My group benefit plan

TRUSTEES OF I.A.T.S.E. LOCAL 856 HEALTH AND WELFARE BENEFITS PLAN

All Members

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

My Canada Life at Work

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

With My Canada Life at Work you can:

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

Canada Life's Toll-Free Number

To contact a customer service representative at Canada Life for assistance with your medical and dental coverage, please call 1-855-729-1839.

Customer complaints

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

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

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

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

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 164615 and 164649 issued by Canada Life and Policy No. BSC 9425789 issued to I.A.T.S.E. Local 856 by AIG Insurance Company of Canada. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is underwritten by

and administered by

J&D Benefits Inc.
#228-8901 Woodbine Ave.
Markham, ON L3R 9Y4

This booklet was prepared on: June 13, 2022

Access to Documents

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

Legal Actions

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

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

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

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

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

Protecting Your Personal Information

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

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

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

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

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

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to the plan administrator.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

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Benefit Summary

This summary must be read together with the benefits described in this booklet.

	Level 1	Level 2	Level 3	Level 4
Member Basic Life Insurance (for Members under age 85)	$25,000	$50,000 reducing by 50% at age 70	$100,000 reducing by 50% at age 70	$100,000 reducing by 50% at age 70
	The minimum amount of Member Basic Life Insurance is $25,000			

Optional Life Insurance (for Members under age 85)	Available in $10,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both a member and a spouse, you are limited to the $500,000 maximum

	Level 1	Level 2	Level 3	Level 4
Short Term Disability Income Benefits (for Members under age 65)				
Waiting Period	Not covered		119 days	
Maximum Benefit Period	Not covered		52 weeks	
Amount	Not covered		The maximum weekly payment provided under the Employment Insurance Act	

	Level 1	Level 2	Level 3	Level 4
Healthcare				
	Covered expenses will not exceed customary charges			
Deductible	Not covered	Nil		
Reimbursement Levels				
In-Canada Prescription Drug Expenses	Not covered	80%		
All Other Expenses		100%		
Basic Expense Maximums				
In-Canada Ambulance	Not covered	Included		
In-Canada Hospital		Private room		
Convalescent Care		Semi-private room, maximum 180 days		
In-Caanda Home Nursing Care		$5,000 each policy year		
In-Canada Prescription Drugs		Included		
Cannabis for Medical Purposes		$5,000 each policy year		
Hearing Aids		$400 every 4 years		
Custom-fitted Orthopedic Shoes		$200 each policy year		
Custom-made Foot Orthotics		$150 each policy year		
All Prosthetic Appliances including Myoelectric Arms		$10,000 lifetime combined maximum		
External Breast Prosthesis		1 every 36 months per affected breast		
Surgical Brassieres		2 each policy year		
Mechanical or Hydraulic Patient Lifters		$2,000 per lifter once every 5 years		
Outdoor Wheelchair Ramps		1 in a lifetime to a maximum of $2,000		
Blood-glucose Monitoring Machines		1 lifetime		
Continuous Glucose Monitoring Machines Including Sensors and Transmitters		$4,000 each policy year		
Transcutaneous Nerve Stimulators		$700 lifetime		
Extremity Pumps for Lymphedema		1 in a lifetime to a maximum of $1,500		
Wigs for Cancer Patients		$200 lifetime		
Diagnostic Laboratory and Imaging Procedures		Included		
Other Medical Supplies		Included		

	Level 1	Level 2	Level 3	Level 4
Paramedical Expense Maximums				
Acupuncturists	Not covered	$500 each policy year		
Chiropractors		$500 each policy year		
Massage Therapists		$500 each policy year		
Naturopaths		$500 each policy year		
Osteopaths		$500 each policy year		
Physiotherapists		$500 each policy year		
Podiatrists/Chiropodists		$500 combined each policy year		
Psychologists/Social Workers/Clinical Counsellors		$2,500 combined each policy year		
Speech Therapists		$500 each policy year		
Visioncare Expense Maximums				
Eye Examinations	Not covered	1 every 24 months		
Glasses, Contact Lenses and Laser Eye Surgery	Not covered	$350 combined every 24 months		
Global Medical Assistance	Not covered	Included		
Out Of-Country Emergency Care	Not covered	Included		
Lifetime Healthcare Maximums	Not covered	Unlimited		
		Policy year means July 1st to June 30th		

	Level 1	Level 2	Level 3	Level 4
Dentalcare				
	Covered expenses will not exceed customary charges			
Payment Basis	Not covered		The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered. Specialists' charges are limited to general practitioner fees.	
Deductible	Not covered		Nil	
Reimbursement Level				
Basic Coverage	Not covered		80%	
Plan Maximum	Not covered		$1,000 combined each policy year	
			Policy year means July 1st to June 30th	

Basic Accidental Death And Dismemberment Insurance Plan (Underwritten by AIG Insurance Company of Canada)	See benefit description

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after the completion of 3 complete consecutive calendar months of union membership.

To be eligible for Level 2 or Level 3 coverage, you must have accumulated the required contributions in your Health & Welfare Account as of December 31 of the prior year, in addition to the eligibility waiting period.

To be eligible for Level 4 coverage, the amount in your Health & Welfare Account as of December 31 of the prior year must exceed an amount determined by the Trustees from time to time, in addition to the eligibility waiting period.

- You and your dependents will be covered as soon as you become eligible (Members with Level 1 or Level 2 benefits are not eligible for dependent coverage).

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your plan administrator for details.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. See your plan administrator for details.

SELF PAYMENT

If at any July 1, your Benefit Level drops, you can make a self-payment to continue at the level that you lost.

Information will be provided to you each year by the plan administrator.

DEPENDENT DEFINITION

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least **12 months**.

- Your unmarried children under age 21, or under age 25 if they are full-time students.

  Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your plan administrator.

MEMBER LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements to your beneficiary.

- Your life insurance will not continue past the end of the day before the date you reach age 85.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Canada Life will determine your qualification for waiver of premium benefits. If you believe you may qualify, contact your plan administrator for claim forms. You must apply for waiver of premium benefits within 12 months of the date you qualify.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 60 days after your group insurance terminates. See your plan administrator for details.

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance, you must provide proof of insurability, and your application must be approved by Canada Life. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements. If your spouse dies you will be paid the amount for which your spouse was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your spouse will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If you are not actively at work because of disease or injury, your optional life insurance may be continued on the same basis as your basic life insurance.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your plan administrator for details.

- Your optional life insurance will not continue past the end of the day before the date you reach age 70. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 70, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received.

SHORT TERM DISABILITY (STD) INCOME BENEFITS
(Not applicable to Level 1 or Level 2)

The plan provides you with regular income to replace income lost because of a disability due to non-occupational disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled or until the end of the benefit period, whichever comes first. Check the **Benefit Summary** for the benefit amount, waiting period and benefit period.

- STD benefits are payable after the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

- If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.

- Separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 2 continuous weeks of recovery.

- Benefits are taxable.

- Your STD coverage will not continue past the end of the day before the date you reach age 65.

Other Income

Your STD benefit is reduced by other income you are entitled to receive while you are disabled. Other income includes:

- disability benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts

- benefits under any Workers' Compensation Act or similar law

- to the extent permitted by law, loss of income benefits payable under a provincial or territorial automobile insurance plan that does not take income benefits payable under the Employment Insurance Act (Canada) into account when determining its benefits

Earnings received from an approved rehabilitation plan are not used to reduce your STD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your weekly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation is intended to help you return to your job or other gainful employment. A plan will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Any period:

  - preceding the date you are first treated by a legally licensed doctor of medicine; or
  - in which you do not participate or cooperate in a reasonable and customary treatment program.

  A reasonable and customary treatment program is systematic treatment:

  - that is performed or prescribed by a legally licensed doctor of medicine or other health care provider or health care facility;
  - that is of the nature and frequency usually required for the condition involved; and
  - where attendance, participation and progress can be verified through medical records.

  Notwithstanding the above, based on the nature or severity of the condition, for a treatment program to be considered reasonable and customary, Canada Life may:

  - require you to be under the care of a legally licensed doctor of medicine instead of or in addition to another health care provider or health care facility; and
  - require the treatment program to be prescribed, performed or supervised by a legally licensed doctor of medicine certified as a specialist for the condition involved.

  If the use of drugs or alcohol contributes to your disability, the treatment program must be overseen by a legally licensed doctor of medicine and the treatment program's primary goal must be abstinence, unless otherwise approved by Canada Life.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

- Any period of employment, except in an approved rehabilitation plan.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan.

- Any period after you fail to participate or cooperate in a recommended medical coordination program.

- The normal recovery period for treatment performed for cosmetic purposes only. This limitation does not apply where such treatment was undertaken as a result of a disease or injury.

- Any period of confinement in a prison or similar institution.

- Disability arising from war, insurrection or voluntary participation in a riot.

- Charges for un-kept appointments or to complete forms or reports.

How to Make a Claim

- To submit claims online, go to www.canadalife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M5454) and follow the guide's instructions.

  You can get this form from your plan administrator, or online from the Canada Life corporate website. To access the form online, go to www.canadalife.com.

To permit prompt assessment of your claims, please ensure that your claim is submitted to Canada Life within 10 days after the onset of your disability. Canada Life will not be liable for claims submitted more than 3 months after the end of your waiting period or the date your employer's plan ends, whichever is earlier.

HEALTHCARE
(Not applicable to Level 1)

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available.

- Hospital or nursing home confinement or home nursing care if it represents acute, convalescent, or palliative care.

  Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

  Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care. Semi-private room and board is covered for a maximum of 180 days per condition.

  Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

  - Preferred accommodation in a hospital or accommodation in a nursing home is covered when provided in Canada.

    For hospital accommodation, the plan covers the difference between the hospital's private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered.

    The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person’s home province.

    For accommodation in a nursing home, the plan covers the government authorized co-payment.

    Limitation

    Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

  - The plan covers home nursing services of a registered nurse, a registered practical nurse if the person is a resident of Ontario or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada.

    Nursing care is care that requires the skills and training of a professional nurse, and is provided by a professional nurse who is not a member of the patient's family.

    You should apply for a pre-care assessment before home nursing begins.

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision.

  - Drugs are covered if they are prescribed and they are listed in the TELUS Complete Managed Formulary developed and maintained by TELUS Health, in effect on the date of purchase.

  - The following diabetic supplies are covered:

    (a) insulin syringes
    (b) disposable needles for use with non-disposable insulin injection devices
    (c) lancets, test strips, and sensors for flash glucose monitoring machines

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

  For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

  You are required to register with Manitoba Pharmacare every year. A copy of the letter you receive each year from Manitoba Pharmacare stating the amount of your Pharmacare deductible, must be provided to the plan administrator. Your claim will not be paid until the Pharmacare letter is received.

- Cannabis for medical purposes when obtained from a licensed producer pursuant to a medical document issued by an authorized healthcare practitioner, and provided that all other requirements under the Cannabis Act and the Cannabis Regulations (as they may be amended or replaced from time to time) have been complied with. “Medical document” means a medical document as defined in the Cannabis Regulations under the Cannabis Act (as it may be amended or replaced from time to time).

  Cannabis does not include seeds or plant material that can be used to propagate cannabis.

  Limitations

  The limitations that apply to coverage for drugs and drug supplies apply with equal force to coverage for cannabis, except that cannabis does not require a drug identification number as defined by the Food and Drugs Act, Canada.

  Notwithstanding any other provision, cannabis represents reasonable treatment only on the terms and conditions and for those diseases or injuries, or stages or progressions of diseases or injuries, determined by Canada Life from time to time at its discretion.

- Rental or, at Canada Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician, chiropractor or podiatrist, as the case may be:

    - Breathing equipment: oxygen and the equipment needed for its administration; intermittent positive pressure breathing machine; continuous positive airway pressure machine; apnea monitors for respiratory dysrhythmias; mist tents and nebulizers; chest percussors. Drainage boards, and sputum stands; suction pumps; tracheostoma tubes

    - Orthopedic equipment; braces and cervical collars; custom fitted orthopaedic shoes; custom made foot orthotics; casts, splints including shoes attached to a splint; external electrospinal stimulators for the correction of scoliosis; non-union bone stimulators; prone standers

    - Mobility Aids: canes; walkers; crutches; parapodiums; mechanical or hydraulic patient lifters – once every five years; rechargeable batteries for covered wheelchairs; outdoor wheelchair ramps – once per lifetime; wheelchairs, including repairs

    - Artificial limbs (including repairs and shoulder harnesses), artificial eyes (including rebuilding and polishing); cleft palate obturators; myoelectric arms (including repairs); external breast prosthesis; surgical brassieres

    - Medical supplies: hospital beds, bed rails, trapeze bars, head halters, and traction apparatus, colostomy and ileostomy supplies; catheters and catheterization supplies; food substitutes that must be administered through a tube feeding process; tube feeding pumps and pump sets; transcutaneaous nerve stimulators for the control of chronic pain; custom made pressure supports for lymphedema

    - Extremity pumps for lymphedema or severe postphlebitic syndrome; custom-made burn garments; elevated toilet seats, shower chairs, bathtub rails; standard commodes

    - Wigs for cancer patients undergoing chemotherapy

    - Intraocular lenses following cataract surgery

    - One pair of eyeglasses or contact lenses following non-refractive eye surgery

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

- Continuous glucose monitoring machines prescribed by a physician, including sensors and transmitters

- Diagnostic laboratory and imaging procedures performed in the person’s province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

- Treatment of injury to sound natural teeth or a fractured jaw. Treatment must start within 60 days after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

  Limitations

  No benefits are paid for:

  - accidental damage to dentures
  - dental treatment completed more than 12 months after the accident
  - orthodontic diagnostic services or treatment

- Out-of-hospital services of a qualified acupuncturist when prescribed by a physician
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist when prescribed by a physician
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital treatment of foot disorders by a licensed chiropodist
- Out-of-hospital treatment by a registered psychologist, qualified social worker or clinical counsellor when referred by a physician.

  Treatment by a registered clinical counsellor is only eligible if provided in British Columbia. Treatment by all other clinical counsellors are covered.

- Out-of-hospital treatment of speech impairments by a qualified speech therapist when prescribed by a physician

Visioncare
(Not applicable to Level 1)

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

Global Medical Assistance Program
(Not applicable to Level 1)

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Canada Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation

  Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Limitation

Meal expenses are not covered.

Out-Of-Country Emergency Care
(Not applicable to Level 1)

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

  - treatment by a physician
  - diagnostic x-ray and laboratory services
  - hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
  - medical supplies provided during a covered hospital confinement
  - paramedical services provided during a covered hospital confinement
  - hospital out-patient services and supplies
  - medical supplies provided out-of-hospital if they would have been covered in Canada
  - drugs
  - out-of-hospital services of a professional nurse
  - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
  - dental accident treatment if it would have been covered in Canada

  Limitation

  If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

Other Services and Supplies

Canada Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Limitations

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

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

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Canada Life to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Custom-Made Compression Hose, Elastic Support Hose and Stump Socks
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Canada Life would have paid benefits for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Charges for periodic or routine health examinations or examinations for a third party (for example, if you need to get a medical exam in order to get a license)

- Charges for un-kept appointments or to complete forms or reports

- Chronic care

- Visioncare services and supplies required by an employer as a condition of employment

- Services or supplies that Canada Life has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Canada Life may take any factor into consideration including, but not limited to, the following:

    - clinical practice guidelines;
    - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
    - information provided by a manufacturer or provider of the service or supply; and
    - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Drugs or drug supplies that appear on an exclusion list maintained by Canada Life. Canada Life may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. Canada Life may add or remove a drug or drug supply from an exclusion list at any time.

  For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

    - Canada Life determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or

    - Canada Life determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Allergy extracts

- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

- Preventative immunization vaccines and toxoids

- Smoking cessation products

- Fertility drugs, whether or not prescribed for a medical reason

- Drugs used to treat erectile dysfunction

Prior Authorization

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

For services and supplies, including a listing of the prior authorization drugs, go to www.canadalife.com.

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

If the use of a lower cost alternative service or supply represents reasonable treatment, Canada Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

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

In determining whether to implement health case management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Canada Life has recommended or approved health case management, Canada Life can require that a service or supply be purchased from or administered by a provider designated by Canada Life, and:

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

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Canada Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Canada Life requires participation, Canada Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Out-of-country claims (including those for Global Medical Assistance expenses)** should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access My Canada Life at Work to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your plan administrator. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Canada Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government's share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Canada Life's Out-of-Country Claims Department at 1-855-729-1839.

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

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

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

- **We also accept paper claims for all Healthcare expenses.** Access My Canada Life at Work to obtain a personalized claim form or obtain form M635D from your plan administrator. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

- **For drug claims**, your plan administrator will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

CONTACT – MEMBER ASSISTANCE PROGRAM

The Contact member assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact member assistance program are available by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English or French:	1-866-289-6749
TTY:	1-877-338-0275

For more information on the services available under the Contact member assistance program, please see the member assistance program brochure provided by your plan administrator or visit the member assistance program: **login.lifeworks.com**.

VIRTUAL HEALTH SERVICES
(Not applicable to Level 1)

Virtual health services are available to you and your dependents by downloading the service provider's application specified by Canada Life from time to time. These services include the following:

- access to virtual health services 24 hours a day, 7 days a week
- unless prohibited by applicable laws, access to an unlimited number of consultations via telephone calls, text messaging and videoconferencing with medical professionals
- prescriptions and prescription renewals, when medically needed
- where diagnostic or laboratory tests are medically needed:
    - completion of necessary requisitions
    - results of the diagnostic or laboratory tests provided and accessible through the provider's application
- access to specialists such as psychologists, dieticians and work and life coaches for an additional fee
- access to self-guided internet-based cognitive behavioral therapy (iCBT)

DENTALCARE
(Not applicable to Level 1 or Level 2)

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level for a general practitioner shown in the **Benefit Summary**, except that:

- denturist fee guides are applicable when services are provided by a denturist.
- dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.
- specialist fee guides are applicable when specialists provide services within their speciality.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist's supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

You are covered for only the dentalcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

Treatment Plan

- Before incurring any large dental expenses, ask your dental service provider to complete a treatment plan and submit it to Canada Life. Canada Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
    - one complete oral examination every 36 months
    - limited oral examinations once every 9 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
    - limited periodontal examinations once every 9 months
    - complete series of x-rays every 24 months
    - intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- Preventive services including:
    - polishing and topical application of fluoride each once every 9 months
    - scaling, limited to a maximum combined with periodontal root planing of 8 time units each policy year

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
    - oral hygiene instruction once every 9 months
    - space maintainers
    - finishing restorations
    - interproximal disking
    - recontouring of teeth
- Minor restorative services including:
    - caries, trauma, and pain control
    - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
    - retentive pins and prefabricated posts for fillings
    - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
    - root planing, limited to a maximum combined with preventive scaling of 8 time units each policy year
    - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 36 months
    - denture rebases for dentures at least 2 years old, once every 36 months
    - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
    - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
    - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- Oral surgery
- Adjunctive services

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- Pit and Fissure sealants
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions
- Hypnosis or acupuncture
- Crowns (other than prefabricated crowns), bridgework and dentures
- Orthodontic treatment
- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare
- Expenses private plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage

- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Charges for unkept appointments or to complete forms or reports
- Charges for ongoing treatment that started before you became insured under this plan
- Charges for examinations by specialists
- Mouth guards and habit breaking appliances

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your plan administrator and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

- **For all other Dentalcare claims**, access My Canada Life at Work to obtain a personalized claim form or obtain form M445D from your plan administrator. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA) – Health SolutionsPlus (Not applicable to Level 1, Level 2 and Level 3)

A Health Care Spending Account (HCSA) is an account through which you may be reimbursed for healthcare and dental expenses up to a predetermined annual credit amount. Your plan administrator will establish the credits for your account prior to each policy year (policy year means July 1st to June 30th). These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

How will I know the balance of my HCSA account?

To check your current account balance, contact a customer service representative at Canada Life toll-free at 1-877-883-7072. Hours of service are 7 a.m. to 6 p.m. CST for service in English and 7 a.m. to 5 p.m. CST for service in French.

Eligibility

You and your dependents are eligible for HCSA credits if the amount in your Health Plan Account at December 31st exceeds an amount determined by the Trustees from time to time. HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act (Canada).

Termination

Your HCSA coverage terminates when your basic healthcare coverage terminates or you cease to qualify for Level 4 coverage.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

Coverage is provided for those expenses:

- that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time, or
- that Canada Life deems to be eligible medical expenses under a private health services plan, as defined by the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Canada Life toll-free at 1-877-883-7072.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when you or your dependent receives the service or supply.

Credits are available for covered expenses incurred in a policy year. Any remaining credits will be carried forward for covered expenses incurred in the following policy year. If they are not used for expenses incurred in that policy year, they are automatically forfeited.

The maximum annual payment available under your account will consist of the amount of the credit directed to it for the policy year plus any unused amount from the previous year.

Limitations

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits have been paid under your basic health plan, another group plan or a government plan

How to Make a Claim

You have the option of submitting a claim by using the Health SolutionsPlus card, or by using the Health SolutionsPlus claim form.

The Health SolutionsPlus card is made available to you for use for covered expenses in accordance with the terms and conditions set out in your cardholder agreement.

You may submit a claim against the HCSA plan first, or you may choose to first submit it to a government plan or another private insurance plan under which you or any eligible dependents are covered. If other plans have paid first, you may submit a claim for any remaining balance of the expense to the HCSA plan, using the Health SolutionsPlus claim form.

If you use the Health SolutionsPlus card:

- For drug expenses, you must first use your Pay Direct drug card to claim benefits from your basic plan. You would then use your Health SolutionsPlus card to claim benefits for any balance from your HCSA plan
- For dental expenses for which your dental office submits your claim electronically, your claim will be considered first under your basic plan. You would then use your Health SolutionsPlus card to claim benefits for any balance from your HCSA plan
- For other expenses, your claim will be considered first under your HCSA plan, even though a portion of the expense may be covered under the basic plan sponsored by your plan administrator

If you choose to use your Health SolutionsPlus card to pay for an expense, the amount will be drawn from the credits in your account whether or not coverage is available for the expense under another plan. However, if the expense would have been partially or completely covered under the basic plan, you may submit a claim for the expense to the basic plan.

The amount that would have been paid under the basic plan may be credited back to your account and paid instead under the basic plan if:

- No other coverage is available for that expense except under the basic plan, or
- Other coverage is available for that expense under another plan, but the basic plan would pay benefits before the other plan

Using the Health SolutionsPlus card:

- You must activate the card in order to use it, following the card activation instructions on the card
- To use your card to pay for prescriptions, you must activate your card at least one full business day before ordering or dropping off a prescription at the pharmacy
- The card is intended for use in Canada and can only be used at merchants who accept VISA®, and are included in the Health SolutionsPlus approved provider network
- The card will not work at automated teller machines (ATMs) or retail stores
- The card will not work if the expense exceeds your current account balance. Ask your provider if you can split the cost at the register. Use the balance on your card, and then pay the remaining amount using another method of payment
- You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request
- Canada Life may, in its own discretion, suspend or terminate the use of your Health SolutionsPlus card at any time, with or without cause, and without prior notice
- If your card is lost or stolen, contact a customer service representative immediately at Canada Life toll-free at 1-877-883-7072
- If your card is declined, use the claim form option

Using the Health SolutionsPlus claim form:

If you elect to use the claim form, use form M445D(HSPT) for dental claims, and form M635D(HSPT) for all other claims.

Claim submission deadlines:

Claims against the HCSA must be submitted to the Canada Life Benefit Payment Office before the earliest of the following:

- 60 days after the end of the policy year in which the expenses are incurred
- the date the HCSA contract terminates
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

COORDINATION OF BENEFITS

- If you or a dependent is entitled to benefits for the same expenses under another group or government plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You may submit a claim to the plan of your spouse for any amount which is not paid by this plan.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES
(Teladoc Medical Experts)
(Not applicable to Level 1)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents, parents and parents in-law (each a “person” for the purpose of this service) can generally access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-2378 toll-free or via teladoc.ca/canadalife/.

- The person accessing the service will be connected with a member advocate who will be dedicated to the person’s case and will provide support through the process. The member advocate will take the necessary medical history and answer the person’s questions. Any information provided is not shared the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet the person’s health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the person’s medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes several weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the person decides to seek treatment by a different physician, a member of the Teladoc Medical Experts team can help identify a specialist qualified to meet the person’s specific medical needs either in their geographic area or outside of Canada.

- The member advocate may identify a Teladoc Medical Experts specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Limitations

- Expenses incurred for travel and treatment are not covered by this service.

- Access to this service may be restricted to persons for whom their physician has made a diagnosis of a physical or mental illness or condition for which there is objective evidence, or where a physical or mental illness or condition is suspected.

These services are not insured services. Canada Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

For: IATSE LOCAL 856 HEALTH AND WELFARE TRUST
POLICY No: BSC 9425789

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer has provided for you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered after the completion of 3 complete consecutive calendar months of union membership in IATSE Local 856 for a Principal Sum amount of *$75,000.* Coverage terminates at age 70.

Here's What You Get

Broad Accident Insurance Coverage—Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance—Coverage is provided regardless of your health history.

24/7 Worldwide Coverage—Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Member" means you, if you are a member in good standing of the Policyholder.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands	The Principal Sum
Loss of use of one hand or one foot	Three-quarters of the Principal Sum
Loss of use of one arm or one leg	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the 1st phalange; “Fingers” means the complete severance through or above the 1st phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of use provided the Loss is continuous for twelve consecutive months and such Loss of use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Permanent and Total Disability Indemnity

If you suffer injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable for the same loss. Permanent and Total Disability means as a result of an injury, you are unable to perform at least two of the Activities of Daily Living described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

Activities of Daily Living are:

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with the Policyholder.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 consecutive nights, or (ii) $1/30^{th}$ of the amount determined under (i) for hospital confinements of more than 5 but less than 30 consecutive nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return the body to the city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit

Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify the body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which the seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to $15,000 for your Spouse’s expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement and Trauma Counseling Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Felonious Assault Benefit

Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an member of the Policyholder, other than an act of a fellow employee or a member of your family or household.

Serious Illness Benefit (Non-Cancer)

Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- Major Burns (3rd degree)
- Multiple Sclerosis
- Necrotizing Fasciitis
- Parkinson's Disease
- Major Organ Failure Requiring Transplant
- Motor Neuron Disease
- Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This benefit is payable only once even if you are diagnosed with more than one covered serious illness.

Coma Benefit

Pays a monthly benefit of 1% of the difference between Principal Sum and any other amount payable under the Plan in connection with the injury for up to 100 months, if you suffer an injury for which you receive a benefit under the Plan, and within 90 days of the date of the covered accident are disabled by coma which lasts for at least 6 consecutive months and is then determined by a physician to be permanent.

Burn Benefit

Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn. Please see the Policy for details.

War Risk Coverage

You may be eligible for coverage for injury or loss resulting from declared or undeclared war in certain countries. Please see the Policy for specific details.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;

(b) self inflicted injury or any attempt thereat by you while sane or insane;

(c) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;

(d) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

(e) sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(f) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

(g) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:

I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

II. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

III. riding as a passenger in an aircraft owned or leased by the Policyholder;

(h) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(i) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

(j) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

(k) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;

(l) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

(m) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(n) natural causes.

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Member”.

Termination Date

Coverage ends on the earliest of:

(1) the date the policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date you no longer satisfy the definition of an Insured Member; or (4) the first day of the month following the date you no longer belong to an Eligible Class of Members as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.