverage ends at age 65) ✓ Optional spousal life insurance (coverage ends at age 65) ✓ Optional child life insurance (coverage ends at age 65) ✓ Optional accident insurance (coverage ends at age 65)	At retirement If you don't enrol or you waive benefits coverage, you have 12 months from your date of retirement to enrol for coverage; however, you will need to provide **proof of good health** for health coverage and dental benefits will be limited.

How to Join the Plan

To join the plan, follow these simple steps:

Step 1: Johnson Inc. will provide you with a Retiree Enrolment form 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, available on **canadalife.com** 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:

Health	• For you and your family: – If you enrol over 31 days after your retirement 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.

Benefit Rules During Retirement

- Proof of good health is not required to continue coverage when you retire, provided you enrol within 31 days of your retirement. However, to continue health or dental coverage, you must be participating in the plan as an active employee when you retire.
- If you continue travel coverage at retirement, you can opt out at a later date, but you will **not** be able to rejoin.
- During retirement, you will have an annual opportunity to change your health and dental options effective each April 1.
- When you reach age 65, drugs available under the government's Seniors' Drug Cost Assistance Program (DCAP) will be covered under that program rather than by the PSGIP.
- If you are over age 65 and your **spouse** is under age 65, you may each choose single coverage under a different health option, e.g., Option 1 for yourself and Option 3 for your spouse. Once your spouse reaches age 65, you will have an opportunity to select family coverage for you and your spouse under one of the health options.

About the Seniors' Drug Cost Assistance Program (DCAP)

The Seniors' Drug Cost Assistance Program (DCAP) helps seniors with the cost of prescription drugs. The program is available to residents of PEI who are entitled to Medicare benefits and are age 65 and over. You do not need to apply for the DCAP, as all PEI residents who are eligible for Medicare are automatically registered in the program at age 65. All you need to do is notify your pharmacy when you reach age 65.

For more information about the DCAP, call 1 877 577-3737 (toll free in PEI).

What Happens if I Don't Enrol at Retirement?

- If you waive health or dental coverage at retirement, you may re-enrol only within 12 months of retirement, provided you previously had coverage as an active employee. You may not re-enrol at a later date. If you enrol within the 12-month period:
  - For health, you and your covered **dependents** will be required to provide proof of good health, and
  - For dental, you and each covered dependent will be limited to $100 during the first 12 months of coverage.
- If you waive travel coverage at retirement, you may join the travel plan at any time. Once in the plan, you can subsequently withdraw, but only one time. **Once you withdraw, you may not rejoin at a later date.**
- If you decide to opt out of health, dental or travel coverage at retirement because you are covered under your **spouse**'s plan and coverage under your spouse's plan ends, you may re-join the PSGIP within 31 days of the termination of your spousal coverage without having to provide proof of good health.

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 bank 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.

	Option 1	Option 2	Option 3	Option 4
Prescription drugs (mandatory generic substitution)	80% reimbursement of the first $150 per eligible drug expense, and 100% thereafter	You pay an annual* deductible before drug coverage begins ($300 single/$600 family**); 80% of the first $150 per eligible drug expense, and 100% thereafter	You pay the first $50 per eligible drug expense, and 100% thereafter	Coverage for vaccines only: 80%, to a $500 lifetime maximum per person

* April 1 – March 31

** $600 family refers to $300 for yourself and another $300 for all of your eligible **dependents** combined

	Option 1	Option 2	Option 3	Option 4
Hospital accommodations	No private or semi-private coverage			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

Option 1	Option 2	Option 3	Option 4
80% of the first $150 per eligible drug expense, and 100% thereafter	You pay an annual deductible before drug coverage begins ($300 single/$600 family) 80% of the first $150 per eligible drug expense, and 100% thereafter	You pay the first $50 per eligible drug expense, and 100% thereafter	Coverage for vaccines only: 80%, to a $500 lifetime maximum per person
Reimbursement is based on your prescription drug coverage option: • $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, unless your doctor provides medical evidence that the prescribed drug cannot be substituted.

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.

OPTION 1

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.

	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 the first $150 = $120 100% of the remaining $50 = $50 $120 + $50 = $170
You pay	20% of $50 = $10	20% of $150 = $30

OPTION 2

Each policy year (April 1 to March 31), you pay the first $300 (single coverage) or $600 (family coverage) of eligible prescription drug expenses before the plan begins to cover drug expense.

After you have met your deductible, 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.

	Example 1	Example 2
	$50 Prescription Cost (lowest-cost generic)	**$200 Prescription Cost (lowest-cost generic)**
Annual deductible	$300 single $600 family	$300 single $600 family
The plan pays	80% of $50 = $40	80% of the first $150 = $120 100% of the remaining $50 = $50 $120 + $50 = $170
You pay	20% of $50 = $10	20% of $150 = $30

OPTION 3

You will not pay more than $50 per eligible drug appearing on your prescription if you select the lowest-cost generic drug or a brand name drug without a generic equivalent.

	Example 1	Example 2
	$50 Prescription Cost (lowest-cost generic)	**$200 Prescription Cost (lowest-cost generic)**
You pay	$50 of the first $50	$50 of the first $50
The plan pays	$50 - $50 = $0	$200 - $50 = $150

OPTION 4

No coverage for drugs, except for vaccines.

Note About the Seniors' Drug Cost Assistance Program (DCAP)

The PSGIP covers non-DCAP drugs. If you are participating in the government's Seniors' DCAP and you purchase a prescription under DCAP, you will have to pay $8.25 plus $7.69 of the pharmacy professional fee per drug.

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 or 1 800 371-9516).

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
- Products used to quit smoking, except nicotine replacement products
- Spring-loaded devices used to hold lancets
- Sunscreens
- Vitamins (except injectible), minerals, dietary supplements

HOSPITAL ACCOMMODATIONS

Under Option 4, 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 (regardless of option) 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 (regardless of option) 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:

- Chiropodists or podiatrists
- Chiropractors
- Massage therapists
- Occupational therapists
- Osteopaths
- Registered physiotherapists

Laboratory tests and X-rays are covered if they are recommended by one of the covered licensed practitioners.

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 $80 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.

Eligible Expenses	Special Notes
Certain diagnostic tests, radium treatments, and X-rays	–
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.
Raised toilet seat	–
Stump socks	–
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.
Surgical/ mastectomy bras	2 per calendar year

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.

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
- TENS units
- Transfer bench
- Trapeze
- Wigs

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), except for temporomandibular joint dysfunction appliances.

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, for the first 180 days of your trip. 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.

Eligible Expenses	Special Notes
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.

Eligible Expenses	Special Notes
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

Travel Coverage and Stability – What Does it Mean?

A **stable condition** refers to any medical condition or related condition (including any heart or lung condition) for which there has been:

- no new treatment or new prescribed medication,
- no change in treatment or change in prescribed medication (including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type),
- no new symptoms, more frequent symptoms or more severe symptoms experienced,
- no test result showing a deterioration, and
- no hospitalization or referral to a specialist (made or recommended) or the results of further investigations not yet completed for that medical condition or related condition (including any heart or lung condition).

The travel plan will not pay for any expenses incurred directly or indirectly as a result of:

- your medical condition or related condition (including any heart or lung condition), if at any time in the six months before you depart on your trip:
  - your condition or related condition has not been stable,
  - for a heart condition, you have taken nitroglycerin more than once per week specifically for the relief of angina pain, or
  - for a lung condition, you have been treated with home oxygen or taken oral steroids (prednisone or prednisolone).

If you consult your doctor prior to travel, please show your doctor the insurer's definition of a stable condition.

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

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 $500 per calendar year

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 5 months
	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 5 months
	Recall package – Polishing, recall scaling, recall examinations, and fluoride	Once every 5 months
	Recall scaling	1 treatment every 5 months 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 5 months

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 $500 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

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 AD&D Insurance

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.

If you were under age 65 at retirement, you had 31 days to convert all your basic and optional life and AD&D insurance to individual policies.

Life and AD&D insurance under the retiree PSGIP is only available to retirees from the Civil Service and Health PEI.

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	AD&D Insurance
Retirees of Civil Service	• Retiree life (mandatory) • Optional life (optional)	Basic AD&D (mandatory) Optional AD&D (optional)
Retirees of Health PEI	• Retiree life (mandatory) • Optional life (optional)	Optional AD&D (optional)
For your spouse	• Basic dependent life (optional) • Optional life (optional)	Optional AD&D (optional)
For your children	• Basic dependent life (optional) • Optional life (optional)	Optional AD&D (optional)

LIFE INSURANCE

If you retire at or after age 55 with 10 years of service and you are eligible for a pension as a Civil Service employee or retire at or after age 55 with two years of service as a Health PEI employee, you are automatically insured for $5,000 of retiree life insurance (limited to one benefit payment per individual).

The plan offers Retiree life insurance for you and basic dependent life insurance for your **spouse** and **children**. At retirement you had the option to continue your coverage for optional life for you, your spouse or child. Keep in mind that all optional coverage will terminate at age 65 (for you and your spouse).

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

Retiree Life 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 Retiree life insurance and basic dependent life insurance protection, the plan automatically provides you with basic AD&D insurance – an extra measure of protection against a number of losses. At retirement you had the option to continue your coverage for optional AD&D for you and your family. Keep in mind that all optional coverage will terminate at age 65.

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

Basic AD&D insurance is only available to Civil Service retirees who retired at or after age 55 with at least 10 years of service and are eligible for a pension.

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.
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.

Basic Coverage	
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.
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.

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.
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**.

Optional Coverage

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.

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.

Optional Coverage		
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.

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 change your retirement health and dental coverage options as of April 1st of each year. Four to six weeks before the enrolment window, you will receive a reminder by mail.

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 at Retirement?** for more information.

Health coverage	You may change from single to family coverage, and vice versa, change your coverage option, or add new **dependents**. **Proof of good health** may be required.
Dental coverage	You may change from single to family coverage, and vice versa, change your coverage option, or add new dependents.
Travel coverage	You may change from single to family coverage, and vice versa. If you previously opted out of travel coverage, you may not opt back in, even if you experience a life event.

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 (available on **canadalife.com** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516):
   - If you enrol your spouse in the PSGIP over 31 days after the **life event**, you must provide proof of good health for health 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.

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 or 1 800 371-9516).
   - If you are applying to cover the child after 31 days of being eligible, you may be required to 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 their date of eligibility, 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.

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 (available on **canadalife.com** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516), 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.

REACHING AGE 65

When you reach age 65, your coverage under the plan will be affected as follows:

- Certain drugs previously covered by the plan will instead be covered by the province's Drug Cost Assistance Plan (DCAP). Should you purchase a prescription under Seniors' DCAP, you will have to pay up to $8.25 plus $7.69 of the pharmacy professional fee per drug.
- Optional life and accident insurance will end for both you and your family.
- If you retired from Health PEI, basic dependent life insurance coverage will end.

What to Do

Contact **Johnson Inc.** to inform them that you have reached age 65.

DEATH

If You Pass Away

If you pass away and you had coverage under the plan for life and AD&D benefits, your beneficiary will receive the following death benefits:

- Retiree life insurance plus optional life insurance (if you purchased optional coverage and are under age 65)
- Plus, if the death was as a result of an accident
- Basic AD&D insurance (Civil Service) plus optional AD&D insurance (if you purchased optional coverage and are under age 65)

Life and AD&D insurance under the retiree PSGIP is only available to retirees from the Civil Service and Health PEI.

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 and they had coverage under the plan for life and AD&D benefits, you will receive the following death benefits:

- Basic life insurance plus optional life insurance (if you purchased optional coverage and are under age 65)

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

- Optional AD&D insurance (if you purchased optional coverage and are under age 65)

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

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

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 Group Net for Plan Members.

Paper Claims

To submit a paper claim, complete the appropriate form (available on **mybenefitplan.ca** or by contacting Johnson Inc. at (902) 628-3537 or 1 800 371-9516):

- 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 **canadalife.com**, click on GroupNet for Plan Members 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.

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 and AD&D

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 or 1 800 371-9516 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.

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	• Retiree Enrolment form – For Civil Service and Health PEI retirees – For CUPE Retirees – For all other retirees • Retiree Health and Dental Change 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	• GWL's Request for Brand Name Drug Coverage form
To submit a complaint to the PSGIP Trustees	• PSGIP Complaint form

DOCUMENTS

For information about the plan and rate changes	· Benefits Notices – Issued February 2018 – Issued February 2017 – Issued February 2016 – Issued February 2015 – Issued February 2014
For quick reference of your benefits coverage	· Benefits At-a-Glance
For information about your current rates	· Retiree Benefits Rate Sheet
If you need a print copy of your benefits coverage	· PSGIP: Retiree 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/

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

- Basic life and dependent life: 165211
- Optional life: 159864
- Basic AD&D: AB10232401
- Optional AD&D: OE10232401

When to Contact Johnson Inc.

For information about coverage or to make changes **To claim AD&D 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 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.

GROUPNET TEXT

Get instant answers to many of your benefit coverage questions with GroupNet Text. Simply text certain keywords like PHYSIO or DENTAL to (204) 289-1667 from your mobile device to access detailed plan information, including:

- coverage details,
- reimbursement amounts,
- benefit maximums, balances, and
- plan and member identification numbers.

GROUPNET MOBILE APP

Download Canada Life's free GroupNet Mobile app and access the convenience of GroupNet for Plan Members 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 for a continuous period while covered by the plan and were under age 21 or under age 25 if a full-time student 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

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.
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.

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.
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.

GLOSSARY

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.
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.
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.
Stable condition	Any medical condition or related condition (including any heart condition or any lung condition) for which there have been: • no new treatment or new prescribed medication, and • no change in treatment or change in prescribed medication (including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type), and • no new symptom, more frequent symptom or more severe symptom experienced, and • no test result showing a deterioration, and • no hospitalization or referral to a specialist (made or recommended) or the results of further investigations not yet completed for that medical condition or related condition (including any heart condition or any lung condition).

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.