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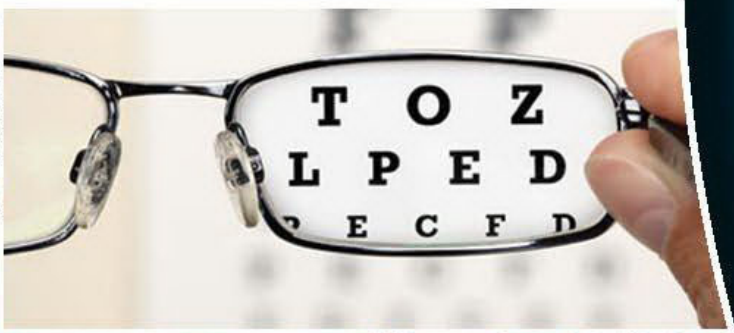

Out-of-Scope Extended Health Care and Enhanced Dental Plan

Commentary

FOR CERTAIN OUT-OF-SCOPE AND NON-UNIONIZED EMPLOYEES WHO PARTICIPATE IN THE 3sHEALTH BENEFITS PLANS.

This Commentary is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the policy.

GENERAL INFORMATION

Access to Documents

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

Legal Actions

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

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

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

Employer Role

The employer's role is limited to providing employees with information and not advice.

Insurance Fraud

Fraud happens when someone knowingly lies or falsifies information to obtain a benefit to which he or she is not entitled. This includes but is not limited to intentionally providing false information to ensure the payment of a claim, withholding information that would affect payment of a claim, or submitting a fictitious claim.

Any incidents of fraud, suspicious activity, or other irregularities will be investigated. Cases of fraud will be reported to the participating employer, which could lead to disciplinary action. Police services may also be contacted.

Help protect your benefit plan!

- Examine your forms and receipts to make sure information is correct. You are responsible for the information you submit.
- Do not give a provider pre-signed claim forms, never alter or change a receipt, and keep your plan number and Benefit ID (BID) secure.
- Review this booklet and understand your benefits.
- Report suspicious situations by calling the Canada Life tip line at 1-866-810-8477.

PROTECTING YOUR PERSONAL INFORMATION

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

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

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

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

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

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

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

TABLE OF CONTENTS

YOUR EXTENDED HEALTH CARE AND ENHANCED DENTAL PLANS

This commentary outlines each of the extended health care and enhanced dental benefits which provide protection and security for you and your family. The information in this commentary is important. Familiarize yourself with its contents and keep it handy for reference.

If you have questions about your eligibility or level of coverage under the plan, please contact 3sHealth. If you have questions about the plan benefits or a specific claim, please contact Canada Life at the address or telephone number shown at the back of this commentary.

In order to maintain the financial health of the plan, please use it wisely and prudently. Cost over runs may result in a reduction to the plan benefits or a contribution increase.

This commentary contains general information, and is subject to all of the provisions, limitations, exclusions and restrictions contained in the policy issued to the Health Shared Services Saskatchewan.

ELIGIBILITY

You and your Dependents are eligible for coverage upon meeting the eligibility requirements shown below.

Eligibility - Employee

You are eligible if:

- you work for an employer which participates in the 3sHealth benefit plans,
- you are in an insured class of Employees covered by the plan,
- you are paid a regular wage or salary, and
- you complete the minimum waiting periods and hours requirement for your job classification shown below.

Permanent Full-Time Employees

If you work for a participating employer on a permanent full-time basis you are eligible for coverage on the first day following a 26 week period of continuous full-time employment, provided you are Actively at Work. If you are not Actively at Work, your insurance will begin on the date you are again Actively at Work.

You will be considered continuously employed during the period of an approved leave of absence to a maximum of 18 months or 2 years plus 119 calendar days, if you are on disability.

All Other Employees (All Other Than Full-Time (OTFT) Employees)

If you are other than a permanent full-time Employee working for a participating employer on a part-time, temporary or casual basis and work at least 40% of the number of hours normally worked by a full-time Employee, you will become eligible for coverage if you have worked 390 hours during the first 26 week period of your employment. If you meet this requirement, the coverage will start on the day following the end of the 26 week period, provided you are Actively at Work. If you do not become eligible after this 26 week period, you will become eligible for coverage once it has been determined that you worked at least 780 hours in a full calendar year period of employment (January 1 – December 31) provided you are Actively at Work. If you had already become eligible for coverage under this plan and your coverage terminated because you did not work the minimum number of hours required in the previous calendar year, you will again be eligible for coverage on the January 1st following the full calendar year in which you work at least 780 hours.

If you are returning to work from an approved 3sHealth disability claim, your coverage will be reinstated on the date you return to work. You will not be measured for plan eligibility until you have completed a full calendar year of employment.

Eligibility - Dependents

Coverage for your Dependents becomes effective on the same date your coverage becomes effective. All coverage for a new-born Dependent is effective from live birth.

ELIGIBILITY

Termination of Coverage - Employee

Your coverage will terminate on the earliest of:

- the January 1st following any full calendar year in which you worked less than 780 hours;
- the date you cease to work for an employer which participates in the 3sHealth plans,
- the date you no longer qualify for membership in an insured class within the plan;
- the end of the period for which premiums have been paid for your coverage;
- the date immediately prior to the date you commence active full-time service as a member of the armed forces of any country;
- the date the policy cancels;
- the date your employer's coverage under the policy cancels;
- the date your class cancels;
- the date shown in the benefit descriptions; or
- benefits will not be continued during a period of salary continuance or vacation payout following your date of termination or retirement.

If you are absent from work due to a leave of absence, your coverage may be continued. If you are laid-off, your coverage will end on the date the lay-off begins.

If you terminate employment for reasons other than a lay off, and within 30 days of your termination, you recommence employment in a class of Employees covered by the plan with the same or another 3sHealth participating employer, your coverage will be reinstated at the level in effect prior to your termination.

If you terminate employment due to a lay-off, and within 12 months of your termination, you recommence employment in a class of Employees covered by the plan with the same or another 3sHealth participating employer, your coverage will be reinstated at the level in effect prior to your termination.

You must advise your new participating employer of your previous eligibility under the plan.

Termination of Coverage - Dependent

Your Dependent coverage will terminate on the earliest of:

- the date your Employee coverage terminates;
- the date your Dependent no longer satisfies the definition of Dependent;
- the end of the period for which premiums have been paid for Dependent coverage; or
- the date shown in the benefit descriptions.

Coverage for a Child (non-student) terminates on the Child's 21st birthday. Coverage for a Child (student) terminates on the Child's 26th birthday.

OVERVIEW

This section contains:

- an explanation of how benefits are determined,
- general information,
- definitions, and
- limitations that apply to your coverage.

Payment of Premiums

Monthly contributions are paid to a fund established to pay the plan premiums. At the discretion of each participating employer, the contributions may be paid by the insured employee, the participating employer, or cost-shared between them. In the event the contributions are not sufficient to pay the required premiums, the plan will be amended to ensure the funding limitations of the plan are not exceeded.

Leaves of Absence

Your coverage may be continued until the end of the 18th month following the date your approved leave of absence began.

Continuation of Coverage During A Period of Approved Disability

If you become disabled your Extended Health Care and Enhanced Dental coverage may be continued for up to two years and 119 days from your date of disability as accepted under one of the below plans:

- a disability income plan administered by 3sHealth or the Public Employees Benefits Agency (PEBA), or
- a waiver of premium benefit has been approved in accordance with your membership in a 3sHealth benefit plan.

Beneficiary Designation

You may make, alter or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your participating employer.

Definitions

Actively at Work means that you are
- actually performing your normal duties, if it is a scheduled work day, or
- capable of performing your normal duties, if you were not at work due to a non-scheduled work day, holiday or vacation and you are scheduled to return to work, at your normal place of employment or at some other location where your participating employer's business requires you to be.

Child - a person who is unmarried, dependent on you for financial support, and who is your natural child, your legally adopted child, a step-child or child of your common-law Spouse who lives with you, or a child for whom you have been granted custody pursuant to an Order of a Court.

Unless otherwise shown in a benefit, a Child must be:
- under 21 years of age, or
- between the ages of 21 and 25, inclusive, and in full-time attendance at an accredited college or university, or
- 21 years of age or older and dependent upon you for support by reason of a mental or physical disability.

In order to continue the coverage of a mentally or physically disabled Child who has attained age 21, you must complete an Application for Continuance of Insurance for a Mentally and/or Physically Challenged Child, and submit proof of the child's incapacity within 31 days of the child's 21st birthday.

Dependent - your Spouse or Child. A Dependent does not include a child who has reached the age of 18 and is no longer financially reliant on their parents for support; a child who is employed and covered under their own benefit plan.

Emergency - any sudden, critical, unforeseen or unexpected occurrence requiring immediate medical attention and takes place outside your province or territory of residence while the coverage is in force. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

Employee – a person who works for a participating employer and who is classified as an out-of-scope or non-unionized employee.

Employer – a health-care facility in the Province of Saskatchewan that participates in the 3sHealth Benefits Plans and that is contributing to the plan with respect of any of its Employees.

Government Plan - the Saskatchewan Health Drug and Extended Benefit Plan, Workers' Compensation, Saskatchewan Government Insurance or any other government/provincial programs or legislation providing medical or dental services.

Hospital - an institution that is licensed to provide active, convalescent or chronic care treatment by the government that is responsible for the issue of such licenses in the area that it is located. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care. An institution which employs registered nurses 24-hours a day and is equipped to handle diagnosis, treatment or surgery.

Insured Person – you or your dependent, excluding any person who does not reside in Canada or the United States, or who is on active full-time service in the armed forces of any country.

Maximum Reimbursement Schedule – the 3sHealth Enhanced Dental Payment Schedule, which may be amended from time to time.

Medically Necessary - a care, service or supply (based on generally recognized standards of health care) which is accepted by the medical profession as effective, appropriate and essential in the diagnosis or treatment of injury, disease, illness, pregnancy or mental disorder.

Definitions (Continued)

Participating Employer - an employer that participates in the 3sHealth benefit plan and who has agreed to make contributions in respect of your coverage.

Prescription - an order from a duly licensed prescriber to a registered pharmacist for the dispensing of a drug or medicine for an Insured Person, stating the name, strength and quantity of the drug or medicine prescribed, directions for its use, the date the prescription is issued and the refill frequency limit.

Reasonable and Customary Charges - charges for diagnosis, treatment, care, services, or supplies at the usual level for cases similar in nature and severity. Charges are representative fees and prices in Saskatchewan, as determined by Canada Life.

Reasonable Treatment - means treatment that is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is a form, intensity, frequency and duration essential to diagnosis or management of the injury, disease, illness, mental disorder or pregnancy.

3sHealth – Health Shared Services Saskatchewan.

Spouse – a person to whom you are legally married, or a person with whom you have been cohabiting in a spousal relationship for the past 12 months.

Where both a legal Spouse and a common-law Spouse exists, coverage for the legal Spouse will cease immediately upon coverage becoming effective for the common-law Spouse.

CLAIMS

This section contains information about the payment of claims, the appropriate claim forms to use and the documents that are required to ensure that claims are paid promptly. Claim payments are accompanied by statements explaining how benefits have been determined according to the plan.

How to Submit a Health Care Claim

For drug claims, 3sHealth will provide you with a prescription drug identification card. The card will be mailed to your personal address. Please read the information provided with your prescription drug identification card and contact Canada Life if your spouse has coverage through an employer sponsored benefit plan.

Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

You may submit all Healthcare claims online. To use this online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after you incur the expense.

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For all other Healthcare claims access My Canada Life at Work to obtain a personalized claim form or obtain a claim form from your participating employer or online at www.3sHealth.ca or www.canadalife.com. Once you have completed and signed the form, attach the original receipts or invoices. Note that you must also submit the original prescription for those services and supplies that are identified as requiring a prescription from a physician. Also, if the claim is for medical supplies or equipment it is recommended that a report from the physician be included with the claim form stating a description, the purpose of the item and the recommended frequency of its use. Submit the form and original prescriptions, reports, receipts or invoices directly to Canada Life at the address shown on the back of the form.

Note: To ensure prompt claims service, any receipts should include:

- your name or your dependent's name receiving the service or treatment
- the date and the type of each service or treatment
- the charge for each date
- the prescription numbers for prescribed drugs and medicine
- the name of the drug or the medicine

CLAIMS

How to make an out-of-province/country claim:

There are special rules for claiming the costs of emergency treatment outside of your province or territory of residence or Canada.

For all medical expenses, you must contact the Travel Assistance provider at the time of the emergency. This will enable the Travel Assistance provider to co-ordinate payment directly with the hospital and/or medical provider involved. In addition, with your approval the Travel Assistance provider will co-ordinate payment with your Provincial Health Care plan.

If a medical provider or hospital bills you directly, send the bill along with your claim form to the Travel Assistance provider.

How to Submit a Dental Claim

When you wish to submit a claim:

1. obtain a 3sHealth Dental Claim form from your participating employer or online at www.3sHealth.ca or www.canadalife.com;

2. complete the Employee section (Part 2) of the claim form;

3. have the dentist complete the Dentist section (Part 1) of the claim form; and

4. submit the completed form to Canada Life at the address shown on the claim form.

Canada Life also accepts electronic submission of dental claims from your dental service provider's office as well as Member eClaims. In these cases, no paper claim form is required. In order to register for eClaims submissions, you will need to register to My Canada Life at Work and for direct deposit.

Claims (Continued)

Co-ordination of Benefits

Benefit payments under the plan may be co-ordinated with the benefits provided by any other plan to provide up to 100% of the Eligible Expenses, as long as the total amount received from all sources does not exceed the amount of the actual expense incurred.

If the claim is for you, submit the claim first to this plan, and second to your spouse's plan.

If the claim is for your spouse, submit the claim first to your spouse's plan, and second to this plan.

If the claim is for a dependent child, submit the claim first to the plan of the parent who has the first birth date in the year, and second to the alternate plan.

If the alternate plan does not provide for co-ordination of benefits, all claims should be submitted to the alternate plan first.

Payment of Claims

All benefits will be paid to you unless Canada Life is directed otherwise.

Deadline for Submitting Claims

Claims must be submitted within 120 days of the earlier of:

- your termination of employment, and
- the end of the calendar year in which the expense was incurred, or the services were performed.

For the purposes of all calculations made under this benefit provision, expenses for services and supplies are considered to be incurred when the items claimed for are received.

Examination

Canada Life has the right to require the Insured Person to have a medical examination as often as reasonably necessary. Canada Life will choose the physician and cover the cost.

Right to Recover

If Canada Life pays any benefits to you which you have the right to recover from any person or corporation, Canada Life reserves the right to work with you to recover those payments.

EXTENDED HEALTH CARE BENEFITS

This benefit provides reimbursement against the cost of those eligible, Medically Necessary services and supplies and represents reasonable treatment given or ordered by a physician, when there is only partial or no reimbursement from your provincial medical plan, and the cost(s) are incurred from sickness or accidental bodily injury.

Benefit Entitlement

Permanent Full-Time Employees

Permanent full-time Employees are entitled to 100% of the benefit payment.

All Other Employees (All Other Than Full-Time (OTFT) Employees)

If you are other than a full-time permanent Employee working for a participating employer on a part-time, temporary or casual basis for at least 40% of the number of hours normally worked by a full-time Employee your benefits will be pro-rated, except Eligible Charges for eye examinations, special contact lenses, the diagnosis and treatment of accidental injury or disease to eyes, out-of-country emergency treatment and travel assistance will be reimbursed at 100%. All other vision care (eyeglasses and contact lenses) and Extended Health Care Eligible Charges are subject to pro-rating.

Better than Benefit

The Better than Benefit provides 100% extended health care coverage to plan members who qualify for 80% or 90% enhanced dental.

Benefit Amount

Benefits are limited to the maximums identified for specific Eligible Charges.

Eligible Charges Inside Canada

Drugs and Medicine - charges for drugs and serums listed on the Saskatchewan Drug Plan Formulary, provided they are obtained through a written prescription and are dispensed by a registered pharmacist entitled by law to dispense them. Charges for all anti-smoking agents obtained by prescription will be covered, but are limited to a lifetime maximum of $500 per Insured Person.

No benefit is payable for:

- drugs not approved for legal sale to the general public
- medical soaps and creams, cosmetics and shampoos
- skin-lotions, eye and contact-lens solutions, mouth washes
- publicly advertised items
- cough and cold preparations, antihistamines
- laxatives, antidiarrhals (with approved exceptions)
- products commonly considered household remedies
- preventative immunization vaccines and toxoids. This limitation does not apply to routine vaccines.
- fertility drugs
- over the counter medicines (other than those on the Saskatchewan Drug Plan Formulary and anti-smoking agents obtained by Prescription)
- anti-obesity treatments including proteins and dietary or food supplements
- health foods, vitamins (unless injected)
- fees for the administration of serums, vaccines and injectable drugs.

Eligible Charges Inside Canada (Continued)

Drugs and Medicine (Continued)

Dispensing limitations are not to exceed a 100 day supply.

Diabetic supplies may be purchased using your pay direct drug card. Diabetic equipment may not be purchased using your pay direct drug card.

All claims for prescription drugs whether by pay direct drug card or by manual submission, must first be submitted to the Saskatchewan Provincial Drug Plan for eligibility. In order to ensure proper coordination with the employee's Saskatchewan Health coverage, the employee, when requested, may be required to apply for any and all support or coverage programs that may exist or may come to exist. Canada Life coverage applies after the benefits of the government plans, including but not necessarily limited to the Saskatchewan Provincial Drug Plan, have been determined.

Deductible

- if claims are submitted directly to Canada Life for payment a fee of $9.00 will be deducted from your reimbursement for each differently dated official prescription receipt submitted for reimbursement. The deductible does not apply to anything other than the purchase of Prescriptions made at a pharmacy.

Example: If 3 prescriptions are purchased on same day there would only be one $9.00 deductible applied. If 3 prescriptions were all purchased on separate days, each prescription would have a $9.00 deductible totaling $27.00.

- if claims are paid using your Pay Direct Drug card you are responsible for a deductible amount of $10.00 per drug identification number (D.I.N.) at time of purchase. The deductible does not apply to anything other than the purchase of Prescriptions made at a pharmacy.

Private Duty Nursing - charges made for private duty care given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) that is necessary for the medical treatment of sickness or injury. The care must be the type that can only be performed by an R.N. or L.P.N. and does not include custodial care such as homemaking or companionship duties. Charges for private duty nursing services performed in-hospital, or when the nurse normally resides in the patient's home are not considered Eligible Charges. Pre-approval is recommended.

The maximum benefit payable is $10,000.00 per calendar year per Insured Person.

Hospital - charges made by a Hospital for services and supplies which are necessary for the medical treatment of sickness or injury, including charges for a semi-private room, but not when occupied primarily for the purposes of custodial care. Charges for a private room are covered up to the cost of a semi-private room. Charges for custodial care in a chronic and/or convalescent Hospital are limited to $20.00 per day for a maximum stay of 90 days, but are not considered Eligible Charges if the Insured Person was hospitalized in either a chronic and/or convalescent Hospital on or before the effective date of your coverage.

Ambulance – licensed ambulance or other emergency service, when Medically Necessary, to transport an Insured Person from the place where the medical condition occurred to the nearest Hospital where adequate treatment can be rendered, from one Hospital to another, and from a Hospital to the Insured Person’s residence. Charges for non-transportation and waiting time are not eligible.

Charges for the fare of one attendant to accompany the Insured Person if transportation is not provided by a licensed ambulance service.

Eligible Charges Inside Canada (Continued)

Accidental Dental – charges made by a licensed dentist for dental treatment of injuries to natural teeth, or replacement of natural teeth, for accidents suffered by an Insured Person while covered under this benefit.

The charge will only be considered an Eligible Charge, if all of the following conditions are satisfied:
- The treatment is necessitated by a direct accidental blow to the mouth and not by an object or food placed wittingly or unwittingly in the mouth.
- The treatment is received within 12 months after the accidental blow.
- The treatment is the least expensive that will provide a professionally adequate result.
- The charge does not exceed the amount shown for the treatment in the current Dental Association Schedule of Fees for General Practitioners in your province of residence.
- A treatment plan is submitted to Canada Life within 90 days of the accident, if treatment is to be received more than 90 days after the accidental blow.

Paramedical & Professional - charges for services provided by any of the legally licensed practitioners listed below are covered to a maximum of $400 per Insured Person each calendar year:
- acupuncturists
- chiropractors, including diagnostic x-rays
- osteopaths, including diagnostic x-rays
- naturopaths
- physiotherapists/occupational therapists/athletic therapists
- podiatrists/chiropodists, including diagnostic x-rays performed by a licensed podiatrist
- speech therapists

Charges for services provided by any of the legally licensed practitioners listed below are covered to a maximum of $500 per Insured Person each calendar year:
- massage therapists

Charges for services provided by any of the legally licensed practitioners listed below are covered to a maximum of $2,000 per Insured Person each calendar year:
- psychologists/ social workers

The charges for services provided by a practitioner, who is also a family member, regardless of whether or not the practitioner is normally a resident in the Insured Person's residence, are not eligible. For the purposes of this provision, a family member includes the Insured Person's mother, father, brother, sister, husband, wife or child.

Diabetic Supplies - charges for diabetic supplies, excluding cotton swabs and rubbing alcohol, are covered. Diabetic supplies include:
- insulin syringes
- Novolin pens, or similar injection devices using a needle
- test strips
- blood letting devices, including platforms and lancets
- insulin infusion sets
- sensors for flash glucose monitoring machines
- transmitters and sensors for continuous glucose monitoring machines

Diabetic equipment may not be purchased using your pay direct drug card

Eligible Charges Inside Canada (Continued)

Medical Supplies – charges for the following supplies when prescribed by a physician:
- anesthesia, oxygen, blood and blood products
- initial provision of crutches, splints, canes, casts, braces (excluding dental braces)
- catheters, urinary kits, irrigating sets, bags, deodorants, pads, adhesives or skin creams following colostomy or ileostomy
- hairpieces following chemotherapy or surgery where the head was shaved, limited to a maximum amount payable of $200 per Insured Person in a lifetime.

Medical Equipment – charges for the following equipment when prescribed by a physician or nurse practitioner:
- orthopaedic shoes and orthotics which are specifically designed and melded for the Insured Person when prescribed by a nurse practitioner, physician, chiropodist, podiatrist or orthopaedic surgeon, limited to a maximum amount payable of $300.00 in any one calendar year. To be eligible for payment, the orthotic devices must be diagnosed as being necessary by a biomechanical examination or gait analysis. Modifications to existing or new shoes and custom fit shoes such as Birkenstocks, Finn Comfort, Rockport or Nike etc. shoes are not considered Eligible Charges.
- charges for rental of, or at Canada Life's option, the purchase of the following (if Canada Life determines that the cost of purchase is less than the anticipated total cost of rental).
  - manual wheelchairs
  - standard hospital beds

  Charges for wheelchairs and hospital beds will only be considered Eligible Charges if they are required as a result of a bodily injury or sickness which occurred while the Insured Person was covered under this plan or the previous plan which was replaced by this plan.
- initial placement of non-myoelectric limbs and artificial eyes
- charges for the subsequent replacement of artificial limbs and eyes will only be considered Eligible Charges once every five calendar years, or when a physical change in the Insured Person necessitates the replacement
- mastectomy forms, limited to one per side per Insured Person, once every two calendar years
- surgical bras, limited to two per Insured Person in any one calendar year
- initial pair of frames and one corrective prosthetic lens for each eye, when prescribed after cataract surgery
- compression hose, surgical stockings and elastic support stockings with a minimum of 15mmHg or higher, limited to 2 pairs per calendar year
- continuous positive airway pressure machines (CPAP) and automatically adjusting positive airway pressure machines (APAP), including humidifiers, limited to once every 5 years

If plan members get a Continuous Positive Airway Pressure (CPAP) machine from the Saskatchewan Aids for Independent Living (SAIL) program, the benefits plan may reimburse the SAIL program fee. SAIL provides CPAP machine loans to medically eligible Saskatchewan residents. Patients are required to pay SAIL a program fee of $275. Plan members can then submit a claim for reimbursing the fee through Canada Life. For more information on SAIL program, please visit Government of Saskatchewan website www.saskatchewan.ca.

Please note that neither SAIL nor your benefits plan provide reimbursement for privately purchased CPAP machines.

SAIL also covers Automatic Positive Airway Pressure (APAP) and Bilevel Positive Airway Pressure (BiPAP) machines at no cost to the patient.

SAIL will replace a machine once every five years but may replace machines sooner when necessary. The initial and replacement machines are eligible for replacement once every five years. SAIL may replace a machine sooner when medically necessary.

If your physical address is outside of Saskatchewan, please call Canada Life directly.

Eligible Charges Inside Canada (Continued)

Medical Equipment (Continued)

- charges for the following items, limited to a lifetime maximum per Insured Person of $2,000.00 for any one or like piece of equipment
  - transcutaneous nerve stimulators (TENS)
  - cervical collars
  - aerosol equipment
  - mist tents and nebulizers, excluding humidifiers and vaporizers
  - traction apparatus
  - mozes detectors
  - apnea monitors
  - peak flow meters

- flash glucose monitoring machines
- charges for the following items, limited to a lifetime maximum per Insured Person of $2,000 for each piece of therapeutic equipment:
  - diabetic monitoring and administration equipment
  - external insulin infusion pumps
  - needleless insulin jet injectors, and
  - blood glucose monitoring machines or continuous glucose monitoring machines to a combined maximum of once every 4 calendar years.

Laboratory Expenses - charges for diagnostic tests, radium treatments and X-ray examinations, excluding dental X-rays, that are incurred in your province or territory of residence.

Hearing Tests – charges for hearing tests when performed by an audiologist, limited to once every 4 years up to the following maximums:
- $120 for you or your Spouse
- $140 for each Child under age 18.

Hearing Aids - charges for the cost of, repair (excluding batteries or routine maintenance of) and installation of a hearing aid(s) purchased on the written recommendation of an audiologist, limited to a maximum amount payable of $1,500.00 per ear per Insured Person every five consecutive calendar years.

Speech aids – charges for Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible, limited to a lifetime maximum per Insured Person of $1,000.

Nursing Home - active treatment or convalescent care provided by a legally licensed nursing home. The maximum number of days of benefit is 90 days in any one continuous period of confinement, limited to $20 per day. One continuous period of confinement includes all periods not separated by more than 30 consecutive days for you or by more than 180 consecutive days for your dependent. Once you attain age 65, the maximum amount payable is $500 less any benefits paid during the 3 preceding calendar years.

Other Services and Supplies - We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Eligible Charges Outside Canada

Emergency Treatment

The following Emergency treatment required by an Insured Person while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions.

The Maximum Amount is $1,000,000 for each Insured Person for all the Eligible Charges incurred during the first 60 days of a trip, related to any one emergency under this provision and the Travel Assistance provision. These limitations are not applicable to in-Canada emergency health care benefits. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

Charges for the following are included:

- Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day of confinement.
- Hospital services and supplies furnished by a Licensed Hospital.
- Diagnosis and treatment by a physician or surgeon legally licensed to practice medicine.

A Dependent Child attending an accredited university or college outside of Canada is eligible for Emergency Treatment as long as the student continues to be covered under a provincial medical plan. Reasonable and Customary Charges for medical care, services or supplies are covered only if they are required to treat a medical emergency.

In the event of a medical emergency, you or someone acting on behalf of the Insured Person, must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, you or the Insured Person must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to the emergency out-of-country coverage and Travel Assistance coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends the Insured Person be moved to a different facility at the destination, and the Insured Person chooses not to go, eligible costs for emergency coverage and Travel Assistance coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to the emergency out-of-country maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends the Insured Person return to their home province, and you the Insured Person chooses not to go, emergency coverage and Travel Assistance coverage will end.

"Hospital" means an institution having diagnostic facilities that provides active, chronic care or emergency treatment with physicians and registered nurses in attendance 24 hours a day and is licensed by the appropriate governmental authority. It does not include an institution providing convalescent care, a nursing home for the aged, a rest home or any other facility providing similar care.

Eligible Charges Outside Canada (Continued)

Referral

Charges for the following services provided in Canada and the United States but outside your province or territory of residence if they are not available in your province or territory of residence and are performed on the written referral of a physician or surgeon regularly attending you or your dependents in your province or territory of residence.

1. Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day that you or your dependents are confined in the hospital.

2. Hospital services and supplies furnished by a Licensed Hospital.

3. Diagnosis and treatment by a physician or surgeon legally licensed to practice medicine.

Full details of the services to be provided must be submitted by the referring doctor to, and approved in advance by, Canada Life.

The maximum amount payable under this provision with respect to you or your dependents during your lifetime will be $50,000.

Travel Assistance Benefit

The following services with respect to medical and personal emergencies required by an Insured Person while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions.

The Maximum Amount is $1,000,000 for each Insured Person for all Eligible Charges incurred during the first 60 days of a trip, related to any one emergency under this provision and the Emergency Treatment provision. These limitations are not applicable to in-Canada emergency health care benefits. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

The following services are included:

- on the spot medical assistance
- emergency medical payments
- telephone interpretation service
- medical evacuation
- assistance with lost documents or luggage
- return of dependent children or a travelling companion
- visit of a family member
- transmission and retention of urgent messages
- help to locate Embassy or Consulate services

Eligible Charges Outside Canada (Continued)

Travel Assistance Benefit (Continued)

- assistance in the event of death to transport the remains

- return of a vehicle to your home or nearest rental agency

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while the Insured Person was operating a vehicle, vessel or aircraft, if the Insured Person:
    i) was impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

Note: For specific details, please refer to your Canada Life Travel Assistance Brochure which can be obtained through 3sHealth. If you are travelling and require medical care, please contact the Assistance Centre using the telephone number on the Travel Assistance card. The Travel Assistance Centre number and services are available 24 hours a day.

Limitations

We can decline a claim for services or supplies that were purchased from a provider that is not approved by us.

We can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

No amount is payable by Canada Life for any of the following services or charges:

- a medical examination for the use of a third party;
- any care, service or supply in connection with a change in gender;
- obtaining further medical information regarding claims for covered expenses, or any expenses incurred for the completion of claim forms;
- charges which Canada Life is not permitted by law/legislation to cover. Any changes to provincial legislation or the government health insurance plan will not automatically result in a change of coverage provided under this plan;
- cosmetic surgery, services or treatment which are not necessary for treatment of a sickness or injury;
- the failure of an Insured Person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to a Government Plan to which they are entitled. If an Insured Person is not a member of a Government Plan by reason of having "opted-out", or for any other reason is not a member of a Government Plan the Insured Person will be deemed, for the purposes of this plan, to be a member of the Government Plan;
- extra charges which may result due to the physician opting-out of the government health insurance plan;
- the renovation or alteration in any physical way to an Insured Person's residences, vehicles, or place of business, including the filtration or purification, whether mechanical or electronic, of air, water or other environmental factors;
- the repair or alteration of any prosthetic device incurred after the initial placement and fitting or charges incurred due to the replacement of any prosthetic device unless the replacement is due to a change in the Insured Person's physical condition;
- private or semi-private room charges in an acute care Hospital where the type of care is primarily custodial care or while awaiting admission to a custodial care facility;
- the purchase of a myoelectric controlled prosthetic. However, Canada Life will pay an amount equal to the Reasonable and Customary Charges of a non-myoelectric prosthetic device;
- charges for any method of contraception other than covered drugs and products containing a contraceptive drug;
- in excess of the specific limitations and maximum amounts described under Eligible Charges;
- in connection with general health examinations;
- for which the Insured Person obtains or is entitled to obtain benefits under any Government Plan;
- for which the Insured Person is entitled to obtain without charge;
- which result from insurrection or war (declared or not), any related act, or participation in any riot;
- which are not Medically Necessary, including blood pressure monitors;
- for experimental treatment not generally accepted by the medical community or involving therapies not prescribed or paid for under provincial or federal medical reimbursement plans;
- for sport or recreational services or supplies, including sports mouth guards;
- that are in excess of Reasonable and Customary Charges for the least expensive appropriate treatment;
- which result from any sickness or bodily injury occurring in the course of employment if an Insured Person is eligible for coverage through the *Workers' Compensation Act,*

Limitations (Continued)

- any treatment that has as its purpose the correction of temporomandibular joint dysfunction;
- the commission or attempted commission of any offence contained in the *Criminal Code*;
- services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply determined by us to be a covered service or supply;
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital and
- telephone and/or television during a hospital stay.

Prior Authorization

In order to determine whether coverage is provided for certain services and supplies, we will maintain a limited list of services or supplies that require prior authorization.

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, an insured person may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Health Case Management is a program recommended and approved by us that may include but is not limited to:

- consultation with the insured person and his attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the insured person's attending physician of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the insured person's attending physician of opportunities for education and support; and
- monitoring the insured person's adherence to the treatment plan recommended by the insured person's attending physician.

In determining whether to implement Health Case Management, we may assess such factors as the service or supply, the insured person's medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

We can, on such terms as we determine, limit the payment of benefits for a service or supply where:

- we have implemented Health Case Management and the insured person does not participate or cooperate; or
- the insured person has not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with Health Case Management may be paid for by us at our discretion. Expenses claimed under this benefit provision must be pre-authorized by us.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that a new service or supply be purchased from or administered by a provider designated by us, and:

- limit the covered expenses for a service or supply that was not purchased from or administered by a provider designated by us to the cost of the service or supply had it been purchased from or administered by the provider designated by us; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by us.

Patient Assistance Program

A patient assistance program means a program that provides assistance to persons with respect to the purchase of services or supplies.

We can require an insured person to apply to and participate in any patient assistance program to which the person may be entitled. Further, we can reduce the amount of a covered expense for a service or supply by an amount of financial assistance the insured person is entitled to receive for that service or supply under a patient assistance program.

VISION ASSISTANCE

Charges resulting from visual supplies recommended by a licensed optometrist or ophthalmologist are payable.

Eligible Charges

Eye Examinations - charges for eye examinations performed by an optometrist or ophthalmologist provided no part of the cost is covered by any Government Plan. Charges are limited to one examination for each Insured Person:

- every 24 month period, beginning on the date the first charge for an eye examination is made, for you or your Spouse, and
- every 12 month period, beginning on the date the first charge for an eye examination is made, for each Child under age 21.

Frames, lenses and contact lenses not covered by any Government Plan.

Laser eye surgery.

A pair of contact lenses up to a lifetime maximum of $200 if visual acuity is improved to at least a 20/40 level and this level of acuity is not possible through wearing eye glasses accompanied by a letter of verification. Otherwise, contact lenses are subject to the maximum as stated for eye glasses.

Services received in Canada for visual training and remedial exercises subject to 50% reimbursement, regardless of the benefit maximum. Diagnosis and treatment received in Canada for accidental injury or disease to eyes.

All claims must be supported by an official receipt indicating name of patient and the date the eyewear was received.

Eye Glasses, Sunglasses, Safety Glasses or Contact Lenses

Benefit Amount

The Benefit Amount is a maximum of $300 per Insured Person for every 24 consecutive months, beginning on the date the first charge for a visual supply is made. The $300 maximum is pro-rated based on the reimbursement percentage you qualify for as described under the benefit plan. The following schedule illustrates the pro-rated maximum Benefit Amount based on the reimbursement percentage that applies to you:

If your reimbursement percentage is:	Your maximum Benefit Amount is:
100%	$300
70%	$210
60%	$180
50%	$150

Laser Eye Surgery

Benefit Amount

The Benefit Amount is once per lifetime up to a maximum of $600 per Insured Person. The $600 maximum is pro-rated based on the reimbursement percentage you qualify for as described under the benefit plan. The following schedule illustrates the pro-rated maximum Benefit Amount based on the reimbursement percentage that applies to you:

If your reimbursement percentage is:	Your maximum Benefit Amount is:
100%	$600
70%	$420
60%	$360
50%	$300

Eye glasses, sunglasses, safety glasses or contact lenses will not be covered for a period of 4 years following the date of the laser surgery.

Lost or Stolen Pay Direct Drug Cards

Lost or stolen cards should be reported immediately, to Canada Life by telephone or in writing. Upon notice, a replacement card will automatically be issued with a new issued number. In most cases, the pharmacist will not honour the lost or stolen card because the name on the prescription will be different from that on the card. However, if you notify Canada Life immediately it will greatly reduce the risk of fraudulent claims being paid.

Survivor Benefit
(Not applicable to Employees and their Dependents who are eligible for Out-of-Country Emergency and Travel Assistance benefits only)

If you die while insured for Extended Health Care or Enhanced Dental Care benefits, your Dependent coverage will continue to be payable until the earlier of the date your Spouse remarries or the date which is the second anniversary of your death, provided this benefit is in force.

DENTAL PLAN HIGHLIGHTS

The ***3sHealth Core Dental Plan*** provides:

- up to 100% reimbursement for covered preventive services,
- up to 75% reimbursement for covered basic and routine services,
- up to 50% reimbursement for covered major restorative services,
- spousal and dependent coverage, and
- co-ordination of benefits with other plans.

The ***3sHealth Out-of-Scope Enhanced Dental Plan*** provides:

- over 270 additional coverage codes,
- 100% reimbursement for additional covered preventive service codes,
- 100% reimbursement for additional covered basic and routine service codes,
- top-up coverage to enhance the existing 75% coverage codes for basic and routine services to 100%,
- 75% reimbursement for additional covered major restorative service codes, and
- 50% reimbursement for covered orthodontic codes up to a lifetime maximum of $2,500 for each dependent child and $1,500 for you or your spouse.

** the maximum reimbursement schedule can be found at www.3sHealth.ca

Benefit Entitlement

Permanent Full-time Employees

Permanent full-time employees are reimbursed for covered procedures at the following levels:

Level I – Preventive Services

The lesser of 100% of the Eligible Charge or the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* fee for the specified procedure, minus core coverage.

Level II – Basic & Routine Services

The lesser of 100% of the Eligible Charge or the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* fee for the specified procedure, minus core coverage.

Level III – Major Restorative Services

The lesser of 75% of the Eligible Charge or the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* fee for the specified procedure, minus core coverage.

Level IV – Orthodontic Services

The lesser of 50% of the Eligible Charge or the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* fee for the specified procedure up to a lifetime maximum of $2,500 for each dependent child and $1,500 for you or your spouse.

Other than Permanent Full-time Employees

Other than permanent full-time employees are reimbursed for covered procedures at the following levels:

Level I – Preventive Services

Your level of coverage multiplied by the lesser of
100% of the Eligible Charge or the 3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule fee for the specified procedure, minus core coverage.

Level II – Basic & Routine Services

Your level of coverage multiplied by the lesser of
100% of the Eligible Charge or the 3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule fee for the specified procedure, minus core coverage.

Level III – Major Restorative Services

Your level of coverage multiplied by the lesser of
75% of the Eligible Charge or the 3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule fee for the specified procedure, minus core coverage.

Level IV – Orthodontic Services

The lesser of 50% of the Eligible Charge or the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* fee for the specified procedure up to a lifetime maximum of $2,500 for each dependent child and $1,500 for you or your spouse.

Benefit Entitlement (Continued)

The following schedule details the levels of coverage under the plan:

Percentage of Regular Full-Time Hours	Level of Coverage
Less than 40%	NIL
40% - 50%	50%
51% - 60%	60%
61% - 70%	70%
71% - 80%	80%
81% - 90%	90%
91% - 100%	100%

If you have questions about your level of coverage under the plan, please contact your participating employer.

Important Notice About Reimbursement

Only those procedures listed in the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule* are covered under the plan. You are encouraged to access a copy of the current *Schedule* from www.3shealth.ca or by phoning 3sHealth and present it to your dentist each time you or your dependents have dental services performed.

To receive reimbursement for a dental expense, your coverage must be in effect on the date of your dental treatment.

Canada Life reserves the right to determine the amount of any dental benefit payable under the plan by taking into account possible alternative procedures, services or courses of treatment which are based upon accepted dental practice.

For orthodontic claims, payment for charges incurred will be based on one of the following:

(1) If an estimated cost of treatment is used in place of an itemized statement, benefits for the insured cost of the charge will be payable on a monthly or quarterly basis as billed by the dentist. The average monthly benefit will be the total estimated cost of treatment, less the initial cost (case diagnosis, initial appliance cost, treatment plan) divided by the number of months in the treatment plan as specified by the dentist.

(2) If a separate estimate of the cost of the initial appliances is included, the first payment will be an amount equal to the insured cost of the appliance. The remainder of the payments will be calculated in accordance with the terms of clause (1) above.

(3) If a statement is submitted for each treatment as the charge is incurred, payment for the insured cost of the charge will be made as such charge is incurred.

(4) Notwithstanding anything to the contrary in this provision, if an insured described above incurs charges described in another section of this provision as part of a treatment described in the Level IV section, then such charges will be deemed to have been incurred under this Level IV section for the purpose of calculating benefit amounts and maximum benefit amounts.

Pre-authorization

You are encouraged to submit a pre-treatment estimate where the cost of the proposed services is expected to exceed $500.00. The estimate should be submitted on a standard claim form marked “ESTIMATE”. A detailed explanation of covered and excluded services will then be provided directly to you.

Examples Of Eligible Dental Services

Not all procedures are covered by the 3sHealth Out-of Scope Enhanced Dental Plan. Members should refer to the 3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule for the list of procedures covered by the plan. Copies of the Schedule are available from www.3shealth.ca or by phoning 3sHealth.

Level I – Preventive Services

- oral examinations (maximum twice per calendar year)
- fluoride treatments (maximum twice per calendar year)
- bitewing x-rays (maximum of twice per calendar year)
- full mouth x-rays (maximum of once per 24 months)
- study models

Level II – Basic & Routine Services

- amalgam, composite or acrylic fillings
- retentive pins
- extractions
- dental surgery including x-rays and laboratory services
- endodontics
- periodontics both surgical and non-surgical
- emergency treatment for pain
- repairs to existing dentures
- relining and rebasing of existing dentures
- re-cementing of existing inlay or crown
- prefabricated stainless steel crowns

Level III – Major Restorative Services

- installation of crowns, complete or partial dentures or fixed bridges
- repairs to and re-cementing of an existing fixed bridge
- replacement of crowns, dentures, or bridges where:
    1. the existing appliance is at least 5 years old and cannot be made serviceable, or
    2. the replacement is for an equivalent denture or bridgework, or
    3. the existing appliance is replaced because additional teeth have been extracted after the denture or bridgework insertion, or
    4. the existing appliance is an immediate temporary appliance, for which impressions were taken while insured. The permanent replacement appliance must be placed within 12 months from the date of installation of the immediate temporary appliance.

Level IV - Orthodontic

- charges incurred for all necessary dental services or treatment which has as its objective the correction of malocclusion of the teeth including but not limited to examinations, x-rays, models, photographs, reports and surgical exposure of teeth.

Dental Plan Limitations

No amounts are paid by Canada Life for expenses incurred for, or as a result of:

- procedures not contained in the *3sHealth Enhanced Dental Plan Maximum Reimbursement Schedule*;
- war, insurrection or hostilities of any kind whether or not you or your dependent were a participant in such action,
- participation in a riot or civil commotion,
- the commission or attempted commission of any offence contained in the *Criminal Code*,
- any dental care or treatment for which you are not legally obliged to pay,
- any dental care treatment which is principally for cosmetic purposes,
- any appointments not kept or for the completion of claims forms,
- any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction,
- any endodontic treatment commencing before you or your dependent became insured under this benefit,
- replacement of mislaid, lost or stolen appliances,
- any crowns placed on teeth that are not functionally impaired by incisal or cuspid damage,
- any crowns, bridges or dentures for which tooth preparations were made before you or your dependent became insured under this benefit,
- any procedures, appliances or restorations used to increase vertical dimensions, or to repair teeth damaged or worn due to attrition or vertical wear or to restore occlusion,
- any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants,
- any orthodontic expenses which were incurred prior to the date on which you became insured,
- charges in excess of the specific limitations and maximum amounts,
- experimental treatment,
- sport or recreational services or supplies,
- charges in excess of Reasonable and Customary Charges for the least expensive appropriate treatment,
- any services related to dietary planning,
- congenital or developmental malformation, and
- services or supplies which are not in accordance with generally accepted dental practices.

Canada Life will conclusively determine if any expense falls within any of the above categories.

In cases where coverage exists through any other government, medical or dental program, including the Saskatchewan Medical Services Plan, Worker's Compensation, Saskatchewan Government Insurance or any other government programs or legislation, the plan will not accept responsibility for claim payment.

CANADA LIFE'S GROUP CUSTOMER CONTACT SERVICE CENTRE

English: 1-866-408-0213
TTY – Available for the Deaf or Hard of Hearing: 1-800-990-6654
Fast, Easy, Convenient
Available Monday – Friday
6:30 a.m. to 6 p.m. CST (April – October)
7:30 a.m. to 7 p.m. CST (November – March)

When you have questions about your coverage or claims, you know you can call the number above. And when you do, a customer service representative will provide quick and easy answers to all your questions.

When you call you'll be greeted by an automated attendant. You will then need to select the appropriate option, medical or dental, which will connect you to a customer service representative who will assist you with your inquiries.

When calling you will need:
- **Touch-tone phone**
- **Group Number (335663)**
- **Certificate Number/Benefit ID Number**

The customer service representative will ask you for this information.

Don't know your group or certificate numbers? While any caller can receive general information, to protect your privacy, you'll need those numbers if you want details about your confidential paid claims. These numbers can be found on your Explanation of Benefits statement and your pay direct drug card.

My Canada Life at Work

As a Canada Life plan member, you can register for My Canada Life at Work™ at www.mycanadalifeatwork.com. Make sure to have your plan and ID numbers available when registering.

With My Canada Life at Work you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

Canada Life Online

Information and details on Canada Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website www.canadalife.com.

CANADA LIFE'S GROUP CUSTOMER CONTACT SERVICE CENTRE

Customer complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

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