Vision & Hearing Plan

RSMC & Urban Bargaining Units

The Vision and Hearing Plan pays for eye examinations, prescription glasses, contact lenses, and hearing aids *(with certain maximums)*. It's called "Vision and Hearing Plan 51392" and the company that looks after it is Great-West Life.

You are automatically enrolled in this plan, which is mandatory. **You do not have to fill out an enrolment form.** Eligible employees are automatically covered on the first day of the month following their date of hire, or on the first day of the month following the date on which they become eligible.

This plan is 100% paid by Canada Post and you pay no premiums or deductible.

Eligible:

Rural and Suburban Mail Carriers: All RSMC route holders, regardless of the number of hours worked as well as Permanent Relief RSMCs are eligible from the date they were hired, or the date they began working in an eligible position.

Urban operations bargaining unit: **Regular employees** are eligible from the date they were hired as regular employees, or become regular employees. A regular employee is a permanent employee, full-time or part-time.

Temporary employees working in Group 3 (maintenance) positions are eligible

NOT Eligible:

Temporary employees, except for those working in Group 3 (maintenance) positions, are <u>not</u> eligible. When temporary employees become regular (permanent) employees, they become eligible for the plan.

RSMC helpers and replacements are <u>not</u> eligible *(only Permanent Relief RSMCs are eligible).*

Retirees are <u>not</u> eligible.

The Vision & Hearing Plan covers you, your spouse and your children. You need to put your **dependants** *(spouse & children)* on the Vision & Hearing Plan. Great West Life administers the Extended Health Care, Vision/Hearing and Dental Plans. The company uses the same Dependent Information Form for all three plans, so you only need to fill out one form.

*Your **spouse** is defined as*

- *the person to whom you are married and with whom you live, or*
- *the person to whom you were (or are) legally married and whom you support, or*
- *the person with whom you have been living in a common-law relationship for at least one year*

***Children** must be unmarried and financially dependent on you for support and (unless they are full-time students) under the age of 22. A child who is a full-time student is covered up to the age of 25. There is no age limit for offspring who are differently-abled and unable to support themselves, provided they were differently-abled and covered (as children under age 22, or as full-time students under age 25) when coverage would otherwise have ended.*

When does coverage start?

Coverage begins on the first of the month following the date you are hired as an eligible employee, or become eligible. For example, if you are hired on June 12, coverage begins on July 1.

When does coverage end?

Coverage for you, your spouse and your children ends on the date in which the following occurs:

- when your employment ends
- when you retire
- when you are on strike
- when you die
- your last day at work, when you go on leave of absence without pay for more than 30 calendar days (except for maternity, parental, adoption, or sick leave)

Note: Your spouse or child may lose coverage earlier than you do if they are no longer eligible.

Does my coverage continue when I am off work (on leave)?

Sick Leave (paid or unpaid)	coverage continues
Disability Insurance (DI)	coverage continues
Maternity, Parental and Adoption Leave	coverage continues
Any other leave of absence without pay of more than 30 calendar days (e.g., Education Leave, Care and Nurturing Leave, Sabbatical Leave	coverage ends on your last day of work

Before going on any type of leave you should check to confirm your entitlements with a CUPW Shop Steward, a local Union officer or Great West Life. Also ensure that both the employer and CPC Human Resources *(formerly called Pay and Benefits are)* are informed.

Vision expenses covered under the plan:

A maximum of $300 for each covered person every four calendar years for:

- prescription glasses / frames
- single vision, Bifocal & Trifocal lenses,
- lens tints
- contact lenses
- medically required contact lenses
- repairs to glasses

There is no deductible and it is reimbursed at 100% to a maximum of $300 in one of the four year periods as listed below:

- January 1, 2011 — December 31, 2014
- January 1, 2015 — December 31, 2018

Example: *If you buy glasses in June 2012, this purchase falls within the January 1, 2011 to December 31, 2014 four-year period. The Vision/Hearing Plan will reimburse you a maximum of $300 during this period. You must wait For the NEXT four-year period (January 1, 2015 to December 31, 2018) for another $300 maximum to kick in under this plan.*

You also have more vision coverage under the Extended Health Care Plan (51391). **The EHCP plan is optional & this extra coverage only applies if you have applied for the EHCP.** The EHCP is the Primary Plan and is paid out at 80% of $400 *(to a maximum of $320)* for the same above said four year period.

You also have a $300 life time maximum coverage for laser eye surgery under the Vision & Hearing Plan *(51392).* This life time maximum is in addition to the regular vision coverage and can be combined with the $300 for coverage as specified in 51392. The life time coverage can also be combined with the EHCP *(51391)* vision coverage. This gives plan members a total reimbursement of $920 for laser surgery *(if you are covered by both plans).*

Covered under the plan, but not part of the $300 vision care maximum:

- eye examination (to a maximum of $125 coverage from both plan *51392 & EHCP 51391)*

Hearing expenses covered under the plan:

A maximum of $750 for each covered person in any rolling 60-month (five-year) period for: *There is no deductable and reimbursement is 100% up to the $750 maximum*

- purchase of hearing aids when medically required and prescribed by an ear, nose and throat specialist
- repairs to hearing aids

Covered under the plan, but not part of the $750 hearing care maximum:
• batteries for hearing aids *(only when purchased at the initial time of hearing aid purchase)*

You also have more hearing coverage under the Extended Health Care Plan (51391). **The EHCP plan is optional & this extra coverage only applies if you have applied for the EHCP.** The EHCP is the Primary Plan and is paid out at 80% of $500 *(to a maximum of $400)* for the same rolling 60-month (five-year) period.

Each province has its own provincial hearing plan. The Provincial Plan is considered the "Primary Plan" and any request for reimbursement must first be submitted to the Provincial Plan before accessing the GWL Vision & Hearing (51391) as well as the EHC (51392) plans.

Exclusions *(what's NOT covered)*

The Vision and Hearing Plan does not reimburse expenses for:

- broken appointments (that a doctor billed you for)
- the filling out of claim forms
- safety glasses or sunglasses
- artificial eyes
- hearing tests
- the cost of recharging devices, or other such hearing aid accessories (but batteries are covered)
- supplies or services that are:
  - eligible for reimbursement under any government plan (such as provincial or territorial funding for hearing aids), or for which a government or government agency prohibits payment of benefits
  - received from a medical department maintained by Canada Post, an association, a union, or a similar type of group
  - required as a result of intentional self-inflicted injury, war (declared or undeclared), insurrection, or participation in a riot
  - provided principally for cosmetic purposes
  - clearly experimental in nature
  - not considered justifiable and reasonable by the insurer (however, the portion that would have been charged for an alternative treatment that is considered justifiable or reasonable will be covered)
  - required as a condition of employment
- supplies or services for which there would have been no charge in the absence of this insurance

Coordination of Benefits:

1. When two Spouses *(as defined above)* both work for Canada Post and are both on the Vision & Hearing Plan, as employees with family coverage, they can claim benefits from two plans. *When this type of coordination of benefits you don't have to worry about whose plan pays what when you file a claim. Great-West Life does these calculations.*

2. You can also have a coordination of benefits with two Spouses *(as defined above)*, where only one Spouse works at Canada Post *(with family coverage)* and the other Spouse has family coverage under a different plan and with a different employer.

In this case each Spouse must apply for reimbursement with their own "Primary Plan" first, before applying for coordination of benefits with the "Secondary Plan".

When submitting a claim for a dependant child's vision or hearing benefits the parent who has legal and permanent custody of the child must first submit the claim to their benefit plan (*"Primary Plan"*) before applying for coordination of benefits with the "secondary Plan". When legal and permanent custody is shared then the parent with the first birthday in the year must submit the claim to their benefit plan as the "Primary Plan" before applying for coordination of benefits with the "Secondary Plan".

Using this benefit:

Your purchase or service must be authorized by the appropriate health professional. An ear, nose and throat specialist must prescribe the hearing aids. and an optometrist or ophthalmologist must prescribe the glasses/contact lenses.

You must pay up front for the service and/or item and apply to be paid back under the plan. You need a receipt and a claim form. The claim form you need is the Extended Health Care (EHCP)/Vision and Hearing Care Expense Statement.

You then send the form to Great-West Life, along with the receipt. **Be sure to make a copy of everything you send.** It normally takes about two weeks from when you mail your claim to when you will receive your cheque from Great-West Life

You can also submit a claim online through GWL Groupnet for members. To do this you must register and sign up for direct deposit. It is important note that if you have not previously signed up for Direct Deposit, you will need to allow at least an additional 2 business days from the time you submitted your request for changes to take place and be processed.

Be sure to write your Canada Post employee number (HRID number) on the claim form and sign it.

Be sure to fill out the Coordination of Benefits section if you are covered by more than one plan; you'll get more money back. Highlight the fact you have coordination of benefits on the form.

Remember: to send in your claim as soon as possible. Claims more than a year old *(received more than 12 months from the date of the expense)* will be rejected

DON'T buy new glasses or hearing aids until you've checked to see if Great West Life will cover you.

You can also check your Great West Life account on the GWL website at www.greatwestlife.ca

You log onto the Great-West Life website using the number of a GWL plan and your Canada Post employee number (HRID number).

Or contact GWL with any questions at:

Great-West Life
P.O. Box 3050
Winnipeg MB
R3C 4E5
1-(800)-957-9777 or 1-866-716-1313

On the following pages you will find:

1) GWL Extended Health Care / Prescription Drug Plan (51391) - Vision & Hearing Care Plan (51392) Claim form
2) Extended Health Care Plan – Health, Drugs, Vision (51391) application form
3) Dependent Information form

ARE / 21-08-2013

CANADA POST / POSTES CANADA

CLAIM FORM
EXTENDED HEALTH CARE/PRESCRIPTION DRUG PLAN (51391)
VISION & HEARING CARE PLAN (51392)

THE Great-West Life ASSURANCE COMPANY

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.
All claims under this group benefits plan are submitted through the employee. We may exchange personal information about claims with the employee and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

EMPLOYEE'S STATEMENT

Last Name | First Name | Date of Birth (Year / Month / Day) | Employee ID No.

Address | City | Province | Postal Code

Phone Number
HOME: ( ) WORK: ( )

Language Preference
☐ English ☐ French

COORDINATION OF BENEFITS:

- Are you or any other member of your family entitled to benefits under any **other** health care plan? ☐ Yes ☐ No
  If "Yes", name of family member insured _____
  Relationship to employee _____ Spouse's date of birth ____ / ____ (Month / Day)
  Name of other insurance company _____
  Policy Number _____ I.D. Number _____
- Is any member of your family (other than yourself) entitled to benefits as an employee under the Vision and Hearing Care Plan (51392)? ☐ Yes ☐ No
  I.D. Number _____
- Is treatment required as the result of an accident? ☐ Yes ☐ No
  If "Yes", give date, location and explain how accident happened
  _____
- Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

INSTRUCTIONS

Send form to Great-West Life:

QUEBEC RESIDENTS, OTHER THAN NATIONAL CAPITAL REGION RESIDENTS:
Montreal Benefit Payments
Place Bonaventure
Suite 5800
800 de la Gauchetière St. W
Montreal QC H5A 1B9

FOR ALL OTHER RESIDENTS:
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 0E6

1.866.716.1313
TTY line - available for the deaf or hard of hearing
Toll Free: 1.800.990.6654

DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth (Year / Mth / Day)	If child is 21 years of age or older: Full-Time Student? YES NO	With a Disability? YES NO
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐

CLAIM DETAILS

Patient Name	Type of Expense	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

PLEASE KEEP A COPY OF THIS FORM, RECEIPTS AND ANY OTHER RELEVANT DOCUMENTATION FOR YOUR RECORDS

EMPLOYEE'S AUTHORIZATION

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

CANADA POST / POSTES CANADA

Canada Post Corporation / Société canadienne des postes
EXTENDED HEALTH CARE/PRESCRIPTION DRUG PLAN (51391)
RÉGIME DE SOINS MÉDICAUX COMPLÉMENTAIRE/ RÉGIME DE MÉDICAMENTS SUR ORDONNANCE (51391)

Effective date of coverage will comence on the day your completed Application Form is received at AccessHR. Coverage will terminate at the end of the month in which the termination notice is received. / La date de prise d'effet de la protection correspond à la date à laquelle AccèsRH reçoit votre formulaire dûment rempli. La protection prend fin à la fin du mois au cours duquel l'avis de cessation est reçu.

Application for Coverage (Employee) / Demande de protection (salarié)

☐ Initial Application / Demande initiale ☐ Amendment / Modification ☐ Reinstatement / Remise en vigueur
☐ Termination / Cessation ☐ Refusal of Coverage / Refus de la protection

To be completed by the employee / À remplir par le salarié

1. Last Name / Nom	2. First Name / Prénom	3. Employee ID Number / N° d'identification du salarié

4. Date of Birth / Date de naissance	5. Province of Residence / Province de résidence	6. Gender / Sexe
Y/A M/M D/J		☐ Male / Homme ☐ Female / Femme

7. Persons to be covered / Personnes à couvrir ☐ Single / Protection individuelle ☐ Family / Protection familiale

If family coverage is elected, employees are responsible for updating their dependent information through the completion of the "Dependent Information form" which is to be sent to Great-West Life. / Les salariés qui choisissent la protection familiale doivent remplir le formulaire « Renseignements sur les personnes à charge » et l'expédier à la Great-West pour mettre à jour l'information concernant les personnes à leur charge.

8. Date Family Status Changed (Please give reason) / Date du changement de la situation familiale (indiquer la raison)

Y/A M/M D/J

Reason / Raison

9. Level of Medical Coverage / Niveau de protection soins médicaux ☐ Basic Coverage / Protection de base ☐ Hospital - Option A / Hôpital – Option A ☐ Hospital - Option B / Hôpital – Option B

10. Do you live outside of Canada? / Habitez-vous à l'extérieur du Canada?

☐ No / Non ☐ Yes / Oui

Date departed Canada / Date du départ vers l'étranger

Y/A M/M D/J

PRIVACY / CONFIDENTIALITÉ

Protecting Your Personal Information

At **The Great-West Life Assurance Company,** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We collect, use and disclose the personal information to determine your eligibility for coverage and to administer the plan, including investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines or if you have questions about our personal information policies and practices (including with respect to service providers) write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Protection de vos renseignements personnels

À **La Great-West, compagnie d'assurance-vie**, nous reconnaissons et nous respectons l'importance de la protection de la vie privée. Lorsque vous présentez une demande d'assurance, nous constituons un dossier confidentiel contenant vos renseignements personnels qui est conservé dans les bureaux de la Great-West ou dans ceux d'une organisation autorisée par cette dernière. Vous détenez certains droits d'accès et de rectification à l'égard des renseignements personnels consignés à votre dossier, et pouvez les exercer en présentant une demande écrite à la Great-West. La Great-West peut faire appel à des fournisseurs de services installés au Canada ou à l'étranger. Nous limitons l'accès aux renseignements personnels consignés à votre dossier aux membres du personnel de la Great-West ou aux personnes autorisées par cette dernière qui en ont besoin pour s'acquitter de leurs tâches, aux personnes à qui vous avez accordé un droit d'accès et aux personnes autorisées en vertu de la loi. Vos renseignements personnels pourraient être divulgués aux personnes autorisées en vertu des lois applicables au Canada ou à l'étranger. Nous recueillons, utilisons et divulguons ces renseignements personnels pour déterminer votre admissibilité à la protection et pour administrer le régime, y compris aux fins d'enquêtes et d'évaluation visant les demandes de règlement, ainsi que pour la constitution et la tenue de dossiers concernant notre relation d'affaires avec vous. Pour obtenir un exemplaire de nos Normes de confidentialité ou si vous avez des questions sur nos politiques et pratiques en matière de renseignements personnels (y compris en ce qui a trait aux fournisseurs de services), écrivez au chef de la vérification de la conformité de la Great-West ou consultez l'adresse www.lagreatwest.com.

Please see reverse side - Signature Required
Veuillez vous reporter au verso – Signature requise

AUTHORIZATIONS AND DECLARATIONS / AUTORISATIONS ET DÉCLARATIONS

Authorizations and Declarations

I hereby apply for coverage under the Canada Post Corporation's Extended Health Care/Prescription Drugs Plan.

I authorize:

- my plan sponsor to deduct from my pay the plan member contributions required under the plan if applicable;
- Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorization and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

Autorisations et déclarations

Par la présente, je demande la protection aux termes du Régime de soins médicaux complémentaire/Régime de médicaments sur ordonnance de la Société canadienne des postes.

J'autorise

- le répondant de mon régime à déduire de ma rémunération les cotisations salariales requises aux termes de régime, s'il y a lieu;
- la Great-West, tout fournisseur de soins de santé, le gestionnaire de mon régime, toute autre compagnie d'assurance ou de réassurance, les administrateurs des programmes d'État ou de tout autre programme d'avantages sociaux, toute organisation ou tout fournisseur de soins travaillant avec la Great-West à échanger les renseignements personnels nécessaires, au besoin, afin de déterminer mon admissibilité à la protection et d'administrer le régime.

Si je demande la protection pour mon conjoint ou mes personnes à charge, je confirme que je suis autorisé à agir en leur nom.

Je confirme qu'une photocopie ou une copie sous forme électronique de la présente section Autorisations et déclarations est aussi valide que l'original.

J'atteste que les renseignements donnés sont à ma connaissance véridiques, corrects et complets.

Employee Signature / Signature du salarié : _____ Date: Y/A M/M D/J

To be completed by AccessHR / À compléter par AccèsRH

1. Date Application Received / Date de réception de la demande

2. Coverage Commence or Change / Prise d'effet ou modification des protections Y/A M/M D/J

3. **Certification of Eligibility / Attestation d'admissibilité**
   The employee named herein is eligible to apply for Extended Health Care/Prescription Drugs Plan coverage and the transaction has been entered into SAP. / Le salarié susmentionné est admissible aux protections aux termes du Régime de soins médicaux complémentaire/Régime de médicaments sur ordonnance. La transaction a été saisie dans le système SAP.

Authorized Signature / Signature autorisée _____ Date Y/A M/M D/J
(AccessHR / AccèsRH)

Please return this completed application for to / Veuillez retourner le formulaire à :

ACCESSHR
SUITE B125
2701 RIVERSIDE DRIVE
OTTAWA ON K1A 0B1
CANADA
1-877-807-9090

ACCÈSRH
BUREAU B125
2701 PROM RIVERSIDE
OTTAWA ON K1A 0B1
CANADA
1 877 807-9090

CANADA POST / POSTES CANADA

DEPENDENT INFORMATION

THE Great-West Life ASSURANCE COMPANY

☐ Active (51391, 51057, 51392) ☐ Retirees (51391)

Please complete the information below and return to Great-West Life.
If not received, your dependent claims will not be processed.

EMPLOYEE/RETIREE INFORMATION

YOUR NAME LAST	FIRST	EMPLOYEE ID NUMBER	DATE OF BIRTH YEAR MONTH DAY

Home Address: Street _____

City _____ Province _____ Postal Code _____ Home Tel. (____) _____
Area Code

CHECK REASON FOR USE: ☐ New enrollment ☐ Change in status

If change in status, please complete the following information

Effective date of change _____

Reason for change in status
- ☐ Name change
- ☐ Add dependent(s)/reason _____
- ☐ Delete dependent(s)/reason _____
- ☐ Change in spouse's other coverage

SPOUSAL INFORMATION

SPOUSE'S NAME LAST	FIRST	DATE OF BIRTH YEAR MONTH DAY

Does your spouse have any of the following coverage through his/her employer? ☐ Yes ☐ No

		Insurer	Group Number	Identification Number
• Extended Health Care	☐ Single ☐ Family			
• Vision/Hearing Care	☐ Single ☐ Family			
• Dental Care	☐ Single ☐ Family			

INFORMATION ON UNMARRIED DEPENDENT CHILDREN

LAST NAME	FIRST	DATE OF BIRTH YEAR MONTH DAY	FULL-TIME STUDENT (to age 25)	DISABLED
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

If more children, please use a separate sheet.

NOTE: Canadian Life & Health Insurance Association (CLHIA) regulations state:
1. A spouse must first submit his/her own claims to his/her own employer's plan
2. Claims for the covered children must first be submitted to the plan covering the parent with the earlier date of birth in the year. If both parents are born in the same month, the earlier day is used.

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND CORRECT.
I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE PROOF OF EVIDENCE REGARDING THE ABOVE INFORMATION.

Your Signature _____ Date _____

INSTRUCTIONS:

MAIL COMPLETED FORM TO:

THE GREAT-WEST LIFE ASSURANCE COMPANY
Member Administration
P.O. Box 6000, Station Main
Winnipeg, MB
R3C 9Z9

You must complete a new Dependent Information form each time there is a change in your family status i.e. marriage, birth of a child, coordination of benefit changes and student status.
For any questions or forms, contact your local Payroll and Benefits Office.