Western

My Benefits

For Eligible Full-Time Members of the Professional and Managerial Association (PMA)

May 2024

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» Benefits at-a-Glance

BENEFIT	FEATURES
HEALTH CARE	• Compulsory unless covered by spouse's plan • 85/15 Co-insurance – The plan pays 85% of most medical/dental costs. You pay 15% up to a maximum yearly total of $450 for single coverage/$900 for family coverage in **combined** health care and dental expenses. Expenses above the maximum will be reimbursed at 100%. • Prescription drugs • Dispensing fee - $6.11 per prescription • Vision care - $300 per person every two years (Laser eye surgery eligible) • Paramedical services • Hospital care – semi-private/private • Medical services and supplies, including hearing aids • Emergency Travel Assistance plan - $200,000 per person per 90 day trip

BENEFIT	FEATURES
DENTAL PLAN	• Compulsory unless covered by spouse's plan • 85/15 Co-insurance – Out of pocket maximum per year combined with health care ($450 Single/$900 Family) • Based on current year's Provincial Fee Guide in province where service is rendered • Basic Services • Supplementary Basic Services (e.g. root canal) • Major Restorative Services (crowns, bridges) and dentures
FLEXIBLE BENEFIT CREDITS	• $2,000 per year • Your choice annually where to allocate these flexible benefit credits • Allocate to HCSA and/or PER annually

BENEFIT	FEATURES
HEALTH CARE SPENDING ACCOUNT (HCSA)	• Can be used to pay many medical and dental expenses not covered or only partially covered by Health Care and Dental plans for you and your eligible family members
LIFE INSURANCE	• Basic Life Insurance – two times annual base salary on your life (compulsory life insurance) • Optional Life Insurance – up to an additional five times annual base salary on your life (Basic and Optional Life maximum benefit - $1,000,000) • Dependent Life Insurance - $40,000 (spouse) and $10,000 (each eligible child)
ACCIDENT INSURANCE	• Voluntary Accident Insurance – increments of $10,000 (maximum $500,000) • 24-hour protection against accidents worldwide • Coverage for you or you and your eligible dependents

BENEFIT	FEATURES
SHORT-TERM SALARY CONTINUANCE/LONG TERM DISABILITY	• Protection against loss of income due to medically supported injury or illness • Salary continuance – 100% salary up to a maximum of 15 weeks (105 consecutive working days) • Long Term Disability – 70% of your normal basic monthly salary– maximum benefit $6,000 per month
ADMINISTRATIVE PENSION PLAN	• Defined contribution plan • Your contribution – 5.5% of pensionable earnings • Employer contribution – Under 10 years, 8.0%, 10 to 19 years, 8.5% and 20 or more years, 8.5% (9% if your contribution is 5.5%). • Wide range of investment options and option for voluntary contributions
POST-RETIREMENT BENEFITS	• Health and Dental Care • Emergency Travel Assistance plan – $200,000 per person per trip (60 day duration) • Retirement Death Benefit - $15,000

BENEFIT	FEATURES
OTHER BENEFITS	• Vacation – plus additional days Western designates annually • Dependent Tuition Scholarship • Recognition programs for long service and retirement • Supplemental income for maternity/parental leaves • Employee Assistance Program • Professional Expense Reimbursement • Educational Funding • Leaves and other workload arrangements • Disability Management - services from an ergonomist, a rehabilitation nurse and an occupational therapist

» Eligibility

To be covered by the Western active group benefits program, you and your dependents must reside in Canada, and meet the following eligibility requirements:

EMPLOYEE	• An employee who is actively employed in a full-time PMA position is eligible for coverage on their first day of full-time active employment.
SPOUSE	• The person to whom you are legally married; or • The person who has continuously lived with you in a conjugal relationship outside marriage for at least one year Note: The person you designate as your spouse is recognized until such time you advise otherwise. Any dissolution of a marriage through divorce, or in the case of common-law marriage, actual separation for more than 90 days, results in the loss of status of spouse. Contact Human Resources to remove your ex-spouse from your benefits.
DEPENDENT CHILDREN	• "Child" means a natural, legally-adopted, step or foster child of yours, or of your spouse who is: ○ An unmarried dependent child under age 21, not engaged in full-time employment and dependent on you or your spouse for financial support; **or** ○ An unmarried dependent child under age 25 and a full-time student, not engaged in full-time employment and dependent on you or your spouse for financial support; **or** ○ Dependent on you for maintenance and support because of a mental or physical infirmity that began while the child was under age 21, or age 25 if the child was a student. A child of a spouse who is not legally married to you is eligible if the child's primary residence is with you, the employee. Coverage will continue until the end of the month following the date the child is no longer eligible for coverage as described above.

DEPENDENT CHILDREN STUDYING OUTSIDE CANADA

We recommend that medical coverage be purchased through the academic institution your child is attending. Some schools will not accept the Canadian plan's travel coverage when there are dollar limits (annual or lifetime) on essential benefits. It is typically a minimum requirement of the school that foreign students purchase their student insurance plan.

HEALTH AND DENTAL COVERAGE OPTIONS WHEN NO LONGER ELIGIBLE

The insurance provider offers a full line of individual and family health and dental plans specifically designed for employees and/or their dependents that no longer have group health and dental coverage. Application for coverage must be made within 60 days of termination of benefits from your group health or dental plan. Further information including the application can be found on the Manulife CoverMe website or by contacting Human Resources at 519-661-2194.

» Health Care

Your basic medical needs including doctor visits, hospitalization, many tests and vaccinations are covered by your provincial health plan. Once you reach age 65, some provinces provide a provincial plan that covers prescription drugs. In Ontario, this plan is called the Ontario Drug Benefit (ODB) plan. Western's Health Care plan helps you with expenses not covered by the provincial plan or other government-sponsored programs.

Coverage under the Western plan is available only to a person who is eligible for benefits under his or her provincial health care plan or under another plan providing comparable benefits.

WHAT'S COVERED

Depending on the treatment, the health care plan covers all or 85% of the cost of eligible health care expenses, subject to limits on certain benefits and a prescription drug dispensing fee cap. The expenses must be:

- Medically necessary (as determined by the insurance provider) for the treatment of illness or injury and, in most cases, prescribed by a licensed medical practitioner
- In the insurance provider's opinion, reasonable and customary expenses
- Not covered under the provincial plan or any other government-sponsored program
- Not in excess of any stated maximums
- Used as prescribed or recommended by a physician
- In the insurance provider's opinion due diligence for the drug, supply or service has been completed where required
- A medication that has been approved for use by Health Canada and assigned a drug identification number

New drugs, existing drugs with new indications, services and supplies are reviewed by the insurance carrier using their due diligence process. The insurance provider will decide to either i) include, ii) include with Prior Authorization criteria, iii) exclude or iv) apply maximum limits for the new or existing drug/services/supplies.

The insurance provider maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternatives, you or your eligible dependents may be required to have tried an alternative treatment. To see the list of drugs requiring prior authorization, visit the insurance provider's plan member site. The most up to date listing can be found under Forms - Plan Member Brochures.

At the insurance provider's discretion, medical information, test results or other documentation may be required to determine the eligibility of the drug, service or supply.

The insurance provider has the right to ensure you or your dependents access their exclusive distribution channels where applicable when purchasing a drug, service or supply.

The insurance provider may require you or your dependents to apply and participate in any patient assistance program(s) and reserves the right to reduce the amount of a covered expense by the amount of the financial assistance you or your covered dependents are entitled to receive under a patient assistance program.

We suggest that you check with the insurance provider before incurring large expenses.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of the change, whether the expenses will be eligible or not.

OUT OF POCKET MAXIMUM

The maximum you will pay for **combined** health care and dental expenses in a calendar year is $450 for a single person or $900 for a family. If you reach the maximum, you will be reimbursed at 100% for eligible expenses the remainder of that year. This co-insurance arrangement does not apply to internal maximums already defined within the plan such as:

- Paramedical services
- Vision care
- Major restorative benefits under the dental plan
- $6.11 dispensing fee cap

If your status changes between single and family coverage part-way through the year, any out of pocket expenses covered by the plan you've incurred towards the single or family maximum will be included in the combined maximum for that calendar year.

Example: You and your spouse incur eligible health and dental expenses from January to July totaling $6,000 for which the Western plan paid 85% ($5,100) and you were out of pocket $900. The remainder of the eligible expenses for the balance of the calendar year will be paid at 100%.

Reasonable and Customary Limitations apply to health care and dental benefits. This means claims are adjudicated based on the lowest of the:

- Prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by the insurance provider
- Amount shown in the applicable professional association fee guide
- Maximum price established by law

Temporarily living outside of Canada

You should contact the local ServiceOntario centre to make arrangements for continuous Ontario Health Insurance if you are planning on leaving Canada for a period exceeding 212 days in any 12-month period. Further information can be found on the Ministry of Health website.

Medically Necessary

Means the treatment, service or supply must be accepted and recognized by the Canadian medical profession and the Insurer as effective, appropriate and essential treatment of a phase of an illness or injury. The insurance provider has the right after due diligence has been completed to determine whether the drug, service or supply is eligible under the plan.

PRESCRIPTION DRUGS
85% COVERAGE

With the exception of two categories of drugs, most eligible prescription drugs are covered at 85% when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist. The drug must legally require a prescription. This includes compounded preparations provided at least one of the ingredients is eligible.

In addition, drugs that may not legally require a prescription – but are in an injectable format, or are life sustaining (as determined by the insurance provider), and identified in the therapeutic guide section of the current Compendium of Pharmaceuticals and Specialties – may be covered. These include:

- Antianginal agents
- Antiarrhythmic agents
- Anti-inflammatories
- Anticholinergic preparations
- Antihistamines
- Antiparkinsonian agents
- Antihyperlipidemic agents
- Bronchodilators
- Glaucoma therapy
- Hyperthyroidism therapy
- Oral fibrinolytic agents
- Parasympathomimetric agents
- Potassium replacement therapy

- Topical enzymatic debriding agents
- Tuberculosis therapy

The plan also covers:

- Preventive vaccines and medicines (oral or injected)
- Insulin, needles, syringes, lancets and chemical testing agents for the management of diabetes.
- B6 and B12 injectable vitamins when used for weight loss
- Non-oral contraceptives, limited to a maximum of $50 per person per calendar year (this overall maximum includes expenses for contraceptive devices listed under Medical Aids, Appliances, Services and Supplies)

The following two categories of drugs are covered at 100%, up to the specified maximums shown below:

- Smoking cessation aids – to a lifetime maximum of $500 per person
- Fertility drugs – to a lifetime maximum of $12,000 per person

There are some items not covered by Western's health plan, including, but not limited to:

- Drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- Drugs determined to be ineligible as a result of the insurance provider's due diligence process
- Vitamins (other than injected vitamins), vitamin/mineral preparations and food supplements
- Chelation therapy
- Drugs used in the treatment of sexual dysfunction, other than Caverject and Muse
- Hair growth stimulants
- General public products, whether or not prescribed
- More than a 3-month supply of a drug or medicine
- Dispensing fees that exceed the maximum

There are some items covered by Western's health plan that may also be covered by government programs (e.g. Assistive Devices Program). Please check with your healthcare practitioner to see if the item you require is covered by a government program.

Managing rising costs

Dispensing fee cap – While you can fill your prescriptions at any pharmacy you choose, some pharmacies charge higher dispensing fees than others. The plan limits reimbursement of dispensing fees to $6.11 per prescription. It's a good idea to shop around and find the pharmacy near you that charges the lowest dispensing fee.

Lower cost alternative drug – The maximum coverage for any eligible expense is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by the insurance provider. If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug. This limitation will not apply if the physician indicates in writing that no substitutions may be made for the drug or medicine prescribed.

VISION CARE

- Eye exams – up to $25 per exam
- Prescription glasses and contact lenses (includes repairs) – $300 per person every two years. Laser eye surgery may be claimed under the vision care benefit.
- Lenses after cataract surgery for medically necessary contact lenses - $100 per eye lifetime maximum
- Visual training or remedial exercises – $10 per half hour

Vision care supplies must be prescribed by an ophthalmologist or licensed optometrist for the correction of vision.

Safety glasses and non-corrective glasses or non-corrective sunglasses are not covered.

PARAMEDICAL SERVICES

The plan covers the services of licensed practitioners, up to $15 a visit unless otherwise indicated. A Physician's written recommendation is not required for practitioner services.

Practitioners include:

- Chiropractor - $15 per visit per covered person after the 15th visit per calendar year (includes x-rays, up to $35 per person per calendar year)
- Massage Therapist
- Naturopath
- Speech Pathologist
- Physiotherapist
- Osteopath (Eligibility Memorandum)
- Podiatrist /Chiropodist - (includes up to $200 per calendar year for surgery performed by a podiatrist)
- Acupuncturist

Note: In addition to the coverage noted above, you may use your Health Care Spending Account to cover the remaining cost of the services outlined.

MENTAL HEALTH PROFESSIONAL SERVICES

(Effective January 1, 2023)

The plan covers 85% of eligible expenses for:

Services delivered by individuals who are registered by the College of Psychologists of Ontario, the College of Registered Psychotherapists of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the Ontario College of Social Workers, Ontario Registered Clinical Counsellor or the Canadian Registry of Marriage and Family Therapists

HOSPITAL CARE

The plan covers 85% of eligible expenses for:

- Semi-private or private room and board (not a suite) in an Active Treatment Hospital or Chronic Care Hospital in excess of the Hospital's standard ward accommodation charge

An eligible hospital must:

- Be licensed as a Hospital
- Have physicians and registered nurses on duty or on call 24 hours per day
- Be eligible to receive payments under a provincial hospital program

Confinement in an eligible hospital is covered regardless of the type of care being provided, such as rehabilitation, convalescent care, palliative care or drug and alcohol treatment.

Private hospitals that are not eligible to receive provincial funding are not eligible under the program.

Co-payment fees or similar charges for chronic care are not eligible for reimbursement.

Facilities not covered:

- Federal hospitals
- Rest homes or homes for the aged
- Nursing homes/convalescent nursing homes
- Health spas or hotels

MEDICAL AIDS, APPLIANCES, SERVICES AND SUPPLIES

The plan covers many medical services and supplies however; there are specific requirements and restrictions. This booklet is not exhaustive and there may be additional items covered that are not outlined here. Prior to incurring an expense, you are advised to submit a treatment plan and cost estimate to the insurance provider to determine eligibility and find out how much coverage you can expect. Reasonable and customary limitations apply and items must be deemed to be medically necessary by the insurance provider.

The plan covers the following expenses per covered person, such as:

- Custom-molded orthopaedic shoes, when prescribed by an orthopaedic surgeon, physiatrist, rheumatologist, physician, podiatrist or chiropodist - one pair per calendar year (the first $75 in a calendar year is not covered), **or** modifications to street shoes including scaphoid pads, torque heels, insoles, molded arch supports etc. (limited to one pair per person in a calendar year)
- Custom-moulded orthotics – one pair per calendar year to a maximum of $400, on the recommendation of a physician, chiropodist or podiatrist
- Wigs – for permanent or temporary hair loss as a result of medical treatment to a lifetime maximum of $700
- ObusForme products – up to $100 per 5 calendar years
- Enuresis equipment – up to $100 per calendar year
- Blood glucose monitors– up to $200 per calendar year
- Insulin jet injectors up to $350 per calendar year
- Transcutaneous Electrical Nerve Stimulation (TENS) machine, limited to 50% of the cost
- Intra-uterine devices (IUD's) and contraceptive diaphragms – up to maximum $50 per covered person in a calendar year (this overall maximum includes expenses for non-oral contraceptive drugs listed under Drugs and Medicines)
- Mozes detectors, limited to the cost of three months rental
- Compression garments and medical supplies

The plan covers 85% of many other eligible expenses, such as:

- Diabetic appliances, insulin infusion pumps and accessories
- Hearing aids - cost, installation, repair and initial batteries, maintenance (excludes replacement batteries or hearing tests)
- Private duty nursing (for services that can only be delivered by a Registered Nurse (R.N.) or Registered Practical Nurse (R.P.N.) who is not ordinarily a resident in your home or related to you or your dependents). The insurance provider must pre-approve services in advance.
- Ambulance service, including air ambulance, to the nearest hospital where medical care can be provided, when necessary as a result of a medical emergency
- Rental or purchase of mobility equipment (e.g., crutches, canes, and walkers) and durable medical equipment (e.g. respiratory and oxygen equipment)
- Artificial limbs (when myoelectric prostheses are required, only the amount that would be paid for standard artificial limbs will be eligible), artificial eyes
- Rental or, at the insurance provider's option, purchase of a single-sized, standard-type hospital bed (includes single-sized mattress)
- Rental or, at the insurance provider's option, purchase of a wheel chair or scooter (may include costs for repairs – replacements will only be eligible if existing item cannot be repaired)
- Surgical supports (e.g., surgical elastic stockings up to a maximum of two per calendar year, six surgical brassieres per calendar year)
- External breast prostheses
- Stump socks – up to a maximum of six per calendar year
- Respiratory oxygen and equipment necessary for its administration
- Ileostomy, colostomy and incontinence supplies (excluding gloves)
- Tracheostomy supplies (excluding gloves)
- Diagnostic tests and services carried out in a licensed medical laboratory, in excess of benefits paid by the provincial plan
- Dialysis equipment
- Compressor and equipment necessary for its use
- Apnea monitor
- Equipment for treatment of cystic fibrosis
- Burn pressure garments

- Prostatic Specific Antigen (PSA) test – two tests per 12 consecutive months

EXCLUSIONS

There are various exclusions whereby the insurance provider will not pay benefits for expenses incurred for or in connection with such as, but not limited to:

- Care, services or supplies which are not medically necessary, as determined by the insurance provider
- Care, services or supplies which are for primarily cosmetic purposes, except those which are related to reconstructive surgery required to repair or replace damages by disease or bodily injury
- Care or services which are experimental or investigational – not approved as an effective, appropriate and essential treatment of an illness or injury
- Rest cures, travel for health reasons, periodic health checkups or examinations for the use of third party
- A medical condition caused by or related to war (whether or not war is declared), participation in any civil commotion, insurrection or riot, or while serving in the armed forces
- Services or supplies to the extent they are available under any government plan (benefits under a government plan must be accessed first before any benefits are payable)
- Additional, duplicate or replacement appliances or devices. (Note: subject to prior written approval by the insurance carrier, this exclusion will not apply if the replacement is required as a result of pathological change or because the existing item can no longer be made serviceable due to normal wear and tear)
- The services of a physiotherapist who has an agreement with the provincial health insurance plan
- Committing or attempting to commit, a criminal act
- Fees for completion of claim forms or other documentation, transfer of medical files or failing to keep a scheduled appointment
- Drugs, injectables, supplies or appliances which are experimental or are not approved by Health Canada
- Care, services or supplies used as treatment to a lifestyle choice (as determined by the insurance provider)
- Benefits or that part of benefits which cease to be payable under any government plan
- Drugs, medicines, services or supplies required for the condition requiring hospitalization while you or your dependents is an in-patient in a hospital
- Services or supplies that are covered under the Emergency Travel Assistance plan

RECOVERING OVERPAYMENTS

The insurance provider has the right to recover any overpayment of benefits from the person or organization who received payment that was not covered under the plan. If the overpayment cannot be recovered directly, the insurance provider has the right to reduce future benefit payments until the overpayment has been recovered in full.

» The Emergency Travel Assistance Plan

The Emergency Travel Assistance plan covers 100% of eligible expenses resulting from an accident or a sudden unexpected illness incurred while travelling outside your province of residence or outside Canada, to a maximum of $200,000 per person, per 90 day trip.
Coverage details:

- You must be covered under your provincial health insurance plan to be eligible for this coverage.
- A medical emergency is a sudden, unexpected injury, a new medical condition, or a specific medical problem or chronic condition that was diagnosed but medically **stable** before you began your travels.
- Stable means that in the 90 days before departure, the covered person has not been treated or tested for any new symptoms or conditions; did not have an increase or worsening of any existing symptoms; did not change treatments or medications (other than normal adjustments for ongoing care); had not been admitted to the hospital for treatment of the condition.
- A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

ELIGIBLE EMERGENCY MEDICAL EXPENSES

Emergency medical expenses include the following:

- Prescription drugs
- Physician charges in excess of the amount paid by the provincial health insurance plan
- Hospital accommodation – semi-private or private room and board in an Active Treatment Hospital in excess of the amount paid by the provincial health insurance plan
- Hospital charges for out-patient treatment
- Licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- Services which are deemed to be within the practice of nursing and which can only be provided by a registered nurse (RN) during or immediately following hospitalization
- Up to $15 per visit for charges made by a licensed physiotherapist, chiropractor, podiatrist / chiropodist or osteopath (including x-rays)
- Laboratory tests and x-rays ordered by the covered person's attending physician
- Medical appliances such as splints, casts, crutches, walkers, and/or the rental of a wheelchair
- Relief of dental pain – expenses for emergency treatment to relieve dental pain, excluding root canals and dental accident expenses incurred for dental treatments to natural teeth caused by an external blow to the mouth – based on Dental Association Suggested Fee Guide for General Practitioners in member's province of residence
- Miscellaneous hospital expenses – up to $100 to cover incidental expenses. Receipts must be submitted.

EXCLUSIONS

There are various items not covered including, but not limited to:

- Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.
- The Emergency Travel Assistance Plan does not cover referrals outside Canada for treatment which is available in Canada.

REMEMBER!

Medically stable means 90 days before departure there has been:

- No treatment or tests for any new symptoms or conditions;
- No increase or worsening of any existing symptoms;
- No changed treatments or medications;
- No admittance to the hospital for treatment of the condition

EMERGENCY TRAVEL ASSISTANCE

Emergency assistance services are available provided arrangements are made through the Assistance Centre. You should contact the Assistance Centre immediately, in the event of an emergency while traveling. Assistance services include:

- 24-hour access, seven days a week
- Medical referral to the nearest physician, dentist, pharmacist or appropriate medical facility
- Claims payment services if a provider or hospital requires a deposit or payment in full for services rendered, and expenses exceed $200 Canadian; payment will be arranged and claims coordinated
- Medical care monitoring by medical staff who will maintain contact with the covered person, attending physician, the covered person's personal physician and family
- Medical transportation to and from the nearest medical facility, and, if medically necessary, round-trip transportation for a qualified medical attendant to accompany the covered person
- Trip interruption/delay
- Meals and accommodations
- Visit of family member; return home of dependent children
- Vehicle return
- Return of deceased covered traveler

For more details, please see the Emergency Travel Assistance brochure.

NON-EMERGENCY MEDICAL TREATMENT OUT OF PROVINCE/CANADA

Non-Emergency treatment means treatment received outside your province of residence that requires immediate attention, but is not considered emergency or life threatening. This includes any medical treatment required to allow the covered person to resume normal activities or travel plans. It is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will be notified of any benefit that will be provided. The treatment must be recommended by a physician practicing in Canada and not be available in Canada. This is covered under either the Non-Emergency or Elective Treatment provisions under the Health Care benefit. You will need to pay for any expenses in full and submit them to the provincial plan for reimbursement. Any balances can be submitted to the insurance provider for consideration, along with a copy of provincial plan statement of payment/denial. Eligible expenses are subject to any coinsurance and/or maximums applicable under the Health Care benefit. The Non-Emergency treatment provision provides coverage for out of country incidents/illnesses that require immediate attention, but are not eligible under the Emergency Travel Assistance plan. Treatment that is not under either the Emergency Travel Benefit or Non-emergency Treatment provision is considered to be elective.

Reimbursement for eligible expenses is based on the amount you could expect to pay for the same treatment in your province of residence, with the following exceptions:

- Services of a physician or surgeon when those services are received outside Canada for non-emergency treatment or elective treatment, in excess of the amount payable by the covered person's provincial health insurance plan
- Hospital room and board rates (semi-private or private), subject to a maximum of $200 per day

» Dental

Regular dental care is a vital part of good health. Western's dental benefit provides comprehensive coverage to meet your needs.

WHAT'S COVERED

The plan provides payment towards reasonable and customary charges for necessary dental services up to the current Dental Association Suggested Fee Guide for General Practitioners, or any dental specialist's fee guide approved by the dental association in effect in the province where treatment is rendered. For most dental expenses, the plan reimburses you 85% of the cost.

However, under the out-of-pocket maximum provision the maximum you will pay for accumulated health care and dental expenses which are subject to the 85% reimbursement provision in a calendar year is $450 for a member with single coverage and $900 for a member with family coverage. If you reach the maximum, you will be reimbursed at 100% of eligible expenses for the remainder of that year. Eligible expenses covered at 80% do not accumulate towards the out of pocket maximum.

PAYMENT OF BENEFIT

You will be reimbursed provided eligible expenses are:

- For services or supplies ordered or provided by a Dentist or Denturist
- For services or supplies which are generally accepted by the dental profession as essential, effective, appropriate and customarily used in the diagnosis, care or treatment of a specific dental condition or injury; and
- For services or supplies specified below which are not performed or provided in connection with an ineligible service or supply
- Not in excess of
    - Any maximum amount specified in the applicable fee guide; or
    - Reasonable and customary charges, as determined by the insurance provider, for expenses not included in the applicable fee guide

The plan covers 85% of eligible expenses such as:

- Complete oral exams, once every three years
- Emergency examinations
- Recall exams, bitewing x-rays and fluoride treatments, once every nine months
- Full-mouth x-rays, once every five calendar years
- Panoramic x-rays, once every five calendar years
- Scaling and polishing, one unit of time, once every nine months
- Fillings, retentive pins and pit and fissure sealants
- Space maintainers (appliances placed for orthodontic purposes are not covered)
- Extractions
- Routine diagnostic tests and laboratory exams
- Minor surgical procedures and post-surgical care
- Anesthesia and conscious sedation
- Periodontal procedures
- Endodontic procedures – root canals and therapy

The plan covers 80%* of eligible expenses such as:

- Denture repairs and additions
- Denture remake, relines and rebases once every two calendar years

Once every 60 months, for natural teeth only:

- Full or partial removable dentures
- Crowns and bridges and onlays
- Metal inlays and onlays
- Fixed bridgework
- Gold foil restorations
- Veneers (laboratory processed)

* Expenses covered at 80% do not accumulate towards the out of pocket maximum.

DENTAL ACCIDENT COVERAGE

The Health Care plan also includes coverage for dental care provided by a dentist to repair or replace natural teeth damaged as a result of a direct external accidental blow to the mouth. Coverage is based on rates in the Dental Association Suggested Fee Guide for General Practitioners. If a dental accident happens outside Canada, the plan does not cover any amount that is greater than it would pay for such expenses when incurred in the province of residence. Treatment must be reported and approved for payment within 12 months of the date of the accident.

Pre-approval of large expenses

If the cost of a proposed dental treatment is expected to exceed $500, you are strongly advised to submit a detailed treatment plan to the insurance provider beforehand to find out how much will be covered by the plan.

EXCLUSIONS

There are various items not covered including, but not limited to:

- Any dental procedure which is not eligible
- Services or supplies performed or provided in connection with an ineligible procedure
- Dental care, services or supplies which are primarily for cosmetic purposes, as determined by the insurance provider
- Services performed by a dental hygienist in an independent private practice
- Services or supplies to which you or your eligible dependent are entitled to receive under any Government plan
- Services or supplies which would be available without charge if this benefit was not in effect
- Conditions arising from war (whether or not war is declared), participation in any civil commotion, insurrection or riot, or while serving in the armed forces
- Temporomandibular joint-related problems
- Laboratory fees which exceed Reasonable and Customary charges, as determined by the insurance provider

REMEMBER!

In addition to the coverage noted above, you may use your Health Care Spending Account to cover the remaining cost of the services outlined

» Flexible Benefit Credits

In addition to many other benefits, Western provides you with flexible benefit credits that may be allocated into one of the following accounts to reimburse for a wide variety of expenses:

- Health Care Spending Account (HCSA)
- Professional Expense Reimbursement Account (PER)

Annually, you will receive $2,000 in flexible benefit credits. You will have an option to allocate these credits towards a Health Care Spending Account (HCSA and or a Professional Expense Reimbursement (PER) Account – the choice is yours.

If you don't make your election by the deadline, the flexible benefit credits are irrevocably allocated to the default option.

MAKING YOUR CHOICE

A notice will be sent to you in November each year, letting you know it is time to allocate your flexible benefit credits for the upcoming year. At that time, you may sign into "My Human Resources", prior to the deadline, and make your election. Tax rules stipulate that an irrevocable decision about how much you allocate to the HCSA and PER account must be made in the year prior to the year the account is utilized in order to ensure they remain non-taxable benefits to you.

For information on the value of your flexible benefit credits, the default option when no elections are made and more details on the plan provisions see the document Flex Credits Allocation on the HR website or your collective agreement.

» Health Care Spending Account (HCSA)

A Health Care Spending Account (HCSA) complements your group benefit plan. The HCSA can be used to pay for many medical and/or dental expenses that are not covered or only partially covered by your Health Care and Dental plans or provincial health care plans. The reimbursement of expenses through the HCSA is non-taxable to you which means that your money goes a lot further than if you paid the same expenses out of pocket. The HCSA not only provides you with the flexibility when budgeting to meet the specific health care needs of you and your dependents, but also gives you more control over funding of your health care expenses.

Eligible expenses means health care and dental care expenses which qualify as a medical expense under section 118.2(2) of the Canadian Income Tax Act and Regulation 5700, as amended from time to time, or health care and dental care expenses the insurance provider deems as an eligible medical expense under a private health services plan or a group accident and sickness plan, provided eligible expenses are:

- Medically necessary for the treatment of an illness or injury of a covered person
- Incurred for the care of the person while covered under the HCSA
- Not covered under a provincial plan or any other government-sponsored programs; and
- Not prohibited by law from being covered

Western establishes a HCSA with the insurance provider at the beginning of each calendar year. The insurance provider will pay benefits for eligible expenses incurred by you and any individual who meets CRA definition of financially dependent, which may include individuals not covered under Western's Health Care and Dental Plan (e.g. eldercare). The amount of credits remaining in your HCSA at any given time will be your account balance.

If you have a balance in the HCSA at the end of the calendar year, that amount will be carried forward to the next calendar year. Reimbursement will be first paid from the earlier year's credits. At the end of the second calendar year, tax laws require that any credits remaining from the previous year be forfeited.

As Canada Revenue Agency (CRA) decides what expenses are eligible under the HCSA, it is recommended that you access the CRA published list of expenses for the most up to date information. You may access this list by visiting the CRA eligible medical expense website.

PAYMENT OF BENEFITS

An eligible expense is allocated to the plan year in which it is incurred. An eligible expense is incurred on the date the services are received or on the date supplies are purchased or rented. Therefore, eligible expenses incurred in one plan year may not be claimed against the plan credits allocated for the next plan year.

ELIGIBLE EXPENSES

Eligible expenses may include, but are not limited to the following expenses:

- Drugs and medicines
- Vision care
- Deductibles and coinsurance amounts under both the Health Care and Dental plans and under any other medical or dental plans
- Practitioner services – fees for services of:
  - Acupuncturists
  - Chiropractors
  - Chiropodists/Podiatrists
  - Naturopaths
  - Nurses
  - Optometrists
  - Osteopaths
  - Physiotherapists
  - Practical nurses
  - Psychoanalysts and psychologists

- Speech therapists
- Masseurs

- Dental care – preventative, diagnostic, restorative, orthodontic and therapeutic dental care
- Facilities including (but not limited to):
  - Meals, lodging and treatment in a treatment centre for alcoholism or drug addiction
  - Care in a nursing home
  - Care in a self-contained domestic establishment (such as a covered person's home)
  - Payments to a public or licensed private hospital
- Devices and supplies such as:
  - Artificial eye or limbs
  - Crutches
  - Device/equipment designed to pace or monitor the heart of a covered person who suffers from heart disease
  - Device or equipment exclusively to enable a covered person with a mobility impairment to operate a vehicle
  - Electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard
  - Hearing aids
  - Hospital bed, including attachments
  - Mechanical device or equipment designed to assist an individual to enter a bath tub or shower
  - Orthopaedic shoes or boots or an insert for shoes or boots made to order
  - Wheelchairs, walkers and limb braces

- Other expenses include:
  - Costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist if a covered person is blind or profoundly deaf
  - Modifications to a home for a covered person who lacks normal physical development or is confined to a wheelchair
  - Costs of medical services and supplies outside of province of residence
  - Diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis
  - Reasonable expenses to locate a donor for a bone marrow or organ transplant and reasonable travelling, board and lodging expense of the donor in respect to the transplant
  - Transportation by ambulance to or from hospital for a covered person
  - Transportation expenses paid to an individual who is in the business of providing transportation services to transport a covered person and one additional person (some conditions apply)
  - Reasonable expenses for meals and accommodation of a covered person and, if required, the accompanying individual (some conditions apply)
  - Reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language incurred to adjust for a covered person's hearing or speech loss

» Life Insurance

An essential part of financial planning is creating provisions for your family and loved ones following your death. Life Insurance can ensure financial security to those who mean the most to you, such as your spouse, children and other beneficiaries. Western offers several different types of life insurance.

EMPLOYEE BASIC LIFE

- Compulsory
- Life insurance on your life at two times your annual base salary (rounded to the next higher $1,000)
- Premium for the first $ 50,000* is paid by Western
- Employer paid premium is a taxable benefit
- No medical evidence is required

* Western provides a Sick Leave benefit that qualifies for a reduction in the EI premiums. Currently, a portion of the reduction (5/12) is used to pay $25,000 of the $50,000 of coverage.

EMPLOYEE OPTIONAL LIFE

- Optional
- You pay the premium based on your age, gender and smoking status
- No medical evidence is required if you apply within 31 days of first being eligible
- Additional life insurance on your life at 1/2, 1, 1½, 2, 3, 4 or 5 times your annual base salary

DEPENDENT LIFE

- Optional
- You pay the premium
- No medical evidence is required if you apply within 31 days of each dependent first being eligible
- Spouse - $40,000
- Child - $10,000 on each eligible child

OPTIONAL SPOUSAL LIFE

- Optional
- Premiums are dependent on your spouse's age, gender and smoking status
- Increments of $25,000 to a maximum of $500,000
- Medical evidence is required

MAXIMUM BENEFIT

The maximum combined benefit for the Basic and Optional Life insurance on your life cannot exceed $1,000,000.

LIMITATION OF COVERAGE

In the event of death by suicide, the Optional Life Insurance and/or the Optional Spousal Life Insurance death payment (if the life benefit was in force for less than one consecutive year) will be limited to the return of premiums.

DEATH BENEFIT

The amount of life insurance at the time of death is paid by the insurance provider when in receipt of the appropriate documentation.

BENEFICIARY DESIGNATION

In the event of death, your designated beneficiary will receive a lump sum payment, based on the level of coverage you choose. It is in your best interest – and your loved ones' – to ensure that your beneficiary designations are up-to-date and that your current wishes are documented and on file. This will ensure that when you die your benefits are paid-out according to your intended wishes. If you do not name a beneficiary, or your beneficiary dies before you and you have not updated your designation(s), the death benefit is paid to your estate. Anyone can be named as your beneficiary, however, if a beneficiary is under the age of 18 or mentally infirm, a trustee must be designated. A contingent beneficiary can also be specified by you and will receive the benefits if your primary beneficiary(ies) is deceased at the time the benefit is to be paid. You are automatically the designated beneficiary for the Dependent Life plan. For more information, consult your financial advisor or a professional well versed in estate planning.

SPECIAL ADVANCE PAYMENT (LIVING BENEFIT)

A Special Advance Payment of the death benefit may be provided to you when all of the following conditions are present:

- In the opinion of insurance provider you are suffering from a condition which is expected to result in death within 24 months of the date of the request for such payment
- Satisfactory medical documentation is provided to the insurance provider by your attending physician
- You are considered, or would be considered eligible under the terms and conditions of Total Disability Waiver of Premiums benefit provision
- You make the request in writing

This Special Advance Payment cannot exceed 50% of the combined amount of your Basic and Optional Life benefit at the time of the request or $50,000 – whichever is less. There can be only one payment payable in a lump sum to you.

The eventual death claim will be reduced by the amount of the loan plus the interest to the date of death. The insurance provider must approve this benefit. If you receive a Special Advance Payment, the amount available for conversion is reduced by the amount of the special advance payment.

CHANGES IN COVERAGE

The Basic and Optional Life plans change in coverage when your basic annual salary is adjusted. If you are not actively at work, the change is effective the date you return to work.

TERMINATION OF COVERAGE

Coverage will terminate on the earlier of one of the following:

Basic and Optional Life Insurance:

- End of the month you terminate your employment
- End of the month you retire
- Your Normal Retirement Date*
- On your death
- The date the plan is cancelled for any reason

Dependent Life-Spouse and Optional Spousal Life Insurance:

- End of the month you terminate your employment
- End of the month you retire
- Your Normal Retirement Date
- The date the plan is cancelled for any reason
- Spouse attains age 65(Optional Spousal Life Insurance only)

Dependent Life Insurance for Dependent Children:

- End of the month you terminate your employment
- End of the month you retire
- Your Normal Retirement Date
- The date the plan is cancelled for any reason

*$15,000 of life insurance is continued beyond your Normal Retirement Date, fully funded by Western.

Conversion Privilege

If your coverage ceases or reduces on or before your Normal Retirement Date (NRD) for any reason other than your request, you may convert your existing group life insurance to an individual policy plan (up to a maximum of $200,000) with the insurance provider without proof of good health, provided you apply and pay your first monthly premium within 31 days of your coverage reducing or attainment of your NRD. During this 31-day period, the amount of life insurance eligible for conversion is continued without charge. To convert your group life insurance to a private policy, contact Human Resources at 519-661-2194. If the coverage ceases for your spouse for any reason other than your request, the spouse may convert their coverage. The conversion option does not extend to any coverage on dependent children.

» Voluntary Personal Accident Insurance

This optional plan offers 24-hour, full-year protection against accidents anywhere in the world, whether you are on or off the job.

You may purchase any amount of insurance in multiples of $10,000 subject to a maximum of $500,000 covering yourself, or yourself and your dependents (Family Plan).

DEFINITION OF DEPENDENTS

Spouse/Partner: Your spouse by virtue of a legal marriage or your partner of the opposite sex or of the same sex who is publicly represented as your spouse and has continuously been so represented for at least the previous year. At any one time, only one person may be insured as your Spouse.

Dependent Children: Your child or the child of your Spouse (biological, adopted or step-child), who is not married or in any other formal union recognized by law, excluding a child who has attained age 21, or age 25 in the case of a full-time student wholly dependent on you for support.

A child who attains the limiting age who is incapable of supporting himself due to physical or mental disability, is dependent on you for support and maintenance, and is not married nor in any other formal union recognized by law is deemed to continue to be a child for as long as these three conditions exist. This continuation is subject to Sun Life Financial receiving proof of the above conditions not later than 31 days after your child attains the limiting age.

THE PLANS

You are insured for the principal sum elected.

If you choose coverage for you and your eligible dependents (Family Plan), your spouse and children will be insured as follows:

- If there are no eligible children, your spouse will be insured for a spouse's principal sum which is equal to 60% of your principal sum
- If there are eligible children, your spouse will be insured for a spouse's principal sum which is equal to 50% of your principal sum, and each eligible dependent child will be insured for a child's principal sum which is equal to 15% of your principal sum
- If there is no spouse, each eligible dependent child will be insured for a child's principal sum which is 20% of your principal sum

An example:
You elect $50,000 on your life and you choose to cover your family consisting of a spouse and three children. Coverage would be as follows:

- You $50,000 (Your Principal Sum)
- Spouse $25,000 (Spouse's Principal Sum)
- Each child $7,500 (Child's Principal Sum)

CHANGES IN AMOUNT OF COVERAGE

You may elect to change the level of your Voluntary Personal Accident Insurance or cancel coverage at any time.

BENEFIT ENTITLEMENTS

If injuries result in death, dismemberment or loss of use within 365 days after the date of the accident, the plan provides the following benefits for you, your spouse and your children:

	You or your spouse (based on you or your spouse's principal sum)	**Your child** (based on your child's principal sum)
Loss of life	100%	100%
Loss of both arms or both legs	200%**	100%
Loss of both hands or both feet	100%	400%
Loss of one hand and one foot	100%	400%
Loss of one hand or one foot, and entire sight of one eye	100%	400%
Loss of one arm or one leg	80%	200%
Loss of one hand or one foot	75%	200%
Loss of four fingers on the same hand	33%	33.33%
Loss of all toes on the one foot	25%	
Loss of four toes on the one foot		50%
Loss of use of both arms or both legs or combination of one arm and one leg	200%**	
Loss of use of both arms or both legs		400%
Loss of use of both hands or both feet or a combination of one hand and one foot	100%	
Loss of use of both hands or both feet		400%
Loss of use of one arm or one leg	80%	200%
Loss of use of thumb and index finger of the same hand	33%	50%
Loss of use of one hand or one foot	75%	150%
Loss of thumb and index finger on the same hand	33%	33.33%
Loss of entire sight of both eyes	100%	400%
Loss of speech and loss of hearing in both ears	100%	400%
Loss of entire sight of one eye	75%	200%
Loss of speech	75%	100%
Loss of hearing in both ears	75%	100%
Loss of hearing in one ear	33%	25%
Quadriplegia	200%**	400%
Paraplegia	200%**	400%
Hemiplegia	200%**	400%

**Subject to a maximum of $1,000,000 per person

Quadriplegia, paraplegia and hemiplegia will become payable after the elimination period of 365 days has been satisfied.

If you or your spouse has multiple losses as a result of one accident, the maximum amount payable will not exceed 100% of the loss of life benefit amount with the exception of the loss of use of both arms, both legs or a combination of one arm and a leg, quadriplegia, paraplegia and hemiplegia. In no event will the maximum benefit amount exceed 200%.

ADDITIONAL BENEFITS

Additional benefits may also be payable. Outlined below is a summary of those benefits. Specific conditions and limitations may apply. Please contact Human Resources should you want more details on these benefits.

Rehabilitation Benefit (Employee Benefit)

A benefit will be paid if an accidental bodily injury prevents you from performing the duties of your regular occupation and requires you to obtain rehabilitation/retraining as determined by a physician approved by the Insurer. Rehabilitation/retraining means the Reasonable and Customary charges for treatment by a therapist licensed, registered or certified to provide such treatment, or confinement in an institution which is licensed to provide such treatment – where treatment is intended to retrain you for work in any gainful occupation including your regular occupation. Treatment must take place under the direction of a certified vocational rehabilitation specialist.

The maximum amount payable is $15,000.

Spouse Occupation Training Benefit (Spouse Benefit)

Benefit is payable only if your spouse incurs expenses within three years following the date of your loss of life. To be eligible for this benefit you must have elected coverage under the Family Plan and enrolled your spouse.

Spouse employment training expenses means the actual incurred costs for tuition, fees, and room and board billed by the institution of higher learning. Also means the costs for required books and course supplies.

The maximum amount payable is $15,000.

CHILD EDUCATION BENEFIT (CHILD BENEFIT)

To be eligible for this benefit you must have elected the Family Plan and enrolled your eligible dependent children.

Education means the actual incurred costs for tuition, fees, room and board billed by the institution of higher learning for the education of your dependent children. The benefit also covers costs for required books and course supplies. Your eligible child must be enrolled as a full-time student at an institution of higher learning on the date of your loss of life or subsequently enrol as a full-time student at an institution of higher learning within two years following the date of your loss of life.

The maximum amount payable is $7,500 per year, subject to $30,000 total benefit payment.

SEAT BELT AND OCCUPANT PROTECTION DEVICE (EMPLOYEE BENEFIT)

Benefits will be paid if, at the time of the accident, you suffer accidental bodily injury resulting in a loss while operating or riding in a private passenger automobile and utilizing a seat belt.

A seat belt means a lap or lap and shoulder restraint device or a child restraint device which meets the Canadian Motor Vehicle Standards.

The maximum amount payable is 10% of benefit amount for seat belt, 10% of benefit amount for occupant protection device to a combined maximum of $50,000.

REPATRIATION BENEFIT

A Repatriation Benefit will be payable when loss of life results in an amount of benefit becoming payable under this benefit.

The maximum amount payable is $15,000.

HOME/VEHICLE ADAPTATION (EMPLOYEE BENEFIT)

The program may provide alterations to your residence that are necessary to make your residence accessible and habitable to you. Adaptation includes modifications to a private passenger automobile that is necessary to make the automobile accessible and/or driveable by you.

The maximum amount payable is $15,000.

FAMILY TRANSPORTATION BENEFIT

The insured person must be confined to a hospital no less than 50 kilometers from his permanent city of residence and the physician recommends the personal attendance of a member of the immediate family.

The maximum amount payable is $15,000.

CHILD CARE EXPENSE (EMPLOYEE/SPOUSE BENEFIT)

The actual incurred costs billed by the provider for the care and supervision of a dependent child under the age of 13.

Expenses must be incurred within 365 days of the loss of life. If, on the date of the insured person's loss of life, the dependent children are not

eligible for child care expenses, a one-time payment of $2,500 will be made in addition to the loss of life benefit.

The maximum amount payable is $5,000 per child per year to a maximum total benefit of $25,000.

IDENTIFICATION EXPENSES

Identification expense (for the purpose of identifying the body of an insured person) means the actual costs for hotel accommodation for a maximum of three days and transportation by a member of the immediate family by the most direct route by a licensed common carrier.

The maximum amount payable is $5,000.

PARENT CARE (EMPLOYEE/SPOUSE BENEFIT)

Dependent parent: parents or grandparent of yours or your Spouse who at the time of an accident is receiving support and care provided by you or your spouse as evidenced by Canadian income tax returns showing parent as a dependent.

The maximum amount payable is $5,000 per eligible parent.

FUNERAL EXPENSES

Funeral expenses means the reasonable costs associated with interment.

The maximum amount payable is $5,000.

PSYCHOLOGICAL THERAPY

Psychological therapy means the reasonable and customary charges for treatment or counselling by a therapist or counsellor, who is licensed, registered or certified to provide such treatment.

The maximum amount payable is $5,000.

VOCATIONAL TRAINING (EMPLOYEE BENEFIT)

Vocational training expenses means the actual costs incurred for tuition, fees, room and board billed by an institution of higher learning that is intended to prepare you for work in any gainful occupation. Includes costs for required books or course supplies.

The maximum amount payable is $15,000.

COMMON ACCIDENT

If a common accident causes you and your spouse's loss of life, the combined Loss of Life benefit amount will be two times the larger of the two Loss of Life benefits amounts payable. This combined Loss of Life benefit amount will not exceed two times your benefit amount.

Common accident means a single accident or separate accidents that occur within the same 24-hour period and result in accidental bodily injury to an insured person and the insured person's spouse. The common accident extension of coverage is subject to a maximum amount of two times your Loss of Life benefits amount.

AGGREGATE LIMIT

When you or your dependent have multiple losses as a result of one accident, the maximum amount payable will not exceed 100% of the Loss of Life benefit amount with the exception of loss of use of both arms, both legs or a combination of one arm and a leg, quadriplegia, paraplegia and hemiplegia.

In no event will the maximum benefit amount per insured person exceed 200%.

BENEFICIARY DESIGNATION

You may designate any person you wish as your named beneficiary and may initiate a change at any time. If the named beneficiary is under the age of 18 or mentally infirm, a trustee must be designated. Benefits payable in the event of your death are paid to your named beneficiary. In the event of your loss under the dismemberment coverage, benefits are payable to you. Losses payable under the Family Plan are automatically paid directly to you.

TERMINATION OF COVERAGE

Coverage will terminate on the earlier of one of the following:

- The date you withdraw from the plan
- The date you terminate your employment
- The date you reach your Normal Retirement Date
- The date you retire; or
- The date the plan is cancelled for any reason

» Sick Leave and Short-Term Disability Benefit

SHORT-TERM DISABILITY-SALARY CONTINUANCE PLAN

During periods of absence due to illness or injury, you will continue to receive your salary from Western as a Short-Term Disability benefit up to a maximum of fifteen weeks (105 consecutive calendar days).

RECURRENT DISABILITY

If you return to work and there is a recurrence of the same or related illness or injury during the first four weeks following your return to work on a full-time basis, you are entitled to the unused portion of the original fifteen week period of Short-Term Disability benefit.

PARTIAL DISABILITY

If you return to work on a part-time basis within the initial fifteen-week period, the sick leave period is extended by any time worked during the initial fifteen-week period.

DISABILITY WHILE ON LEAVE

If you become ill or injured while on Education Leave or Elected Public Office Leave, you can elect to go on sick leave (Short-Term Disability) and the leave would cease to apply.

If your absence due to illness or injury continues beyond fifteen consecutive weeks, you may apply for the Long Term Disability benefit.

NOTIFICATION

If you are unable to report to work because of illness or injury, you must notify your leader or designate of your absence and expected date of return to work as soon as possible.

MEDICAL CERTIFICATION

After an absence of one week, and when reasonably requested thereafter, you will be required to provide a written statement that you are under the care of a health care professional, which describes your ability to attend and perform your work, including an estimated date of return to work.

WORKPLACE ILLNESS OR INJURY

If your illness or injury is a result of and in the course of your employment, an accident report should be completed, signed by your supervisor and submitted to Rehabilitation Services. You will continue to receive your salary as a Short-Term Disability benefit paid by Western, up to the first fifteen weeks (105 consecutive calendar days).

Any benefits (not including a Non-Economic Loss Award) from the Workplace Safety and Insurance Board (WSIB) will be paid to Western. After this period, if you continue to be entitled to these benefits, you will receive the benefits directly from WSIB.

For a disability resulting from workplace injuries or illnesses, the WSIB will pay you directly. You may also qualify for Canada Pension Plan disability benefits.

WESTERN REHABILITATION SERVICES

Rehabilitation Services is a confidential unit that can help connect you with available supports and resources whether you're seeking to optimize your current health or looking for help to navigate through the medical leave, return-to-work or accommodation processes.

TERMINATION OF COVERAGE

Benefit payments will cease on the earliest of:

- The date you cease to be totally disabled or partially disabled
- The date the Elimination Period has been exhausted
- The date you fail to provide satisfactory proof of continuance of total or partial disability; or
- The date you fail to submit to a requested independent medical examination

» Long Term Disability Benefit

After an elimination period of 105 days of total disability has expired, you may be eligible for Long Term Disability benefits payable by our insurance provider. Human Resources will send you a package in advance of the end of the elimination period. You are encouraged to submit your application (which includes an Attending Physician Statement) for Long Term Disability benefits as soon as possible to avoid any late filing penalties and delay in payments to you. If you have made a WSIB claim, you should also apply for Long Term Disability benefits.

During the first 24 months, you are eligible for monthly benefits if you are unable to perform your own occupation. Beyond the twenty-four months you continue to be eligible for benefits if you are not able to perform the duties of your own or any other occupation falling within the broad professional role for which you are reasonably suited by education, training or experience and which has salary rates equal to at least 75% of your indexed pre-disability monthly earnings. In reviewing your claim, the insurance provider can request additional medical information and/or independent medical examinations.

TOTAL DISABILITY BENEFIT

A monthly benefit will be paid to you if you become totally disabled while covered under the Long Term Disability benefit and remain under the continuing care of a physician.

- The benefit commences after the elimination period (after 105 consecutive days of Short-Term Disability)
- Monthly benefit of 70% of your normal basic monthly salary (maximum monthly benefit $6,000)
- The benefit is based on your annual base salary as of the beginning of total disability (first day sick)

PARTIAL DISABILITY BENEFIT

If you are able to return to your regular occupation or any other occupation after a period of total disability that extends past the elimination period, a monthly benefit will be paid, subject to the following conditions. You must be:

- Under the continuing care of a physician
- Not able to perform the essential and material duties of your occupation on a full-time basis
- Not able to earn at least 80% of your indexed pre-disability earnings
- Able to earn at least 20% of your indexed pre-disability monthly earnings

The monthly benefit payable will be the amount in effect on the date you were considered partially disabled. Your monthly benefit payment will be reduced as described in the Integration of Benefits provision to the extent that the monthly benefit together with the income from all sources does not exceed 100% of your pre-disability earnings.

RECURRENT DISABILITY

After the Elimination Period, separate periods of total disability will be considered to be one period of total disability if:

- They result from the same or related causes and are separated by a period of six months or less during which you returned to Active Employment; or
- They result from entirely unrelated causes and are separated by a period of less than one full day during which you returned to Active Employment

If a period of total disability is considered to be a continuation of a previous total disability and benefits had previously been payable, benefits will begin immediately and will continue until the original maximum benefit period has been exhausted. The same monthly benefit amount that was applicable on the original date total disability began will be payable, subject to the Integration of Benefits provision.

TOTAL DISABILITY WAIVER OF PREMIUM

If you become totally disabled prior to reaching your normal retirement date, your Basic Life Insurance will continue based on the amount of coverage in effect on the date you became totally disabled without payment of premiums. After six consecutive months of total disability, premiums will be waived retroactively from the first day of the month following the date the total disability began.

When the Basic Life Insurance benefit premiums are waived, the premiums for your Optional Life, Optional Spousal Life and Dependent Life will also be waived.

Waiver of premium will terminate when the earliest of the following event occurs:

- You are no longer totally disabled
- You reach your Normal Retirement Date
- You retire; or
- You fail to submit required proof of total disability

If the waiver of premium ends and you do not become actively employed with Western, you may choose to convert this coverage to an individual life insurance policy. (Refer to the Conversion Option provision for additional information).

If a period of Total Disability is considered to be a continuation of a previous Total Disability, the waiver of premiums will be automatically reinstated.

COST OF LIVING ADJUSTMENT

On the January 1 that follows the date you begin receiving Long Term Disability payments and on each January 1 following, your monthly benefit (including any prior cost of living adjustments) will be increased by the lesser of:

- 6%
- The increase in the Consumer Price Index for the 12 months period ending on September 30th of the previous year

If you are at the maximum monthly benefit, you are still entitled to any Cost of Living Adjustment. The all source limitation (described in the Integration of Benefits section) will not limit the amount of any Cost of Living Adjustment.

In no event will this adjustment result in a decrease in your monthly benefit.

INTEGRATION OF BENEFITS

The amount of Long Term Disability benefit will be coordinated with other income payments you may become entitled to as a result of your total disability or partial disability. The benefit coordination will be applied as follows:

A. The amount of monthly benefit payable is reduced by any disability benefits available from the Canada or Quebec Pension Plan (employee benefits only), a plan in another country for which there is a reciprocal agreement with the Canada Pension Plan or Quebec Pension Plan, the Workers' Compensation Act or similar legislation

B. The amount determined previously in A may be further reduced if necessary, so that the amount of monthly benefit, together with "income from all other sources" and the direct offsets in A above, does not exceed 85% of your Indexed Pre-Disability Earnings

Income from all sources includes:

- Disability benefits available under any other government program
- Dependent benefits payable to you under a Plan in another country where there is a reciprocal agreement with the Canada Pension Plan or Quebec Pension Plan
- Retirement benefits provided by any employer or government programs
- Income or benefits payable under any group program provided by or through Western
- Income or benefits payable under a plan sponsored by an association, union or fraternal organization for which you are a member
- Income replacement benefits payable under any plan of automobile insurance (where such reduction is not prohibited by law)

- Wages or remuneration payable from any employer but excluding 50% of earnings received under an approved program of rehabilitation; and
- Income from self-employment

During the period of a rehabilitation program, the amount of monthly benefit as defined above will be further reduced if necessary, so that the amount of monthly benefit together with all amounts of income mentioned in A above, including 100% of earnings received from the rehabilitation program and dependent benefits payable to you under the Canada Pension Plan, Quebec Pension Plan or a Plan in another country where there is a reciprocal agreement with the Canada Pension Plan or Quebec Pension Plan, does not exceed 100% of your pre-disability earnings.

The amount of Long Term Disability benefit payable will not be affected by subsequent cost of living adjustments to the Canada or Quebec Pension Plan payments.

REHABILITATION PROGRAM

The insurance provider and Western will work with you to engage in a rehabilitation program for return to employment which is appropriate for your circumstances. Participation in a rehabilitation program does not disqualify you for Long Term Disability benefits while the program continues and while you continue to be otherwise eligible for benefits.

Refusal to enter and participate in a rehabilitation program considered appropriate by the insurance provider will result in termination of benefit payments. A rehabilitation program for your return to employment will consist of either or both of the following:

- Full-time or part-time work or employment for compensation, or
- Any vocational training or re-training program or period of work for the purposes of rehabilitation

EXCLUSIONS AND LIMITATIONS

Benefits are not paid for any total disability or partial disability caused by the use of drugs or alcohol unless you are engaged in, and have completed, a recognized Rehabilitation Program specifically for treatment of substance abuse. Such treatment must begin during the Elimination Period.

This exclusion does not apply if total or partial disability is due to a related organic condition.

Long Term Disability benefits are not payable for any of the following:

- Any period during which you are not under the continuous active care and treatment of a Physician who is a duly qualified specialist
- Any period which you are imprisoned
- Any period during which you are not residing in Canada
- Any total or partial disability due to or resulting from self-inflicted bodily injury or sickness
- Any total or partial disability due to insurrection, war (declared or not) or the hostile actions of the armed forces of any country, service in the armed forces or participation in any riot, civil commotion or any other act of aggression
- Any total or partial disability due to or resulting directly or indirectly from committing or attempting to commit a criminal act
- Any total or partial disability during the period:
    - Of formal maternity leave taken pursuant to the provincial or federal law, or pursuant to mutual agreement with Western, or
    - In which Employment Insurance maternity benefits are being paid or would be paid if you were eligible

CONTINUANCE OF BENEFITS DURING DISABILITY

If you are approved and are in receipt of full Long Term Disability benefits, the following benefits are continued and you are not required to pay the premium/contribution:

- Health and Dental Care
- Basic Life Insurance
- Pension Plan

If you resume working on a gradual basis and are receiving income from the insurance provider and Western, you will be required to make your regular pension contribution based on the portion of pay received from Western. Western's pension contribution will be based on the total amount of yours and Western's contributions at the date of disability less any amounts paid by you.

You will be required to pay the premium to maintain any optional benefits unless the insurance provider approves a Life Waiver of Premiums. The optional benefits include:

- Optional Life Insurance
- Optional Spousal Life Insurance
- Dependent Life Insurance
- Voluntary Personal Accident Insurance

TERMINATION OF COVERAGE

Benefit payments will cease on the earliest of:

- On the date you cease to be totally disabled or partially disabled
- The date your employment terminates
- On your death
- The date the benefit period has been exhausted
- The date you reach your Normal Retirement Date age
- The date you fail to provide satisfactory proof of continuance of total or partial disability; or
- The date you fail to submit to an independent medical examination requested by the insurance carrier

» Critical Illness Benefit

The Critical Illness Benefit is a compulsory benefit that is fully paid by Western. The Critical Illness Benefit applies only to those illnesses or disorders defined below. If more than one critical illness is incurred by and diagnosed for you, payment will be made for only one critical illness under this benefit.

HEART ATTACK

Heart attack means the death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by both new electrocardiographic (ECG) changes indicative of myocardial infarction and the elevation of cardiac biochemical markers to a level considered diagnostic for acute infarction. Heart attack does not include:

- An incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event; or
- Elevation of cardiac markers due to coronary angioplasty, unless there are diagnostic changes of new Q wave infarction on the ECG

LIFE THREATENING CANCER

Life Threatening Cancer means a tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, but excluding:

- Carcinoma in situ
- Malignant melanoma to a depth of 0.75 mm or less
- Any skin cancer that has not spread beyond the deepest layer of the skin
- Stage A prostate cancer; and
- Kaposi's sarcoma

STROKE

Stroke means a cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by either:

- Intracranial thrombosis or hemorrhage; or
- Embolism from an extra-cranial source

There must be evidence of measurable, objective neurological deficit. Transient Ischemic Attacks are specifically excluded.

BENEFIT

If, while covered for this benefit, you incur and are diagnosed with a critical illness and complete the survival period, a lump sum amount of $2,000 will be paid by the insurance provider.

The Survival Period is a minimum number of consecutive days, immediately following the date of diagnosis of a condition, which you must survive before a Critical Illness Benefit becomes payable. The Survival Period is 30 days.

DIAGNOSIS

The diagnosis must be made by a physician in Canada, the United States or any other region that the insurance provider may approve. The Physician must be a person other than you or your dependent, or a relative or business associate of either.

MAKING A CLAIM

When Manulife adjudicates a Long Term Disability application they will also review to determine whether you qualify for the Critical Illness Benefit.

EXCLUSIONS AND LIMITATIONS

Cancer Limitation

No critical illness benefit will be payable if:

- A diagnosis of cancer is made within 90 days after the effective date of coverage

- The date of any sign, symptom or medical consultation that led to the diagnosis of any type of cancer is within 90 days after the effective date of coverage

Critical Illness Benefits are not payable for a critical illness which is due to or results directly or indirectly from any of the following:

- Failure to seek or follow medical advice
- Intentionally self-inflicted injuries, suicide or attempted suicide
- Operating a vehicle while impaired by drugs, toxic substances or an alcohol level in excess of the legal limit
- Travel or flight in any kind of aircraft if you are a member of the aircraft crew; or if you are on the aircraft for purposes of instruction or training
- Participation in underwater diving, hang-gliding, parachuting, skydiving, or any form of motorized vehicle racing; or
- Cosmetic or elective surgery

TERMINATION OF COVERAGE

Coverage will terminate on the earlier of one of the following:

- The end of the month in which you terminate your employment
- Your Normal Retirement Date
- Your Retirement Date
- The date the Critical Illness Benefit was paid; or
- The date the plan is cancelled for any reason

» Administrative Pension Plan

The University of Western Ontario Pension Plan for Members of the Administrative Staff (the Plan) can play an important role in your map to financial security at retirement. The Plan, along with government benefits, your personal savings and other sources of income are important elements of your journey to a financially secure retirement.

Your pension plan at Western is a defined contribution plan - a type of capital accumulation plan in which contributions are made to the plan by both you and Western. Income at retirement is determined by the contributions that are made to your individual account and the investment earnings that your money generates. The amount of retirement income you are able to generate from the Plan depends on different factors including:

- The amount accumulated in your retirement account
- Your retirement date (when you choose to draw on your income)
- Your choice of retirement income vehicle at retirement
- Any legislative requirements

It is your responsibility to make decisions on the investments that are most appropriate to meet your personal goals. Account balances will fluctuate on a daily basis depending on contributions and investment performance. You can choose from a high quality selection of investment options available to plan members. The funds are each managed by external investment managers selected for their demonstrated expertise. Sun Life Financial provides all record keeping and member services for the Western Pension Plan. Sun Life offers information, tools and advice to Western Plan members to help you select the most appropriate investments.

Effective January 1, 2023, PMA-eligible Staff shall be required, as a condition of employment, to become a Member of the Plan no later than the first day of any month coinciding with or following the date of employment as a Full-Time PMA-eligible Staff Employee. You may not join the Plan after December 31 of the year in which you reach age 69 – the day when membership in the Plan ends.

REGULAR CONTRIBUTIONS

You and Western contribute a percentage of your pensionable earnings to the Plan. These contributions are allocated to your *Member Regular* and *Employer Regular* accounts at Sun Life.

You contribute 5.5% of pensionable earnings on a monthly basis, and Western contributes at 8.0% (under 10 years of service) or 8.5% (10 to 19 years of service). Members contributing at 5.5% and who attain 20 years of service will receive an additional 0.5% contribution from Western.

Please note - some members may have a grandfathered contribution rate of 2.5% pensionable earnings.

VOLUNTARY CONTRIBUTIONS

You may choose to further grow your retirement income by making voluntary contributions to your plan, above your required contributions, up to a combined total with required contributions of 18%, subject to the maximum allowed by the Income Tax Act.

These additional contributions are allocated to your *Member Voluntary* account at Sun Life. Voluntary savings may be redeemed at your option at any time, including prior to your retirement. A $25 administration fee applies to withdrawals and funds withdrawn become taxable.

TAX IMPLICATIONS

The Income Tax Act limits the annual tax-deductible contributions you and your employer can make to all your retirement savings plans. The maximum annual amount is 18% of your earned income, up to an annual dollar limit, which changes from year to year in line with changes to average Canadian wages.

This 18% limit is the total you can save under all tax-sheltered retirement plans, including the Western Plan and your personal RRSPs. Every year while you are a member of the Plan, a Pension Adjustment (PA) is reported on your T4. The PA for defined contribution plans – such as Western's – is the total contributions (your required and voluntary contributions and Western's contributions) made to the Plan in the calendar year. Your PA reduces the amount you can contribute to an RRSP the following calendar year. The Canada Revenue Agency (CRA)

informs you each year of your RRSP contribution limits on your Notice of Assessment.

INVESTING YOUR RETIREMENT ACCOUNT

You decide how to invest your retirement account balance – made up of Western's contributions, your contributions and any investment earnings, including any gains or losses. The Plan provides you with a wide range of investment options to choose from to suit your investment goals. Each option comes with a different degree of risk and return and may be appropriate for different points in your career.

Your account balances are split between Member Details and Employer Details. You may allocate these retirement savings to any or all of the available funds. The Plan offers investment options across the three primary asset classes: Cash & Equivalents/Money Market, Fixed Income/Bonds and Equity/Stocks. Each asset class has different properties with respect to risk of loss, chance for growth and how investment return is generated. Before you select your investments, you may want to consider completing the Sun Life Asset Allocation tool online at sunlife.ca/western. It will help you develop an investment strategy based on the amount of risk you are willing to bear and help you consider:

- Your tolerance for negative returns
- Your investment objectives
- How much time you have to invest until you want to use the money

Sun Life provides support through licensed Investment Advice Specialists who are available to provide individual counseling on your Western Plan investments. There are also a variety of tools to support your decision-making. If you do not make an active choice for your retirement account, your money will be automatically invested in the Balanced Growth fund. This is not a recommendation for Balanced Growth.

For more details information on investing your retirement account and tools available, please refer to the Pension Plan Summary document and visit sunlife.ca/western.

MONITORING AND CHANGING YOUR INVESTMENTS

Your online account at sunlife.ca/western provides you with information about your investments and balances are updated daily. In addition, you receive statements twice a year confirming the balances in your account at the statement date, your investment choices and your investment returns. You can change your investment directions and arrange transfers between investment funds. Changes can be made online or by phone any business day through the Sun Life Customer Care Centre.

SUPPLEMENTAL PENSION ARRANGEMENT (SPA)

Sometimes, a Pension Plan member's regular contributions combined with Western's contribution to the member's account exceed the total contributions permitted under the Canada Revenue Agency (CRA) contribution limit for the year. The Supplemental Pension Arrangement (SPA) is a plan that provides a notional account for contributions to a member's pension account that are in excess of the CRA limit.

This occurs for higher earners - for example, members with an earnings level of approximately $233,500 or more who made regular contributions at the 5.5% rate in 2023. In determining whether there is a SPA amount, voluntary contributions are not considered - only the member's regular contributions.

The SPA account is a notional account. A SPA account holder does not direct the investment options for this account. Instead, Western sets aside and invests sums of money equal to the contributions credited to the notional SPA accounts. The SPA accounts are credited with the same return realized by The University of Western Ontario's Operating and Endowment funds.

Members can view their balances online at sunlife.ca/western in addition to receiving an annual SPA statement.

TERMINATION OF CONTRIBUTIONS

The required and/or voluntary contributions end on the earlier of the following:

- December 31 of the year in which you reach age 69
- When you are at least age 65 and your age plus service equals 95.

» Other Benefits

VACATION

Service Level	Entitlement
Full-time continuous service less than 24 months	Accrues at a rate of 1.25 working days for each completed calendar month of regular full-time employment (15 working days per calendar year)
After two years of continuous Full-time service	Accrues at a rate of 1.67 working days for each completed calendar month of regular full-time employment (20 working days per calendar year)
After 10 years of Continuous Regular Full-Time Service [1]	No change in vacation accrual rate. Date used for vacation accrual changes to Service Date
After 19 years of continuous service	Accrues at a rate of 2.08 working days for each completed calendar month of continuous full-time employment (25 working days per calendar year)
After 19 years of continuous service	Entitled to a special one time, additional week (five working days) of vacation
After 26 years of continuous service	Accrues at a rate of 2.16 working days for each completed calendar month of continuous full-time employment (26 working days per calendar year)
After 27 years of continuous service	Accrues at a rate of 2.25 working days for each completed calendar month of continuous full-time employment (27 working days per calendar year)
After 28 years of continuous service	Accrues at a rate of 2.33 working days for each completed calendar month of continuous full-time employment (28 working days per calendar year)

DEPENDENT TUITION SCHOLARSHIP PLAN

Subject to plan conditions, dependent children of current, Regular Full Time PMA Employees are eligible to receive tuition benefits for full-time studies taken for credit towards a degree (undergraduate or graduate) from Western University or colleges affiliated with Western. The value of the scholarship is currently set at $2,500 per academic year, for up to four years. Other modified benefit levels for part-time students are available. See the Registrar's website for more details.

[1] Effective November 1, 2018

LONG SERVICE AND RETIREMENT RECOGNITION

In recognition of service Western provides long-service gifts to faculty and staff:

- After 25 years of employment the member will be presented with a gift to a value of $400
- Upon retirement after five to ten years of continuous employment, a gift to a value of $75
- Upon retirement after at least ten years of continuous employment, a gift to a value of $250

PREGNANCY, PARENTAL AND ADOPTION LEAVE TOP-UP PLAN

The Ontario Ministry of Labour, through the Employment Standards Act, provides eligible employees who are pregnant or who are new parents with the right to take unpaid time off work.

Depending on a number of factors, you may be eligible for the following benefits:

- Maternity (pregnancy) benefits - paid for a maximum of 15 weeks to a birth mother through federal Employment Insurance (EI)
- Parental benefits – paid through EI to either biological or adoptive parents while they are caring for a new-born or an adopted child, up to a maximum of 61 weeks
- Supplemental Employment Insurance Benefits (SEIB) – a benefit for eligible members paid by Western to "top up" EI benefits for a maximum of 17 weeks

Note: You must confirm your eligibility and apply in order to receive benefits through EI and SEIB. For more information visit the HR webpage on Pregnancy/Parental and Adoption Leave.

EMPLOYEE ASSISTANCE PLAN

Every day we encounter stresses in life – and occasionally they can have a detrimental effect on our personal lives and work performance. To help members in those difficult times, Western provides access to an Employee Assistance Plan (EAP). You have quick access to experienced professional counsellors who can help you and/or your family resolve a broad range of personal and work-related issues. Plan includes 24/7 crisis and emergency support, financial/credit counselling, nutrition services, family/career consultation services and more. Western has extended its EAP coverage to ensure that all Western employees, whatever their status, have access to 24-hour crisis support.

Explore on-line information that will help you deal with the challenges of life as well as provide you with practical tips and strategies for living a healthier work and personal life. All Western employees can access the confidential on-line resources, information and tools by logging into the provider's portal. Visit the Employee Assistance website for more information.

PROFESSIONAL EXPENSE REIMBURSEMENT

The Professional Expense Reimbursement Account (PER) can be used to pay for professional expenses including conference registrations, travel and accommodation, membership fees is professional associations, journal subscriptions, to purchase a computer or software, and for other expenses. Claims can be made only if you have chosen to allocate flexible benefit credits to this account as part of your annual flexible benefit allocation between the HCSA and PER each November. Unused credits at the end of each calendar year can be carried forward for two years.

Claims are made through Western Financial Services. For information on PER including making a claim, visit the Financial Services website.

EDUCATIONAL FUNDING

Eligible members may have access to educational funding for a variety of opportunities relevant to your current or future career aspirations at Western. Advance funding is available for many courses. For more information visit the HR website on Educational Funding.

LEAVES AND OTHER WORKLOAD ARRANGEMENTS

Members may take advantage of various leaves such as Deferred Salary Leave, Compassionate Leave, Pregnancy and Parental/Adoption Leave and various other leaves and workload arrangements. Due to the unique nature of each leave or workload arrangement, please contact Human Resources for further details.

» Work/Life Events

CHANGES TO COVERAGE

To ensure that coverage for you and your eligible dependents is up to date, it is vital that you advise us of any family changes in writing within 31 days. If the change is a result of a life event (such as birth or adoption of a child, getting married or divorced), the coverage will become effective on the date of the change without providing proof of good health, provided:

- Written application for the change is submitted within 31 days of the life event, and
- Provided additional requests for coverage have not been previously declined (life insurance)

After the 31-day window has closed, coverage may be subject to a medical questionnaire and approval from our benefit provider.

Necessary forms to make changes such as increasing/decreasing life insurance coverage, adding/removing dependents, updating beneficiaries can be found on the Human Resource Benefits website. Call Human Resources for assistance with making changes to your benefits and completion of forms.

DEATH BEFORE RETIREMENT - SURVIVOR BENEFIT

If you die while you are an active employee and participating in the Health Care, Emergency Travel Assistance plan and Dental Care benefits, Western continues coverage for your surviving covered dependents until the earliest of the following occurs:

- 36 consecutive months from the date of your death
- The date your spouse remarries
- The date the person no longer qualifies as a dependent
- The date the dependent becomes eligible for similar coverage under another group contract

WORKING BEYOND YOUR NORMAL RETIREMENT DATE

Life Insurance

Your life insurance (Basic, Optional, Optional Spousal, Dependent Life and the Voluntary Personal Accident Insurance) plans end at your Normal Retirement Date (NRD). An employer-paid life insurance of $15,000 continues while working beyond your Normal Retirement Date.

- At your Normal Retirement Date, you may convert your present life insurance coverage or the coverage of your spouse, up to a maximum of $200,000, to a private policy without providing evidence of good health provided you make application within 31 days of your Normal Retirement Date
- You may convert the Voluntary Personal Accident Insurance benefit (if applicable) to a private policy (maximum of $100,000) within 60 days of your Normal Retirement Date

Long Term Disability

Long Term Disability benefits and coverage end at your Normal Retirement Date.

Health Care and Dental

Health Care and Dental benefits continue.

Flex Credits

Annual flex credits continue as long as you continue to hold a full-time appointment. Each November, you allocate these flex credits to the Health Care Spending Account and/or the Professional Expense Reimbursement Account for the next calendar year.

Health Care Spending Account

The Health Care Spending Account benefit continues.

Professional Expense Reimbursement Account

The Professional Expense Reimbursement benefit continues.

Dependent Tuition Scholarship Plan

The Dependent Tuition Scholarship benefit continues.

Pension Contributions

Pension contributions continue to be made by you and Western to your account under the University of Western Ontario Pension Plan for members of the Administrative Staff. Pension Plan contributions cease for anyone who continues to hold a full-time appointment past the end of the year in which a member turns 69 or when you are at least age 65 and your age plus service equals 95. If pension contributions cease, pension assets may be withdrawn at this point or may remain invested in the plan. In accordance with the Income Tax Act (Canada) regulations, assets must be removed and a retirement income must be established with registered pension savings by the end of the year in which you attain age 71.

LEAVING WESTERN BEFORE RETIREMENT

This information will help those who leave Western before retirement to understand what happens to benefits. Included is information about converting some benefits to a plan that you would pay for privately.

- Life insurance benefits terminate the end of the month that employment with Western terminates. Life insurance coverage or the coverage of your spouse, up to a maximum of $200,000, may be converted to a private policy without providing evidence of good health provided application is made within 31 days of the date that group life insurance terminates. Premiums are based on private policy rates.
- Voluntary Personal Accident Insurance benefits terminate the end of the month that employment terminates. Coverage, up to a maximum of $100,000, may be converted to a private policy within 60 days of the date that coverage terminates. Premiums are based on private policy rates.
- Salary Continuance and Long Term Disability benefits terminate the date employment ends.
- Extended Health, Dental, and Health Care Spending Accounts terminate the end of the month that employment terminates for any services received prior to the termination date. The insurance provider offers individual and family health and dental plans specifically designed for people that no longer have group health and dental coverage. Application must be made within 60 days of termination of benefits from the group plans.

Read more at Converting/continuing your benefits after leaving Western.

Any outstanding eligible medical and dental expenses must be submitted to the benefit carrier within 90 days after coverage ends.

» Post-Retirement Benefits

ELIGIBILITY

To be covered by the Western Post-Retirement Benefits program, you and your eligible dependents must reside in Canada and meet the following eligibility criteria:

- Eligible to retire (within 10 years of your Normal Retirement Date) and
- Five years of full-time service for members who became full-time on or before June 30, 2007 or
- Ten years of full-time service for members who became full-time on or after July 1, 2007

At the time of retirement you must make application for these benefits for yourself and your eligible dependents to be covered under this program.

BENEFITS AT A GLANCE

Health Care:

- Prescription drugs
- Vision care
- Paramedical services
- Hospital care

Dental:

- Basic services
- Supplemental basic services (e.g. root canal)
- Dentures
- Major restorative (e.g. crowns, bridges)

Retirement Death Benefit:

- $15,000 death benefit – a tax-free benefit payable to the named beneficiary following the death of the retired employee

For full details on Post-Retirement Benefits, see the Post-Retirement Benefits Summary booklet posted on the HR website.

» Claims Process

Managing your health and dental claims effectively can make a big difference in the value you derive from the benefits program. The program makes it easy for you in a number of ways.

ACCESS THE MANULIFE WEBSITE

To register for online access, you will need your **plan contract number (87220)** and your **plan member certificate (Western ID number)** which can be found on either a claim statement or on your benefits card. Go to the Manulife website, hover over the sign in button located at the top of the screen, and select “Plan member” under “Group benefits” from the drop down menu.

On the first visit to the site you will need to fill in all the information on the registration page. Be sure to enter your email address so you will be able to take advantage of the electronic notifications feature.

From the website, you can view the status of your most recent claims, submit online claims, review your claim history, download claim forms, check your HCSA balance, look up drug eligibility, set up direct deposit and access the Manulife Wellness Learning Centre.

ACCESS THE MANULIFE MOBILE SITE AND APP

Installing the Manulife mobile app for your smartphone or tablet allows you the convenience of submitting and reviewing claims on the go. Other benefits include a medication reminder tool and a drug look up tool. The mobile app can be downloaded from the following smartphone app stores:

- Apple App Store℠
- Google Play™
- BlackBerry ® World™
- Windows® Store

HOW TO MAKE CLAIMS

There are several ways to make a claim against your Health and Dental benefits or your Health Care Spending Account (HCSA). These include using your pay direct drug card, having your dentist submit your claim, submitting an electronic claim, having your paramedical practitioner submit an eClaim, or submitting a paper claim.

PAY DIRECT DRUG CARD

Your pay direct drug card will be accepted by most pharmacists in Canada and provides immediate confirmation of your covered drug expenses. The pharmacist will direct bill the insurance provider so you only pay your portion of the costs. Once your card has been recorded for you and your dependents, all the information about your plan coverage will be available online to the pharmacist for future claims. When you use the drug card, you do not have to submit a claim form.

DENTAL CLAIMS

Your dental provider may submit your claims electronically on your behalf or they will provide a paper claim for you to submit directly.

ELECTRONIC CLAIMS

You can submit dental, vision care and paramedical practitioner claims electronically through the Manulife Plan Member website or through their mobile app.

You can request any of your claims to be applied against your HCSA by utilizing the ‘Send a note’ function on the Manulife website or by calling 1-866-896-8515.

You will not need to mail your original receipts unless the provider requests receipts through an audit process. Be sure to retain your original receipts for 12 months from the date of claim submission.

PROVIDER E-CLAIMS (COMING SOON)

eClaims will enable many health care providers such as physiotherapists, chiropractors, vision care providers, as well as acupuncturists, registered massage therapists, naturopathic doctors, to submit claims electronically on behalf of patients at the point of care.

In many instances, this means plan members will only have to pay the amount not covered by the plan for approved claims. To find out if your health care provider is set up for this service, go to the Manulife eClaims website.

PAPER CLAIMS

Paper claim forms for health care, dental and HCSA claims are available on the HR Benefits and Forms website and on the insurance provider website. You can also request forms by contacting Human Resources.

To use the HCSA for any portion of expenses not covered by Western's plan, check the box on the form to indicate you want the balance to be submitted to your HCSA.

Retain a copy of the completed form and receipts for your records, and then mail both directly to the insurance provider at the address indicated on the form.

DIRECT DEPOSIT

You can receive direct deposit of your claim reimbursements by registering and signing up on the Manulife website. You will then be able to add and update your Direct Deposit information.

CLAIM DEADLINES

We encourage you to submit claims as they are incurred and not wait until the deadline is approaching.

Health Care and Dental Plan

Expenses incurred in a calendar year must be claimed by January 31 of the second year following the year the expense was incurred. For example, eligible expenses incurred in the calendar year 2023 must be claimed by January 31, 2025. In other words, you have 13 months after the end of the year in which an expense is incurred to submit any outstanding claims.

Health Care Spending Account (HCSA)

All claims should be submitted during the same plan year in which you paid the expense. However, your HCSA has a 90-day grace period, which allows up to 90 days after December 31 for Manulife to receive expenses incurred during the previous year.

FORFEITURES

Unused credits in a Health Care Spending Account will be carried forward and available the following calendar year. At the end of the second calendar year any credits remaining from the previous year will be forfeited. In November, those who have forfeited any HCSA credits may wish to re-evaluate credit allocations for the following year.

CHECKING YOUR HCSA AND PER BALANCES

To see the current balance in your Health Care Spending Account, login to the Manulife Plan Member website. Select "My Benefits", then the link that says HCSA Balance. For the HCSA, you will see amount deposited in current year, claims paid, and your current balance. To see your claims history details for both the HCSA – see 'Claims History' then choose HCSA.

Login to Western Financials to see the current balance in your Professional Expense Reimbursement Account.

CO-ORDINATION OF BENEFITS

If a spouse has coverage through his/her employer or another retiree program, a member may be able to receive up to 100% reimbursement for medical and dental expenses by submitting claims to both plans using an industry-wide procedure called co-ordination of benefits.

To co-ordinate benefits, first enroll your spouse and children as dependents in the Western benefits program. Your spouse must also enroll you and any children in his/her plan.

Further information on co-ordination of benefits may be found on the Canadian Life and Health Insurance Association web site.

REMEMBER

- Have claims processed in timely manner to avoid denied claims or forfeiture of any HCSA funds.
- Unused HCSA credits are carried forward one plan year. Credits not used in the second plan year will be forfeited.
- HCSA deadline - All claims should be submitted during the same plan year in which you paid the expense. However, your HCSA has a 90-day grace period, which allows up to 90 days after December 31 for Manulife to receive expenses incurred during the previous year.
- Extended Health and Dental Plans deadline - January 31 of the second year following the year in which the expense was incurred

» Definitions

ACTIVELY EMPLOYED
Means the employee reports for work at his or her usual place of employment with the employer, or such other location as may be required, and is able to perform the Essential and Material Duties of his or her regular occupation on a permanent full-time and full-pay basis for a minimum of 25 hours per week, unless specified otherwise. If an employee is not required to report for work on a specified date, he or she will be considered to be Actively Employed if he or she is not disabled to the degree that he or she could not have reported for work at his or her usual place of employment and performed the Essential and Material Duties of his or her regular occupation.

ACTIVE TREATMENT
Means the ongoing and continuous medical or surgical inpatient treatment of a sickness or injury in the acute phase, including active treatment of a chronic sickness.

DUE DILIGENCE
Means a process the insurance provider follows to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the plan. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing federal or provincial formularies, recognized clinical practice guidelines, or an advisory body.

ELIMINATION PERIOD
Means the period of Total Disability that must elapse before Long Term Disability benefits become payable. The Elimination Period is 105 consecutive working days. In the case of an employee who is absent from work as a result of an unpaid leave of absence approved by the employer, the Elimination Period will not commence until the day such employee is scheduled to return to work.

ESSENTIAL AND MATERIAL DUTIES
Means the duties which are required for the performance of an occupation and which cannot be reasonably omitted or modified.

GOVERNMENT PLAN
Means any plan or arrangement provided by or under the administrative supervision of any government, including any provincial health insurance plan, workers' compensation act or any workplace safety and insurance act.

INDEXED PRE-DISABILITY EARNINGS
Means for the first 12 months in which the employee is Totally Disabled or Partially Disabled, the employee's Indexed Pre-Disability Earnings are his or her Pre-Disability Earnings. After this period, the employee's Indexed Pre-Disability Earnings will increase on the anniversary of the date the employee's Total Disability began, by the Cost of Living adjustment. The employee's Indexed Pre-Disability Earnings will not be decreased by a drop in the Consumer Price Index.

LOWER COST ALTERNATIVE
Means if two or more drugs, supplies or services result in therapeutically similar results, the Lower Cost Alternative will be considered.

MEDICALLY NECESSARY
Means accepted and recognized by the Canadian medical profession and the insurance provider as effective, appropriate and essential treatment of a phase of an illness or injury. The insurance provider has the right after Due Diligence has been completed to determine whether the drug, service or supply is eligible.

NON-EMERGENCY TREATMENT
Means treatment received outside of the covered person's province of residence that requires immediate attention, but is not considered emergency or life threatening.

NORMAL RETIREMENT DATE
The first day of the month next following a staff member's sixty-fifth birthday.

PARTIALLY DISABILITY OR PARTIALLY DISABLED
Means that, after a period of Total Disability, an employee returns to any occupation and is earning less than 80% of his or her Indexed Pre-Disability Earnings as a result of continuation of a degree of incapacitation which originated with the Total Disability.

PLAN PERIOD
Means a 12-month period beginning on January 1 and ending December 31.

PRE-DISABILITY EARNINGS
Means for taxable plans, the gross monthly earnings received by the employee immediately prior to the date the Total Disability began; and for non-taxable plans, the gross monthly earnings as defined above minus income tax.

PRIOR AUTHORIZATION
Means a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a Pharmacoeconomic or cost effectiveness evaluation.

PROOF OF GOOD HEALTH
Means all statements of medical evidence of a person's health and other information as required by the insurance provider. All Proof of Good Health must be submitted to the insurance provider for approval.

REASONABLE AND CUSTOMARY
Means a charge which is usually made in the absence of this or any similar coverage, for a specific type of care, service or supply, based on representative fees and prices in the geographic area in which the charge for the care, service or supply was incurred, as determined by the insurance provider.

TOTAL DISABILITY OR TOTALLY DISABLED
An employee will be considered Totally Disabled or to have a Total Disability if, due to sickness or bodily injury, he or she is unable to perform the Essential and Material Duties of any occupation for which he or she is reasonably fitted, or could so become, by training, education or experience and is not engaged in any occupation or employment for wage or profit.

TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT
If the employee becomes Totally Disabled prior to the normal retirement date, the insurance provider will continue the amount of coverage in effect on the date the employee became Totally Disabled, without payment of premiums, provided all requirements are met.

» Costs

MONTHLY GROUP BENEFIT PLAN PREMIUM RATES AS AT MAY 1, 2024

Benefit Plan	Your Premium				Employer Premium
Basic Life Insurance:	$0.151 / $1,000				$0.151/ $1,000
Extended Health:					Single: $184.10 Family: $388.13
Dental:					Single: $51.32 Family: $141.07
Dependent Life Insurance: Spouse: $40,000 Eligible Child(ren): $10,000	$8.65				
Optional Life Insurance	Per: $1,000				
Age Band	Male Non-Smoker	Female Non-Smoker	Male Smoker	Female Smoker	
Less than 24	.020	.014	.049	.020	
24 - 34	.027	.020	.057	.032	
35 - 39	.032	.027	.065	.040	
40 - 44	.049	.032	.088	.057	
45 - 49	.073	.051	.159	.087	
50 - 54	.137	.087	.282	.145	
55 - 59	.231	.137	.471	.231	
60 - 64	.340	.225	.680	.376	
65 - Normal Retirement	.492	.369	.984	.593	
Voluntary Personal Accident Insurance:	Single: $0.015 / $1,000 Family: $0.024 / $1,000				
Long Term Disability:					$2.93/$100 Benefit

» Contact Us

MANULIFE FINANCIAL

Extended Health, Dental, Life Insurance, Disability Insurance and Health Care Spending Account

Group Benefits – Health Claims
PO Box 1653
Waterloo, Ontario. N2J 4W1

Group Benefits – Dental Claims
PO Box 1654
Waterloo, Ontario. N2J 4W2

Phone: 1-866-896-8515

Website: www.manulife.ca/planmember

For all correspondence with Manulife Financial please include your plan contract number (87220) and your certificate number found on your Manulife Card.

GLOBAL EXCEL MANAGEMENT

Emergency Travel Assistance

Phone:

1-800-265-9977 (Canada/United States)

Country Code + 800-9221-9221 (International)

SUN LIFE FINANCIAL

Western Pension Plan

Sun Life Financial Customer Care Centre
Phone: 1-866-733-8612 any business day between 8 a.m. and 8 p.m. ET

Website: www.sunlife.ca/western

Sun Life Retirement & Savings Plan for Western Retirees

Retirees and those within five years of retirement can call 1-866-224-3906 (choose option 1) any business day between 8 a.m. and 6 p.m. ET to speak with a Sun Life Retirement Consultant.

Voluntary Personal Accident Insurance

Sun Life Assurance Company of Canada
Group Life Claims
1155 Metcalfe St.
Montreal QC H3B 2V9

Phone: 1-877-893-9893

TELUS HEALTH

Your Employee (and family) Assistance Program

Phone: 1-855-597-2105 (24 hours)

Website: http://www.uwo.ca/hr/benefits/eap/

WESTERN UNIVERSITY

Pension Plan, Benefit Plans provisions and Other Benefits

Human Resources
Support Services Building, Room 4159
London, ON N6A 3K7

Use ASK HR to submit your inquiry or

Phone: 519-661-2194 (Monday to Friday, 8:30 a.m. to 4:30 p.m., ET)

Fax: 519-661-4104

Website: http://www.uwo.ca/hr/benefits/your_benefits/index.html

FINANCE

Professional Expense Reimbursement

Finance
Support Services Building, Room 6100
London, ON N6A 3K7

Phone: 519-661-3839 (Monday to Friday, 8:30 a.m. to 4:30 p.m., ET)

Email: travel@uwo.ca Fax: 519-661-4104

Website: http://www.uwo.ca/hr/benefits/your_benefits/index.html

PROFESSIONAL AND MANAGERIAL ASSOCIATION

Western University
Room 351, University Community Centre
London, Ontario, Canada N6A 3K7

Phone: 519-661-3005

Email: pmaoffice@uwo.ca

Website: http://www.uwo.ca/pma/index.html

PRIVACY STATEMENT

Western is committed to protecting the privacy of personal information that is shared with us of all individuals who come into contact with it, be they students, alumni, faculty, staff, or members of the general public. It strives to collect only the specific personal information that is related directly to, and needed for, operating its programs and activities. Personal information will be used, maintained, disclosed and disposed of in accordance with the applicable provincial or federal legislation. Western records that are not subject to statutory privacy rules will be protected in accordance with Western policies and agreements.

Collecting personal information about you is essential to our benefit providers to effectively administer your coverage, to offer you high quality insurance products and to provide you with on-going service. Our benefit providers take great care to keep your personal information confidential and secure.

IMPORTANT NOTE

The information contained in this booklet is intended to provide a summary of benefits available to eligible full-time members of the Professional and Managerial Association and does not contain all of the plan provisions. Many aspects of the benefits are provided through a group insurance contract with the insurance provider and your full benefits and rights are governed by the terms of the Group Master Contract with the insurance provider, the Pension Plan for Administrative Staff and your contract with Western University through your agreement with the Professional and Managerial Association. In the event of a discrepancy between this summary and the official plan documents, the official plan documents will prevail.

Contact Human Resources using ASK HR or call 519-661-2194 if you have any questions about your compensation and benefits programs.