My group benefit plan

canada life™

IATSE LOCAL 873
HEALTH AND WELFARE TRUST

Hour Bank Members

About Your Benefit Plan

Your benefit plan is sponsored by the IATSE Local 873 Health and Welfare Trust. The Trust was established on November 17th, 2011 and assumed responsibility for health and welfare benefits for the members of Local 873 on January 1st, 2012.

The basic eligibility requirement for benefit coverage is membership in good standing as determined by the constitution of IATSE Local 873.

The IATSE Local 873 Health and Welfare Trust has five trustees including the elected President and Treasurer and three Trustees elected at large, by the membership.

The benefit plans are primarily funded by employer contributions under contracts negotiated by IATSE Local 873. The plan has three benefit levels: **membership benefits** including life, accidental death and dismemberment, critical illness and a family and employee assistance plan are available to all members in good standing, **working benefits** including short term disability and vision benefits and **extended health benefits** including dental, drug paramedical and hospitalization. All benefits require membership in good standing in the Local. Extended health benefits require producer contribution and/or member contributions.

Life insurance, travel, dental, health and short term disability are underwritten or adjudicated by Canada Life. Critical illness and accidental death and dismemberment are underwritten by CHUBB. Member and family assistance services are provided by Shepell.

J & D Benefits Inc. provides group benefits administrative services to the plan.

This benefit booklet deals with the benefits provided by Canada Life. The other benefit provider booklets are available on the union website and at the union office.

IATSE LOCAL 873 HEALTH AND WELFARE TRUST BENEFITS

THIRD (3RD) PARTY ADMINISTRATOR

J&D Benefits:
905.477.7088 or 1.800.218.7018
iatse@jdbenefits.com

When to Contact J&D:

- To order new/replacement: Telus drug cards, HSP VISA cards or Global Medical Assistance cards.
- To make changes to your coverage, dependant information and any beneficiary changes.
- If you have dependant and/or student eligibility questions.
- To request statements of coverage.
- To re-enroll in the plan annually.
- To confirm what coverage you have.
- Need help to submit a claim.
- To change your address with Canada Life.
- To join the plan and for the cost of benefits.
- To make a payment for the health and dental plan.

I.A.T.S.E. Local 873:
www.873healthplan.com
benefits@iatse873.com

When to contact IATSE 873:

- Vision care eligibility and submitting claims.
- For any Death Benefit, Life Insurance or Accidental Death and Dismemberment claim
- Short Term Disability eligibility, application forms and submitting claims.
- Maternity/Parental Supplement – (taxable $200/week benefit) – contact office for eligibility and claims submission guidelines.
- Critical Illness eligibility, application forms and submitting claims.
- Address changes for your membership file.
- Unresolved Health & Dental Claim issues.

CLAIM FOR BENEFITS

THE CANADA LIFE ASSURANCE COMPANY
(Life Insurance – Policy # 154591 Health & Dental – Plan # 055342)

Canada Life Group Claims – English
Winnipeg Health and Dental Claims Centre
Post Office Box 3050
Winnipeg, Manitoba R3C 0E6
Toll Free: 1-855-729-1839

Canada Life Group Claims – French
Montreal Health and Dental Claims Centre
800 de la Gauchetière Ouest, Suite 5800
Montreal Quebec H5A 1B9
Toll Free: 1-855-729-1839

GLOBAL MEDICAL ASSISTANCE
(Emergency out-of-country travel assistance)
Group Policy # 154591

Within Canada or the US:	1-800-527-0218
Outside Canada or the US:	410-453-6330 (Call Collect)
Mexico:	001-800-101-0061
Cuba:	905-816-1901 (Call Collect)

If there are any issues calling collect, you may pay for the call and then submit the receipt for payment to Canada Life for reimbursement.

CONTACT - MEMBER ASSISTANCE PROGRAM

For service in English: 1-844-880-9142
For service in French: 1-844-880-9143

www.workhealthlife.com

You can browse the site as a guest or access the secure services (book appointments, video, and e-chat) by clicking on the “tell us your organization” link and entering IATSE Local 873.

To register, you will need an email address and will be asked to create a password.

CHUBB

Basic Accidental Death and Dismemberment
- AB10453601 (effective April 1, 2014)

Mandatory Critical Illness
- CI10453601 (effective April 1, 2014)

Optional Critical Illness
- CO10453601 (effective Sept. 1, 2014)

All claims are to be initiated through the IATSE Local 873 office.

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

GroupNet for Plan Members

As a Canada Life plan member, you can register for GroupNet™ for Plan Members at www.canadalife.com or on the GroupNet Mobile app. To register, click “Sign in”. From there, click “GroupNet for plan members”, then follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

With GroupNet and GroupNet Mobile 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 Healthcare and Dentalcare coverage, please call
  1-855-729-1839.
- for assistance with your Health Care Spending Account, please call
  1-877-883-7072.

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. 154591 and 164652 and Plan Document Nos. 55342 and 51908. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document 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 administered by

and

J&D Benefits

This booklet was prepared on: September 7, 2021

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

Insured benefits

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.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

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.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

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.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by IATSE Local 873. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit IATSE Local 873'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 any other benefit, 60 days following receipt of the required proof of claim.

Plan Sponsor Role

For insured benefits, the plan sponsor's role is limited to providing members 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

Your plan sponsor has an agreement with Canada Life in which your plan sponsor has financial responsibility for some or all of the benefits in the plan and we process claims on your plan sponsor's behalf. 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 any of Canada Life's offices or to our head office.

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

Notice of Liability for Benefits

Your plan sponsor has entered into an agreement with The Canada Life Assurance Company whereby the Healthcare (except Global Medical Assistance), Dentalcare and Short Term Disability benefits outlined in this booklet are uninsured and your plan sponsor has liability for them.

This means that the Healthcare (except Global Medical Assistance), Dentalcare and Short Term Disability benefits are:

- an unsecured financial obligation and are payable from your plan sponsor's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts your plan sponsor from the requirements under the Financial Institutions Act (British Columbia).

If Quebec law applies, any uninsured benefit is not under the supervision and control of the Autorité des marchés financiers.

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Benefit Summary

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

Member Basic Life Insurance	$100,000, reducing by 50% at either age 70 or the date of retirement, whichever is earlier
Optional Life Insurance	Available in $10,000 units to a maximum of $500,000, for you or your spouse You and your spouse may each purchase up to $30,000 of Optional Life Insurance without providing evidence of insurability if you apply for coverage within 31 days of the first plan enrolment period If you choose not to apply within 31 days of the first plan enrolment you are no longer eligible for the $30,000 non-medical amount. However, you may apply for coverage at each plan re-enrolment up to the $500,000 maximum by providing 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

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
Reimbursement Levels	
Chronic Care, In-Canada Hospital	
Out-of-Country Emergency Care and Global Medical Assistance Expenses	100%
In-Canada Prescription Drug Expenses	
- for the covered dispensing fee portion of the drug charge	100%
- for the balance of drug expenses	
- brand name drugs that do not have a generic alternative and all other drug expenses purchased from Pocket Pills Pharmacy	90% until $3,000 of out-of-pocket drug expenses has been reached and 100% thereafter
- for brand name drugs that do not have a generic alternative and brand name drugs that have been written and directed by the prescriber not to be interchanged	80% until $3,000 of out-of-pocket drug expenses has been reached and 100% thereafter
- for all other drug expenses	100% of lowest cost generic equivalent
All Other Expenses	90%

Out-of-Pocket Maximum for Quebec Residents

An out-of-pocket maximum is applied to in-province expenses for drugs listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows:

1. reimbursement will be made at 100%
2. no further out-of-pocket amounts will apply

The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	$10,000 each calendar year
Chronic Care	$25 per day
In-Canada Prescription Drugs	Included
Smoking Cessation Products	$500 lifetime or as otherwise required by law
Cannabis for Medical Purposes	$2,500 each calendar year
Dispensing Fee Limits*	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $9.50. This does not apply if you live in Quebec. For maintenance drugs, a maximum of 5 dispensing fees are covered per drug identification number in a calendar year
exception for Drugs Purchased in Saskatchewan	For maintenance drugs purchased in Saskatchewan, a maximum of 12 dispensing fees are covered per drug identification number in a calendar year
exception for Drugs Purchased in Quebec	The dispensing fee frequency limit does not apply to drugs purchased in Quebec
exception for Drugs Purchased at Pocket Pills Pharmacy	The dispensing fee limit does not apply to drugs purchased at Pocket Pills Pharmacy
Hearing Aids*	$500 every 5 years
Custom-fitted Orthopedic Shoes*	$500 each calendar year

Custom-made Foot Orthotics*	$500 each calendar year
Myoelectric Arms*	$10,000 per prosthesis
External Breast Prosthesis*	1 every 12 months
Surgical Brassieres*	2 every 12 months
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 every 4 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters*	$4,000 each calendar year
Transcutaneous Nerve Stimulators*	$700 lifetime
Extremity Pumps for Lymphedema*	1 in a lifetime to a maximum of $1,500
Custom-made Compression Hose*	4 pairs each calendar year
Wigs for Cancer Patients*	$500 lifetime

Paramedical Expense Maximums

Chiropractors	$1,000 each calendar year $40 for x-rays each calendar year
Physiotherapists/Athletic Therapists	$1,000 combined each calendar year
Dieticians**	$500 each calendar year
Podiatrists	$500 each calendar year
Chiropodists	$500 each calendar year
Naturopaths	$500 each calendar year
Osteopaths	$500 each calendar year
Psychologists/Social Workers/ Psychotherapists	$3,000 combined each calendar year
Speech Therapists**	$1,000 each calendar year
Massage Therapists**	$500 each calendar year
Acupuncturists**	$500 each calendar year

Visioncare Expense Maximums

Eye Examinations	1 every 24 months
Eye Examinations, Glasses, Prescription Safety Glasses, Contact Lenses and Laser Eye Surgery	$650 combined every 24 months

Out-of-Country Emergency Care Expense Maximum	$1,000,000 per trip
Lifetime Healthcare Maximum	Unlimited

* Must be prescribed by a physician or a nurse practitioner
** Must be prescribed by a physician or a nurse practitioner annually

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	90%
Major Coverage	60%
Orthodontic Coverage	60%
Accidental Dental Injury Coverage	80%
Plan Maximums	
Basic Treatment	Unlimited
Major Treatment	$2,000 each calendar year
Orthodontic Treatment	$2,000 lifetime
Accidental Dental Injury Treatment	Unlimited

Health Care Spending Account Benefits (HCSA)	HCSA is based on the number of hours worked for the period ending July 31st each year. Members who work 1,680 hours will receive a $750 deposit to their HCSA effective September 1st each year. Refer to the benefit description details for more information.

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the first day of the month coinciding with or next after the date you become a member of the union.

- You and your dependents will be covered when you are advised by J&D that your coverage is effective.

  You may waive health and/or dental coverage if you are already covered for these benefits under another plan.

- To be eligible for coverage, you must be a member of I.A.T.S.E. Local 873 in good standing. The term “in good standing”, as used in the Constitution and By-Laws of I.A.T.S.E. Local 873, means that you have fully complied with all obligations to the Local, not only financially, but in all other respects as well.

  Your hour bank coverage ends if your hour bank balance falls below the minimum 140 hours and you do not make your self-payment by the specified date. You will get a termination notice by email or by Canada Post, if we (J&D Benefits or Local 873) do not have an email for you on file. To reinstate your coverage, contact J&D Benefits in the first three weeks of the month your coverage ends. You will have to self-pay for the number of hours you were short in the current month, plus 140 hours to ensure coverage for the following month. If you do not reinstate your coverage within the first three weeks of the month, you will need to build up 280 hours in your account, to be covered again. You are not permitted to requalify for making self-payments.

Your coverage terminates on the effective date of the change/ event in which you cease to be a member in good standing with Local 873 or when you are no longer eligible, you stop making the required contributions, or the plan terminates, whichever is earliest.

- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.

- 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 sponsor for details.

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

Survivor Benefits

If you die while your coverage is still in force, the Healthcare, Global Medical Assistance, Contact and Dentalcare benefits for your dependents will be continued for a period of 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

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 or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

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

  Note: If you are a Quebec resident, full-time students are covered for prescription drug benefits until age 26.

  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 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 BASIC 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 sponsor 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 75.

- If any or all of your insurance terminates before age 75, you may be eligible to apply for an individual conversion policy without providing proof of your good health. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan sponsor 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 are eligible for $30,000 without proof of insurability if it is applied for within 31 days of the date of eligibility. After 31 days, you must provide proof of insurability, and the 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 sponsor will explain the claim requirements. If your spouse dies you will be paid the amount for which your spouse was insured.

- 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 sponsor 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.

HEALTHCARE

You are covered for Healthcare only if you have enrolled for it with IATSE Local 873 Health and Welfare Trust.

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.

Covered expenses will not exceed customary charges.

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.

  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 semi-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.

- Chronic care, provided in a hospital, nursing home or for home nursing care in Canada, for a condition where improvement or deterioration is unlikely within the next 12 months

- 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 which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

  - Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, and sensors for flash glucose monitoring machines

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

  The plan will also pay for preventative immunization vaccines and toxoids.

  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.

- 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 the plan’s discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician or a nurse practitioner

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician or a nurse practitioner

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

- Diabetic supplies prescribed by a physician or a nurse practitioner: 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 or a nurse practitioner

- Flash glucose monitoring machines prescribed by a physician or a nurse practitioner

- Continuous glucose monitoring machines prescribed by a physician or a nurse practitioner, 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

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

- Out-of-hospital treatment of nutritional disorders by a registered dietician when prescribed by a physician or a nurse practitioner annually

- Out-of-hospital treatment of movement disorders by a licensed physiotherapist or a qualified athletic therapist

- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist

- Out-of-hospital services of a qualified chiropodist
- Out-of-hospital treatment by a registered psychologist, registered psychotherapist or qualified social worker
- Out-of-hospital treatment of speech impairments by a qualified speech therapist when prescribed by a physician or a nurse practitioner annually
- Out-of-hospital services of a qualified massage therapist when prescribed by a physician or a nurse practitioner annually
- Out-of-hospital services of a qualified acupuncturist when prescribed by a physician or a nurse practitioner annually
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital services of a licensed naturopath

Visioncare

- 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, prescription safety 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

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

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

  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

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited 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 benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have 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 the plan administrator to be a covered service or supply
- Extra medical supplies that are spares or alternates
- 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 benefits would have been paid under this plan 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
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
- Visioncare services and supplies required by an employer as a condition of employment
- Prescription sunglasses

- Services or supplies that the plan administrator 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, the plan administrator 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 the plan administrator. The plan administrator 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. The plan administrator 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:

    - the plan administrator 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

    - the plan administrator 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.

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Fertility drugs
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- 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
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction
- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to your plan administrator by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec*.

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your plan sponsor. 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 GroupNet for Plan Members 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your plan sponsor. 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 sponsor 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**.

DENTALCARE

You are covered for Dentalcare only if you have enrolled for it with IATSE Local 873 Health and Welfare Trust.

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.

Covered expenses will not exceed customary charges.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. 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.

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.

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, 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 twice every 12 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 twice every 12 months
  - complete series of x-rays every 36 months
  - intra-oral x-rays to a maximum of 15 films every 36 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 twice every 12 months
  - scaling, limited to a maximum combined with periodontal root planing of 10 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - pit and fissure sealants on bicuspids and permanent molars every 60 months

- space maintainers including appliances for the control of harmful habits

- 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 10 time units every 12 months

  - 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
- Oral surgery
- Adjunctive services
- Personal protective equipment if it must be worn by the patient or the provider of service during treatment in order to provide a barrier to help prevent potential exposure to infectious disease

Major Coverage

- Crowns. Coverage for complicated crowns is limited to the cost of standard crowns.
- Onlays
- Gold foil restorations are covered when a tooth cannot be adequately restored using amalgam or tooth coloured fillings.

  Replacement crowns, onlays and gold foil restorations are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

- Denture-related surgical services for remodelling and recontouring oral tissues

- Appliance maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 months

  - denture adjustments, once every 12 months

  - denture repairs and additions, tissue conditioning and resetting of denture teeth

  - repairs to covered bridgework

  - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Accidental Dental Injury Coverage

- Treatment of injury to sound natural teeth. 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:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling

- 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. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided

- Expenses covered under another group plan's extension of benefits provision

- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services

- Expenses private benefit 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 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, except orthodontics
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan sponsor 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 GroupNet for Plan Members 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 GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan sponsor. 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 (HCSA) – Health SolutionsPlus

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 sponsor will establish the credits for your account prior to each plan year. 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.

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 sponsor

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 sponsored by your plan sponsor, 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, notify your plan administrator immediately by contacting a customer service representative 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:

- 120 days after the end of the plan year in which the expenses are incurred
- the date the HCSA contract terminates, if it terminates because your plan sponsor fails to make a required payment
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

Eligibility

You and your dependents are eligible for HCSA credits through your plan sponsor if you are covered for basic healthcare benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your basic health plan, 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 when your plan sponsor discontinues the plan.

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 plan year. Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan 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 plan 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

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both a member 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 and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

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 serious physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- 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 with the plan sponsor 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 6 to 8 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, the member advocate can help identify a specialist qualified to meet the person's specific medical needs.

- If the person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process.

- The member advocate may identify a Best Doctors 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

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

- Expenses incurred for travel and treatment are not covered by these services.

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.

REHABILITATION PROGRAM FOR SUBSTANCE ABUSE TREATMENT

Coverage is provided for the expenses of a rehabilitation program for substance abuse treatment:

1. that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time; or

2. 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.

Benefits may be paid for 100% of the cost of the rehabilitation program for alcohol or drug misuse to a maximum of $20,000 paid for treatment. This benefit is available to all active Union members in good standing and their eligible dependents and Retirees.

Payment is only available, after successful completion;

- In-patient treatment in a substance abuse treatment facility; or out-patient treatment; and after care treatment by a substance abuse treatment facility
- The program must be coordinated through Shepell (Member Assistance Program)

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