Your Benefits Plan

Halifax Port I.L.A./H.E.A. Health, Welfare & Wellness Benefits Plan

PRODUCED: SEPTEMBER 2023

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Welcome

The Board of Trustees is pleased to provide you with your benefits booklet. It describes the Halifax Port I.L.A./H.E.A. Health, Welfare & Wellness Benefits Plan (Plan). The Plan was established to provide benefits to eligible union members of the International Longshoremen's Association employed in the longshoring industry in the Port of Halifax, Autoport and Shearwater, and their eligible dependents.

The Plan is funded by employer contributions to the Trust Fund as negotiated in the collective agreements between the H.E.A. and the I.L.A. Locals 269, 1341,1738 and/or 1825. It is administered by the Trustees of the Halifax Port I.L.A./H.E.A. Health, Welfare & Wellness Trust Fund. The Trustees are elected or appointed to the Board and exercise their powers pursuant to the terms of the Master Trust Agreement.

Canada Life and SSQ Insurance Company Inc. (SSQ) make payments on behalf of the Plan under policy numbers:

- Health and Dental – Canada Life # 56072
- Travel (for working members only) – Canada Life # 330502 and 56072
- Teladoc Medical Experts – Canada Life # 330502
- Life and Long-Term Disability – Canada Life # 330502
- Short-Term Disability – Canada Life # 56072
- Accidental Death & Dismemberment – SSQ # 1FX80
- Consult+ Virtual Health Care Services – Canada Life #330502

This booklet describes the benefits available to members based on their eligibility for a category of benefits as of April 1 each year. If you have questions about which category of benefits you are currently eligible for, please contact Mercer (the Plan Administrator) at 902-425-4526.

Before you read the other sections of this booklet, take note of the following.

Did you know?

Psst...

As a special feature, this booklet offers tips to help you make the most of your benefits from the Plan and other sources. Just look out for "**Psst ...**" in the shaded boxes like this one as you go through the booklet.

Welcome

Words you need to know

Words shown in blue type are defined in the Glossary section at the end of this booklet or will link you to a section for more information. Click the **Go back** button to return to the page you were on.

About this booklet

This booklet is an important source of information on your health, welfare and wellness benefits. It replaces any booklets that you have previously received and includes plan improvements as of the effective date. Keep it in a safe place for easy reference whenever you require information about your benefits.

Please keep in mind that this booklet is only a summary of the benefits Plan.

The Board of Trustees determines what benefits are offered under the Plan, subject to the requirements of governing legislation, the Master Trust Agreement, and the applicable insurance contracts, which will govern in case of any discrepancy. Benefit details and applicable exclusions and limitations to coverage are described in contracts between the benefit providers and the Trust, and in Board of Trustee resolutions. All terms of the Plan described in this booklet are subject to change.

Please contact the Plan Administrator with any questions you may have about the coverage provided under the Plan or your eligibility.

Need to know more?

For more information on the benefits Plan, see the Who to contact section of this booklet.

Discipline

The Board of Trustees is responsible for protecting the Plan for the benefit of all members. Therefore, the Board of Trustees reserves the right to impose discipline upon members, decline their benefits or remove them from the Plan if they participate in improper activities that threaten the Trust funds or the Trust's relationships with its benefits providers.

Regular benefits

Eligibility

You are eligible for benefits provided you meet the criteria described in this section. If you are considered eligible for coverage, the Plan also covers your eligible spouse and children.

You must give the Plan Administrator information on your eligible spouse and/or children and any changes in your family situation. Otherwise, their claims could be refused. Your eligible dependents will only have coverage once you have actively enrolled them in the Plan.

Joining the Plan and maintaining your eligibility

Eligibility to participate in the Plan must be established for each benefit year, which runs from April 1 of a given year to March 31 of the following year. Every April 1 your eligibility is evaluated and if you are eligible for coverage, your coverage will commence on April 1 and be maintained for the remainder of the benefit year.

If you have questions about which category of benefits you are currently eligible for, please contact Mercer (the Plan Administrator) at 902-425-4526.

Regular benefits

A union member who is not a Plan member, including anyone who has lost eligibility as a Plan member, is eligible to join the Plan only in the Regular benefits – Working members category of benefits and must meet the eligibility criteria described in the table below.

After becoming a Plan member, you must satisfy the eligibility criteria for Regular benefits – either as Working or Disabled – for each subsequent benefit year, as described in the table below.

Regular benefits – Working members	Regular benefits – Disabled members
On the first day of the benefit year, you are an employee and you meet all of the following conditions: • You reside in Canada. • You have not retired. • **If you were *not* a Plan member in the last benefit year**: you have accumulated at least 1,000* work hours in the industry as an employee during the previous calendar year. • **If you were a Plan member in the last benefit year**: you have accumulated at least 1,000* hours (work hours plus deemed hours) in the industry as an employee during the previous calendar year.	On the last day of the previous benefit year, you are a disabled employee under age 65 (age 60 if you became disabled between August 1, 2009 and March 31, 2012) and you meet all of the following conditions: • You reside in Canada. • You are approved for long-term disability benefits under the Plan or disability benefits from the Pension Plan (or you were receiving benefits from one of these plans on the first day of the previous benefit year, provided your employment has not been terminated with cause). • You are not retired.

Note: Coverage begins the day the Board of Trustees determines that you or your dependents have met the eligibility requirements. There are no entitlements under the Plan before the Board has made this determination.

* For April 1, 2022 benefit year, eligibility was based on 600 hours.

Regular benefits

If you cease to satisfy the eligibility criteria for a category of benefits, your Plan membership will be terminated. To rejoin the Plan, you will be required to re-qualify on the same basis as new union members.

It is your responsibility to apply for and provide proof in support of any benefits to which you may be entitled under the Plan. You are also responsible for providing the Plan Administrator with any documents that are required to determine your eligibility.

Failure to pursue benefits to which you may be entitled, such as long-term disability benefits, may result in your ceasing to be eligible to maintain coverage under the Plan. If you fail to pursue such entitlements, you do so at your own risk.

Psst...

We need to hear from you!

- **If you are eligible for deemed hours:** Let the Plan Administrator know if you are receiving Employment Insurance (EI) or workers' compensation benefits.
- **If you are pregnant and plan on taking a maternity leave of absence:** Let the Plan Administrator know when you plan on taking your leave of absence. You may be eligible to receive benefits from the Maternity Leave Supplemental Unemployment Benefit (SUB) plan.

It is very important that you contact the Plan Administrator as soon as possible in these cases. Failure to do so may result in the **loss of benefits**.

Who pays the costs?

Your benefits under the Health, Welfare & Wellness Benefits Plan are 100% paid by the Trust on your behalf. You do not pay any premiums for your benefits coverage.

Regular benefits

Benefits at-a-glance – Working members

The table summarizes the Plan's Regular benefits for Working members. See the Plan details section for more details on coverage, limitations and exclusions. Some of these benefits may be subject to separate Plan maximums and restrictions, as indicated in the Plan details section.

Health care* Canada Life policy # 56072	
Drugs (legally requiring a prescription)	• You pay the dispensing fee and 20% of the cost to an annual out-of-pocket maximum of $500 per family • The Plan pays 80% of the cost until you have reached the annual out-of-pocket maximum and 100% thereafter • Reimbursement is based on the cost of the lowest priced interchangeable (generic equivalent) drug • Fertility drugs, to a lifetime maximum of $2,500 per covered person • Erectile dysfunction drugs, to a maximum of $1,000 per benefit year per covered person • Vaccines and toxoids, to a maximum of $500 per benefit year per covered person • Smoking cessation products, to a lifetime maximum of $500 per covered person • Convenient pay-direct benefit card for drug and medicine expenses
Hospitalization (in your province of residence)	• There is no coverage under the Plan – provincial health plan coverage only
Paramedical practitioners	• 80% reimbursement • Care and services of licensed, registered or certified: acupuncturists, audiologists, chiropractors, naturopaths, osteopaths, physiotherapists/athletic therapists (combined), podiatrists/chiropodists, psychologists, massage therapists and speech therapists, to a maximum of $500 per type of practitioner per benefit year per covered person

Regular benefits

Vision care	• 100% reimbursement • Prescription glasses and contact lenses, to a maximum of $200 every 24 months per covered person (every 12 months for children) • Eye examinations, to a maximum of $100 once every 24 months per covered person (every 12 months for children) • Visual training or remedial exercises, to a maximum of $100 per benefit year per covered person
Hearing aids	• 100% reimbursement • Maximum of $700 every five benefit years per covered person
Medical supplies and equipment	• 80% reimbursement • Specified maximums per covered person
Orthotics and orthopedic shoes	• 80% reimbursement • One pair of custom-made orthotics, to a maximum of $150 every two benefit years per covered person (two pairs for children under age 19) • Custom-made shoes, one pair per benefit year per covered person • Must be recommended by a physician or podiatrist
Accidental dental treatment	• 80% reimbursement • Treatment must begin within 60 days after the accident (unless a medical condition delays treatment)
Ambulance services	• 100% reimbursement • Ambulance transportation to the nearest center where adequate treatment is available

* Expenses under the Health Plan are reimbursed based on Canada Life's assessment of reasonable and customary fees.

Regular benefits

Dental care
Canada Life policy # 56072

Dental fees are based on the current Dental Association Fee Guide for General Practitioners for the province in which the services are performed.

Basic and major services	• 80% reimbursement, to a combined maximum of $1,000 per benefit year per covered person – Recall exams, polishing and fluoride treatment, twice every benefit year (at least five months between recall exams) – Full-mouth x-rays and panorex x-rays, once every 36 months – Bitewing x-rays, four per benefit year – Fillings, oral surgery, extractions, basic restorations and periodontic treatment – Crowns, bridges and partial or complete dentures
Orthodontic services	• 80% reimbursement, to a lifetime maximum of $1,500 per covered person

Travel
Canada Life policy # 330502 and 56072

Out-of-province/country emergency medical	• 100% reimbursement • Limited to the first 60 days for out-of-country trips (no limitation for in Canada) • Must be covered under provincial plan
Travel assistance	• 24/7 services

Life and Accident Insurance

Life Canada Life policy # 330502	• For you: $25,000 • For your spouse: $1,500
Accidental Death & Dismemberment (AD&D) SSQ policy # 1FX80	• For you: $25,000 for accidental death • Percentage of accidental death benefit for certain serious accidental injuries

Regular benefits

Disability

Short-term Disability (STD) Canada Life policy # 56072	• Benefit payable equal to Employment Insurance (EI) maximum (2023 maximum amount is $650 per week) For current maximums, visit https://www.canada.ca/en/services/benefits/ei/ei-sickness/benefit-amount.html • Paid up to 27 weeks (a portion may be covered by EI) • Waiting period of seven days for illness (waiting period will be waived if approved for EI sickness benefit). No waiting period for hospitalization, accident or outpatient surgery. • Paid up to age 65 • Benefits are taxable
Long-term Disability (LTD) Canada Life policy # 330502	• 60% your gross employment income earned in the calendar year prior to disability, to a maximum of $3,000 per month • Limited to 85% of your pre-disability monthly earnings when combined with other sources of income • Paid up to age 65 (for members disabled after termination of employment, paid up to 24 months and terminates when you turn age 65) • Waiting period of 27 weeks of disability • Benefits are taxable

Diagnostic and treatment support services

Teladoc Medical Experts	Support for finding a local specialist, expert mental health guidance, and access to world-class specialists and resources, in the event of a serious medical condition for you and your dependents. Available to members' parents and parents-in-law without restriction.
Consult+Virtual Health Care Services	Consult+ lets you meet with health care professionals using a secure mobile app or website at a time that fits your schedule.

Regular benefits

Benefits at-a-glance – Disabled members

The table summarizes the Plan's Regular benefits for eligible Disabled members. See the Plan details section for more details on coverage, limitations and exclusions. Some of these benefits may be subject to separate Plan maximums and restrictions, as indicated in the Plan details section.

Health care* Canada Life policy # 56072	
Drugs and medicines (legally requiring a prescription)	• You pay the dispensing fee and 20% of the cost to an annual out-of-pocket maximum of $200 per family • The Plan pays 80% of the cost until you have reached the annual out-of-pocket maximum and 100% thereafter • Reimbursement is based on the cost of the lowest priced interchangeable (generic equivalent) drug • Fertility drugs, to a lifetime maximum of $2,500 per covered person • Erectile dysfunction drugs, to a maximum of $1,000 per benefit year per covered person • Vaccines and toxoids, to a maximum of $500 per benefit year per covered person • Smoking cessation products, to a lifetime maximum of $500 per covered person • Convenient pay-direct benefit card for drug and medicine expenses
Hospitalization (in your province of residence)	• There is no coverage under the Plan – provincial health plan coverage only
Paramedical practitioners	• 80% reimbursement, to a maximum of $500 per type of practitioner per benefit year per covered person • Care and services of licensed, registered or certified: acupuncturists, audiologists, chiropractors, naturopaths, osteopaths, physiotherapists/athletic therapists (combined), podiatrists/chiropodists, psychologists, massage therapists and speech therapists

Regular benefits

Vision care	• 100% reimbursement • Prescription glasses and contact lenses, to a maximum of $200 every 24 months per covered person (every 12 months for children) • Eye examinations, to a maximum of $100 once every 24 months per covered person (every 12 months for children) • Visual training or remedial exercises, to a maximum of $100 per benefit year per covered person
Hearing aids	• 100% reimbursement • Maximum of $700 every five benefit years per covered person
Medical supplies and equipment	• 80% reimbursement • Specified maximums per covered person
Orthotics and orthopedic shoes	• 80% reimbursement • One pair of custom-made orthotics, to a maximum of $150 every two benefit years per covered person (two pairs for children under age 19) • Custom-made shoes, one pair per benefit year per covered person • Must be recommended by a physician or podiatrist
Accidental dental treatment	• 80% reimbursement • Treatment must begin within 60 days after the accident (unless a medical condition delays treatment)
Ambulance services	• 100% reimbursement • Ambulance transportation to the nearest center where adequate treatment is available

* Expenses under the Health Plan are reimbursed based on Canada Life's assessment of reasonable and customary fees.

Regular benefits

Dental Plan
Canada Life policy # 56072

Dental fees are based on the current Dental Association Fee Guide for General Practitioners for the province in which the services are performed.

Basic and major services	• 80% reimbursement, to a combined maximum of $1,000 per benefit year per covered person – Recall exams, polishing and fluoride treatment, twice every benefit year (at least five months between recall exams) – Full-mouth x-rays and panorex x-rays, once every 36 months – Bitewing x-rays, four per benefit year – Fillings, oral surgery, extractions, basic restorations and periodontic treatment – Crowns, bridges and partial or complete dentures
Orthodontic services	• 80% reimbursement, to a lifetime maximum of $1,500 per covered person

Life and Accident Insurance

Life Canada Life policy # 330502	• For you: $25,000 • For your spouse: $1,500
Accidental Death & Dismemberment (AD&D) SSQ policy # 1FX80	• For you: $25,000 for accidental death • Percentage of accidental death benefit for certain serious accidental injuries

Diagnostic and treatment support services
Canada Life policy # 330502

Teladoc Medical Experts	Support for finding a local specialist, expert mental health guidance, and access to world-class specialists and resources, in the event of a serious medical condition for you and your dependents. Available to members' parents and parents-in-law without restriction.
Consult+Virtual Health Care Services	Consult+ lets you meet with health care professionals using a secure mobile app or website at a time that fits your schedule.

Regular benefits

Work/life events

Certain work and life events may trigger a change to your benefits or require you to take steps to update your coverage. See the list of work and life events below for details on how each may affect your benefits. If you have questions, please contact Mercer (the Plan Administrator) at 902-425-4526.

Change in family situation

When certain life events occur, you are eligible to modify your coverage to reflect the change in your family situation. Eligible life events include marriage and divorce, the birth or adoption of a child, and the death of a spouse or child.

Here are some of the actions you may have to take if you have a change in family situation:

- Update your personal information – change your address, emergency contact, or add or delete a dependent
- Change from single to family coverage or vice versa
- Update your dependent information
- Review and update your beneficiary designations

To report a change in family situation you must contact the Plan Administrator to ensure that your family is covered and that your beneficiary designations are up-to-date.

Change in employment status

Your eligibility to remain in the Plan, once you have satisfied the initial eligibility requirements, is conditional on maintaining your union membership and work hours. If your employment status changes, due to termination of employment/union membership or declining work hours (other than as a result of illness or injury – see the Disability section for more information), your eligibility in the Plan may be impacted. It is very important that you contact the Plan Administrator to understand the impact on your benefits.

Regular benefits

Disability

If you are on leave from work or experience reduced work hours as a result of disability, you may be eligible for disability benefits under the Plan. For more information about disability benefits, see the Disability section. You may also be eligible for deemed hours to maintain your eligibility in the Plan. You must contact the Plan Administrator, even if you are receiving workers' compensation benefits, to ensure that your benefit entitlements under the Plan are preserved.

Leave of absence (other than disability or maternity and parental leave)

If you are on leave from work for reasons other than disability or maternity and parental leave, your eligibility in the Plan may be impacted. It is very important that you contact the Plan Administrator to understand the impact on your benefits.

Maternity and parental leave

If you are on maternity leave, you may be eligible for benefits under the Maternity Leave Supplemental Unemployment Benefit (SUB) Plan. For more information, see the Maternity Leave Supplemental Unemployment Benefit (SUB) Plan section.

While on maternity or parental leave, you may be eligible for deemed hours to maintain your eligibility in the Plan. It is very important that you contact the Plan Administrator to ensure that your benefit entitlements are preserved.

Working past age 65

If you are a Working Plan member and continue to work beyond age 65, you maintain your coverage as long as you continue to satisfy the eligibility requirements. It is important to note that only pre-retirement work hours count towards eligibility and that there is an age 65 limit on STD and LTD coverage. If you are thinking about retiring or starting your pension, please contact the Plan Administrator to understand the impact on your benefits.

Regular benefits

Leaving the industry before retirement

Your eligibility to remain in the Plan, once you have satisfied the initial eligibility requirements, is conditional on maintaining your union membership and work hours. If your employment status changes because you leave the industry prior to retirement, your eligibility in the Plan will be impacted. It is very important that you contact the Plan Administrator to understand the impact on your benefits.

Retirement

The Plan provides coverage to members who retire while eligible as a Plan member. Your benefits during retirement vary depending on your retirement date and age. If you are thinking about retiring or starting your pension, please contact the Plan Administrator to understand the impact on your benefits.

If you are terminated with cause by your employer, you will not be eligible for retiree benefits.

LTD terminates if a retirement option is exercised. A plan member cannot draw LTD and ILA Pension Benefits at the same time.

Death

If you die while eligible for Regular benefits, the Plan will pay a life insurance benefit (and an AD&D benefit if the cause of death is accidental) to your designated beneficiary, and also provide benefits coverage to your eligible survivors. See the Survivor benefits section for more details. If your spouse dies while you are eligible for Regular benefits, the Plan will pay a life insurance benefit to you.

If you die while eligible for Retiree benefits, the Plan will pay a life insurance benefit to your designated beneficiary if you are eligible for coverage, and also provide benefits coverage to your eligible survivors. If your spouse dies while you are eligible for Retiree benefits, the Plan will pay a life insurance benefit to you if you are eligible for coverage.

It is important to regularly check you beneficiary designation on file with the Plan Administrator to make sure it is current.

Retiree benefits

Eligibility

If you retire while you are eligible for Regular benefits, you will remain in the Regular benefit plan for the remainder of that benefit year. If you are terminated with cause by your employer, you will not be eligible for retiree benefits.

In the following benefit year you will be eligible for Retiree benefits. Your eligibility for Retiree benefits is evaluated every April 1 and is based on your age on the last day of the prior benefit year, as described below, and in your first year of eligibility on your pre-retirement hours. Your coverage will commence on April 1 and be maintained for the remainder of the benefit year, which ends on March 31.

If you are considered eligible for coverage, the Plan also covers your eligible spouse and children. You must give the Plan Administrator information on your eligible spouse and/or children and any changes in your family situation. Otherwise, their claims could be refused. Your eligible dependents will only have coverage once you have actively enrolled them in the Plan.

If you have questions about which category of benefits you are currently eligible for, please contact Mercer (the Plan Administrator) at 902-425-4526.

Involuntary pensioner benefits

In the case of involuntary pension commencement, special rules apply. For this purpose, involuntary pension commencement refers to retirement benefit commencement or transfers from the Pension Plan which are required in accordance with the Canada Revenue Agency's maximum Pension Plan commencement age (the end of calendar year in which the member turns age 71).

You are eligible for Health and Dental Plan coverage if you continue to be a union member in good standing and you have accumulated at least 1,000* hours (work hours plus deemed hours) during the previous calendar year.

If you have any questions regarding your benefits please contact the Plan Administrator at 902-425-4526 (ILAM).

Transitional retiree benefits

You are eligible for Transitional retiree benefits if you accumulated at least 1,000* pre-retirement hours (work hours plus deemed hours) in the industry as an employee during the previous calendar year.

If you are eligible for Transitional retiree benefits, you will receive these benefits for one benefit year. Afterwards you will transfer to either Enhanced retiree benefits for early retirees under age 65 or Retiree benefits for retirees age 65 or over depending on your age.

*For April 1, 2022 benefit year, eligibility was based on 600 hours.

Retiree benefits

Early retirees (under age 65)

If you are an early retiree, you are eligible for Enhanced retiree benefits for a given benefit year if, on the last day of the prior benefit year, you are an early retiree **under age 65** and you meet **all** of the following conditions:

- You reside in Canada.
- You retired while you were eligible for Regular benefits.
- You were not terminated with cause by your employer.

You will transfer to Retiree benefits at the end of the benefit year in which you reach age 65, provided you meet the eligibility criteria for Retiree benefits (age 65 or over).

Retirees (age 65 or over)

If you are a retiree age 65 or over, you are eligible for Retiree benefits for a given benefit year if, on the last day of the prior benefit year, you are a **retiree age 65** or over and you meet **all** of the following conditions:

- You reside in Canada.
- You retired while you were eligible for Regular benefits.
- You were not terminated with cause by your employer.

Retiree benefits

Determining your benefits

The table below shows which category of Retiree benefits you are eligible for depending on your pre-retirement work hours and your age.

Pre-retirement hours worked Jan – Dec of prior year	Transitional retiree benefits	Early retiree benefits (under age 65)	Retiree benefits (age 65 or over)
1,000 or more*	Yes (one year only)	No	No
Less than 1,000*	No	Yes	Yes

Note: Coverage begins the day the Board of Trustees determines that you or your dependents have met the eligibility requirements. There are no entitlements under the Plan before the Board has made this determination.

* For April 1, 2022 benefit year, eligibility was based on 600 hours.

Who pays the costs

Your benefits under the Health, Welfare & Wellness Benefits Plan are 100% paid by the Trust on your behalf. You do not pay any premiums for your benefits coverage.

Retiree benefits

Benefits at-a-glance – Transitional retirees and early retirees (under age 65)

The table summarizes the Plan's Enhanced benefits for eligible transitional retirees and early retirees under age 65. See the Plan details section for more information on coverage, limitations and exclusions. Some of these benefits may be subject to separate Plan maximums and restrictions, as indicated in the Plan details section.

Health care*

Canada Life policy # 56072

Drugs and medicines (legally requiring a prescription)	• You pay the dispensing fee and 20% of the cost to an annual out-of-pocket maximum of $200 per family ($500 for Transitional retiree benefits) • The Plan pays 80% of the cost until you have reached the annual out-of-pocket maximum and 100% thereafter • Reimbursement is based on the cost of the lowest priced interchangeable (generic equivalent) drug • Fertility drugs, to a lifetime maximum of $2,500 per covered person • Erectile dysfunction drugs, to a maximum of $1,000 per benefit year per covered person • Vaccines and toxoids, to a maximum of $500 per benefit year per covered person • Smoking cessation products, to a lifetime maximum of $500 per covered person • Convenient pay-direct benefit card for drug and medicine expenses
Hospitalization (in your province of residence)	• There is no coverage under the Plan – provincial health plan coverage only
Paramedical practitioners	• 80% reimbursement, to a maximum of $500 per type of practitioner per benefit year per covered person • Care and services of licensed, registered or certified: acupuncturists, audiologists, chiropractors, naturopaths, osteopaths, physiotherapists/athletic therapists (combined), podiatrists/chiropodists, psychologists, massage therapists and speech therapists

Retiree benefits

Vision care	• 100% reimbursement • Prescription glasses and contact lenses, to a maximum of $200 every 24 months per covered person (every 12 months for children) • Eye examinations, to a maximum of $100 once every 24 months per covered person (every 12 months for children) • Visual training or remedial exercises, to a maximum of $100 per benefit year per covered person
Hearing aids	• 100% reimbursement • Maximum of $700 every five benefit years per covered person
Medical supplies and equipment	• 80% reimbursement • Specified maximums per covered person
Orthotics and orthopedic shoes	• 80% reimbursement • One pair of custom-made orthotics, to a maximum of $150 every two benefit years per covered person (two pairs for children under age 19) • Custom-made shoes, one pair per benefit year per covered person • Must be recommended by a physician or podiatrist
Accidental dental treatment	• 80% reimbursement • Treatment must begin within 60 days after the accident (unless a medical condition delays treatment)
Ambulance services	• 100% reimbursement • Ambulance transportation to the nearest center where adequate treatment is available

* Expenses under the Health Plan are reimbursed based on Canada Life's assessment of reasonable and customary fees.

Retiree benefits

Dental care

Canada Life policy # 56072

Dental fees are based on the current Dental Association Fee Guide for General Practitioners for the province in which the services are performed.

Basic and major services	• 80% reimbursement, to a combined maximum of $1,000 per benefit year per covered person – Recall exams, polishing and fluoride treatment, twice every benefit year (at least five months between recall exams) – Full-mouth x-rays and panorex x-rays, once every 36 months – Bitewing x-rays, four per benefit year – Fillings, oral surgery, extractions, basic restorations and periodontic treatment – Crowns, bridges and partial or complete dentures
Orthodontic services	• 80% reimbursement, to a lifetime maximum of $1,500 per covered person

Retiree benefits

Life and Accident Insurance

Life Canada Life policy # 330502

If you retired...	For you	For your spouse
On or after March 15, 1992	Under age 70*: $4,000	Under age 70*: $750
Between March 15, 1982 and March 14, 1992	Under age 70**: $8,000 Age 70** and over: $4,000	$750
Between March 15, 1980 and March 14, 1982	$6,000	$750
Between March 15, 1979 and March 14, 1980	$4,000	$500
Before March 15, 1979	$3,000	N/A

For Transitional retiree benefits only

Accidental Death & Dismemberment (AD&D) SSQ policy # 1FX80	For you: $25,000 for accidental death Percentage of accidental death benefit for certain serious accidental injuries

Diagnostic and treatment support services

Canada Life policy # 330502

Teladoc Medical Experts	Support for finding a local specialist, expert mental health guidance, and access to world-class specialists and resources, in the event of a serious medical condition for you and your dependents. Available to members' parents and parents-in-law without restriction.
Consult+Virtual Health Care Services	Consult+ lets you meet with health care professionals using a secure mobile app or website at a time that fits your schedule.

* Coverage ends as of the first day of the benefit year following your 70th birthday

** As of the first day of the benefit year following your 70th birthday

Retiree benefits

Benefits at-a-glance – Retirees (age 65 or over)

The table summarizes the Plan benefits for members eligible for retiree benefits (age 65 or over). See the Plan details section for more information on coverage, limitations and exclusions. Some of these benefits may be subject to separate Plan maximums and restrictions, as indicated in the Plan details section.

Health Spending Account (HSA)

Canada Life policy # 56072

How it works	You received an annual credit from the Trust deposited in an HSA managed by Canada Life. Your HSA allows you to pay certain health and dental expenses for you and your eligible dependents
What is an eligible expense	Expenses that can be paid by credits in your HSA for you and your dependents include, but are not limited to: • Pharmacare drug co-payments • Prescription glasses and contact lenses • Hearing aids • Disposable supplies and a blood glucose monitor for diabetes • Paramedical services • Oxygen • Hospital rooms • Nursing homes • Dental services • Your premiums for coverage under the Nova Scotia Seniors' Pharmacare For a complete list of eligible expenses, visit the Canada Revenue Agency website at: www.cra-arc.gc.ca
Funding	• $1,200 deposited in your HSA annually • You receive your annual allocation of HSA credits on April 1st of each year
Carry-over of leftover credits	• Unused credits within a given year cannot be carried over to the following year • If you do not use your annual balance, legislation stipulates that you lose it **Note:** Expenses incurred in one benefit year may be paid with credits received in the following benefit year

Retiree benefits

Life Insurance
Canada Life policy # 330502

Life	If you retired...	For you	For your spouse
	On or after March 15, 1992	Under age 70*: $4,000	Under age 70*: $750
	Between March 15, 1982 and March 14, 1992	Under age 70**: $8,000 Age 70** and over: $4,000	$750
	Between March 15, 1980 and March 14, 1982	$6,000	$750
	Between March 15, 1979 and March 14, 1980	$4,000	$500
	Before March 15, 1979	$3,000	N/A

Diagnostic and treatment support services
Canada Life policy # 330502

Teladoc Medical Experts	Support for finding a local specialist, expert mental health guidance, and access to world-class specialists and resources, in the event of a serious medical condition for you and your dependents. Available to members' parents and parents-in-law without restriction.
Consult+Virtual Health Care Services	Consult+ lets you meet with health care professionals using a secure mobile app or website at a time that fits your schedule.

* Coverage ends as of the first day of the benefit year following your 70th birthday

** As of the first day of the benefit year following your 70th birthday

Retiree benefits

Psst...

Did you know that you may also use the Plan to pay for the portion of health and dental care expenses not paid by any other plan?

The Canada Revenue Agency has a long list of eligible expenses that you can claim under the Plan if they are not paid by any other plan such as your spouse's plan, another private plan or a government plan. You may want to contact your local Canada Revenue Agency office for details.

Retiree life events

Certain life events may trigger a change to your benefits or require you to take steps to update your coverage. See the list of life events below for details on how each may affect your benefits. If you have questions, please contact Mercer (the Plan Administrator) at 902-425-4526.

Change in family situation

When certain life events occur, you are eligible to modify your coverage to reflect the change in your family situation. Eligible life events include marriage and divorce, the birth or adoption of a child, and the death of a spouse or child.

Here are some of the actions you may have to take if you have a change in family situation:

- Update your personal information – change your address or add or delete a dependent
- Change from single to family coverage or vice versa
- Update your dependent information
- Review and update your beneficiary designations

To report a change in family situation you must contact the Plan Administrator to ensure that your family is covered and that your beneficiary designations are up-to-date.

When you reach age 65

If you turn age 65 while eligible for Early retiree benefits, there is no immediate change to your benefits; however, on the first day of the next benefit year you will transfer to the Retiree benefits plan. Under the Retiree benefits plan (for retirees age 65 or over) you will receive a $1,200 Health Spending Account (HSA) for all eligible health and dental expenses for you and your eligible dependents combined.

Retiree benefits

Your HSA is designed to supplement coverage that may be available to you through individual or public programs, such as Nova Scotia Seniors' Pharmacare. You can even use your HSA to cover your Pharmacare premiums.

Members are encouraged to explore their health and dental coverage options and to make timely application to the provincial Pharmacare plan to avoid late application restrictions. If you require proof of your benefits coverage under the Plan, please contact the Plan Administrator.

When your spouse reaches age 65

Your spouse's benefits coverage is determined by your benefits eligibility and does not depend on your spouse's age. Once you become eligible for Retiree health benefits, you will receive a $1,200 credit in an HSA for all eligible health and dental expenses for you and your eligible dependents combined.

Death

If you die while eligible for Retiree life insurance benefits, the Plan will pay a life insurance benefit to your designated beneficiary, and also provide benefits coverage to your eligible survivors. See the Survivor Benefits section for more details. If your spouse dies while you are eligible for Retiree spousal life insurance benefits, the Plan will pay a life insurance benefit to you.

Survivor benefits

The Plan offers survivor benefits to protect your family in the event of your death. Coverage is provided to your eligible spouse for their lifetime and to dependent children for as long as they remain eligible.

Coverage

Below is a summary of the survivor benefits offered under the Plan. To confirm which coverage applies in your case, please call the Plan Administrator.

If you die while you are covered under the Plan, your spouse and children will be eligible for continued health and dental care coverage, as described below based on the category of benefits you were entitled to at the time of your death.

If you have questions about which category of benefits you are currently eligible for, please contact Mercer (the Plan Administrator) at 902-425-4526.

	If upon your death your survivors are entitled to...	
	Regular benefits or Enhanced retiree benefits	**Retiree benefits**
For the remainder of the benefit year during which you die	Your survivors continue to be eligible for Regular benefits or Enhanced retiree benefits, whichever you have upon your death, with the exception of the travel and life insurance benefits	Your survivors continue to be eligible for Retiree benefits, with the exception of the life insurance benefit
For up to five benefit years following your death	Your survivors are entitled to Regular benefits for a period (up to five years) equal to the number of benefit years during which you would have continued being eligible for Regular benefits or Enhanced retiree benefits had you not died, with the exception of the travel and life insurance benefits **For example:** If you were disabled (in the Regular benefits – Disabled category) or an early retiree (in the Enhanced retiree benefits category), you would have ceased being eligible under these benefit categories on the first day of the benefit year following your 65th birthday.	

Survivor benefits

	If upon your death your survivors are entitled to...	
	Regular benefits or Enhanced retiree benefits	**Retiree benefits**
Afterward	Your survivors are entitled to a spending limit of $1,200 per benefit year deposited into a Healthcare Spending Account. This fixed amount will help your survivors pay for a variety of eligible health and dental care expenses. The Plan also gives them the flexibility to decide how to spend this amount according to their needs. For more information, see the section Benefits at-a-glance – Retirees (age 65 or over).	Your survivors continue to be eligible for Retiree benefits, with the exception of the life insurance benefit

Note: Coverage begins the day the Board of Trustees determines that your dependents have met the eligibility requirements. There are no entitlements under the Plan before the Board has made this determination.

Survivor income beneficiaries

Survivors who reside in Canada and receive a Survivor Income Beneficiaries (SIB) annuity from the Trust are eligible for the following health and dental care coverage:

- If the recipients of the SIB benefit are under age 65 as of the first day of the benefit year: Regular benefits. See the section Benefits at-a-glance – Working members for more information.
- If the recipients of the SIB benefit are age 65 or over as of the first day of the benefit year: A $1,200 spending limit per benefit year deposited in a Healthcare Spending Account. See the section Benefits at-a-glance – Retirees (age 65 or over) for more information.

Survivor benefits

Who pays the costs

Your benefits under the Health, Welfare & Wellness Benefits Plan are 100% paid by the Trust on your behalf. You do not pay any premiums for your benefits coverage.

Life events

Certain life events may trigger a change to your benefits or require you to take steps to update your coverage. See the list of life events below for details on how each may affect your benefits. If you have questions, please contact Mercer (the Plan Administrator) at 902-425-4526.

Change in family situation

If your eligible survivors are enrolled in the Plan at the time of your death, their coverage is maintained. Your surviving spouse will continue their coverage even if they remarry.

Death

There are no life insurance benefits payable upon the death of a surviving spouse.

Plan details

This section of the booklet provides additional Plan details, including important information about your coverage, such as Plan limitations and exclusions. The benefits you and your dependents are eligible for depend on your category of benefits. Consult the table below for a list of the benefits applicable to you and your dependents; then read on for specific information about your coverage. See the Benefits at-a-glance section of this booklet for your group for the reimbursement level and allowable maximums per benefit.

Regular benefits		Retiree benefits			Survivor benefits
Working members	**Disabled members**	**Transitional retiree benefits**	**Enhanced (under age 65)**	**Retiree (age 65 or over)**	
• Health care • Dental care • Consult+ virtual Health Care • Travel • Teladoc Medical Experts • Life Insurance • AD&D Insurance • STD • LTD • Maternity Leave SUB	• Health care • Dental care • Consult+ virtual Health Care • Teladoc Medical Experts • Life Insurance • AD&D Insurance	• Health care • Dental care • Consult+ virtual Health Care • Teladoc Medical Experts • Life Insurance • AD&D Insurance	• Health care • Dental care • Consult+ virtual Health Care • Teladoc Medical Experts • Life Insurance	• Healthcare Spending Account of $1,200 • Consult+ virtual Health Care • Teladoc Medical Experts • Life Insurance (if applicable)	Depends on the category of benefits you were entitled to at the time of your death. See the Survivor benefits section to determine which coverage option is applicable

Plan details

Health care

Illness or injury can strike when you least expect it. When it does, you should be able to focus on getting better, not on how to pay your bills. That's why the Plan offers you and your family health care coverage. It is designed to complement the provincial plan and help pay major health expenses.

What's covered

Eligible expenses must be reasonable and customary, medically necessary and incurred while the individual was covered under the Plan. Payment will be based on reasonable and customary charges in the area in which the treatment is given as determined by Canada Life, who adjudicates benefits. Limits may apply to specific services and supplies, but the Plan has no reimbursement limit for all expenses overall. Please read What's not covered for a list of health care plan exclusions.

Psst...

Call first to avoid any unexpected out-of-pocket costs.

To claim an expense, it must be specifically listed as an eligible item AND not as a Plan exclusion in this section. Even then, the expense may not be fully reimbursed because of reasonable and customary limits. So, before you or a covered dependent incurs significant or unusual expenses, contact Canada Life at 1-800-957-9777.

Items currently paid by the Plan are listed below. However, should provincial health coverage later change to include any of these items, coverage under the Plan would change accordingly.

Plan details

Psst...

The Plan covers you and your dependents only while in Canada.

Medical expenses incurred outside Canada can be catastrophic. If you (or a family member) plan to travel outside the country, be sure to purchase a separate medical/travel insurance policy before leaving.

Note: If you are a working member, you have travel coverage under the plan. See the Travel section for more information.

Drugs

You receive a convenient drug card from the Plan. When you give this card to your pharmacist, you pay only your portion of eligible expenses upfront. You do not have to pay the Plan's portion and then ask Canada Life for your money back.

Psst...

SMART – Drug Review Process

To help us keep our plan affordable and sustainable for the future, Canada Life applies a review process for new high impact or speciality drugs entering the market. The high cost of some of these new drugs can put plans in serious financial hardship.

Under this process, Canada Life leverages internal, external and independent expertise to determine if a new drug should be added to their coverage list, and if approved, the appropriate claims management practice. This review process is known as SMART (Sustainable, Managed and Reasonable Treatment).

When new high impact or speciality drugs are added to the coverage list, they may also be subject to Prior Authorization. This practice ensures proper prescribing practices, taking into account factors including clinical effectiveness, safety, side effects and cost effectiveness. Prior Authorization also includes a determination of whether a drug is proportionate to a disease or injury, or the stage or progression of a disease or injury.

Plan details

Psst...

Did you know that drug costs can vary from one pharmacy to another?

Each pharmacist marks up the cost of drugs and adds a fee to fill your prescription. The markup and the dispensing fee can vary … so shop around for the best buy!

Eligible expenses include charges for drugs requiring a prescription by a doctor, surgeon or dentist, which bear a drug identification number (DIN), and are listed as prescription by drug schedules.

The eligible expense for a drug is limited to the cost of a lower-cost interchangeable drug, including but not limited to a generic equivalent of the brand name drug deemed to be interchangeable by law where the drug is dispensed or a subsequent entry biologic drug.

This limitation does not apply however, if there is a valid medical reason for not substituting your prescribed drug with the lowest-cost interchangeable drug. In this case, you and your doctor will need to complete and submit a *Request for Brand Name Drug Coverage* form before a brand name drug will be approved by Canada Life.

You can also use your drug card for certain supplies, provided they are prescribed and bear a DIN. Eligible supplies include:

- allergy kits; and
- disposable needles, syringes, test strips, insulin and swabs, lancets and chemical reagent testing materials used for monitoring diabetes.

Eligible supplies that do not bear a DIN are treated as major medical expenses, as described in the Major medical section.

Certain expenses are not eligible under the Plan, including:

- drugs or drug supplies that appear on an exclusion list maintained by Canada Life;
- oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition (TPN) solutions, except where a prescription is required by law; and
- drugs on the prior authorization listing maintained by Canada Life, unless otherwise approved by Canada Life for the treatment of the disease or injury on which the individual's claim is based (see the Prior authorization requirements section for more details).

For a complete list of ineligible expenses, see the What's not covered section.

If your physician or pharmacist has any questions about your drug coverage or how the drug card works, they can call Telus Health Solutions (formerly Emergis) at 1-800-668-1608.

Plan details

Drugs maximum restrictions

Some drugs are subject to certain maximum reimbursement levels. These include:

Erectile dysfunction drugs	$1,000 per person per benefit year (must be prescribed by a urologist, endocrinologist or psychiatrist) Please contact the Plan Administrator to obtain the proper form.
Fertility drugs	$2,500 per person per lifetime
Preventative immunization vaccines and toxoids	$500 per person per benefit year
Smoking-cessation products	$500 per person per lifetime Prescription required, even for eligible over-the-counter products such as nicotine gum and patches. Must be dispensed by a pharmacist. Only payable with your pay-direct drug card.

Prior authorization requirements

Prior authorization is required for certain medications so that Canada Life can review and approve a prescription before it is filled.

These medications are generally very costly, or potentially have serious complications or interactions if not taken properly. In addition, prior authorization is often required for medications that are prescribed for off-label uses, which occurs when a drug is prescribed for a use that has not been approved by Health Canada.

Prior authorization ensures proper prescribing practices. This results in better protection of the health of members and cost control.

If you or your doctor has questions about prior authorization, please contact Canada Life at 1-800-957-9777. Be sure to mention your policy number 56072.

Plan details

Health case management

If you or one of your dependents applies for prior authorization of certain supplies or services, 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.

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 dependents have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Plan details

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

Plan details

Major medical

The following items and services are covered as major medical expenses. We encourage you to get approval for any unusual or large expenses beforehand to make sure the Plan covers them.

Covered items

- The following (non-powered) prosthetic equipment is covered:
  - artificial eyes, including rebuilding and polishing of artificial eyes;
  - standard artificial limbs, including repairs, stump socks, and shoulder harnesses;
  - cleft palate obturators; and
  - external breast prosthesis (the initial prosthesis, plus a replacement every two benefit years), and surgical brassieres twice a year. If internal breast prostheses are provided, the Plan will provide alternative benefits based on coverage for external breast prostheses.
- Blood-glucose monitoring machines prescribed by a physician;
- Flash glucose monitoring machines prescribed by a physician;
- External insulin infusion pumps prescribed by a physician, one pump up to $5,000 every five benefit years;
- The following orthopedic equipment is covered, except if used for athletic purposes:
  - braces and cervical collars. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not covered;
  - casts;
  - splints, including shoes attached to a splint. Intra-oral splints are not covered;
  - external electrospinal stimulators for the correction of scoliosis;
  - non-union bone stimulators; and
  - prone standers.

Plan details

- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan;
- Frames and prosthetic lenses after cataract surgery (initial pair of frames and one lens for each eye prescribed after surgery);
- Ambulance transportation to the nearest centre where adequate treatment is available;
- Hearing aids, including repairs, tubing and ear molds provided at the time of purchase, when prescribed by a physician, to reimbursement level defined in the Benefits at-a-glance section for your group;
- Orthopedic shoes: one medically prescribed, custom-made pair every benefit year;
- Orthotics, to reimbursement level defined in the Benefits at-a-glance section for your group;
- The following breathing equipment is covered:
  - oxygen and the equipment needed for its administration;
  - intermittent positive pressure breathing machines;
  - continuous positive airway pressure machines;
  - apnea monitors for respiratory dysrhythmias;
  - mist tents and nebulizers;
  - chest percussors, drainage boards, and sputum stands;
  - suction pumps; and
  - tracheostoma tubes.
- Surgical stockings (including compression stockings), up to four pairs per benefit year;
- Wigs and hairpieces, to a lifetime maximum of $200 if necessary as a result of chemotherapy, or to a lifetime maximum

Plan details

of $250 if necessary as a result of total hair loss from Alopecia Totalis;

- The following mobility aids are covered up to a combined lifetime maximum of $5,000:
  - canes, walkers, crutches, and parapodiums;
  - mechanical or hydraulic patient lifters once every 5 years. The maximum amount payable is $2,000 for each lifter;
  - rechargeable batteries for covered wheelchairs;
  - outdoor wheelchair ramps once in a person's lifetime. The maximum amount payable is $2,000;
  - wheelchairs, including repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.

    If power-assisted patient lifters are provided, the Plan will provide alternative benefits based on coverage for mechanical or hydraulic patient lifters.

    If special wheelchairs are provided in circumstances where the condition does not warrant a special one, the Plan will provide alternative benefits based on coverage for the type of wheelchair required to permit independent participation in daily living.
- Transcutaneous nerve stimulators for the control of chronic pain. The maximum amount payable is $700 in a person's lifetime;
- Extremity pumps for lymphedema or severe postphlebitic syndrome, once in a person's lifetime. The maximum amount payable is $1,500; and

Plan details

- Incontinence supplies. The maximum amount payable is $1,000 every benefit year.

Covered services

- Paramedical practitioners (licensed, certified or registered), for a per practitioner maximum to reimbursement level defined in the Benefits at-a-glance section for your group for the following services:
  - acupuncturists;
  - audiologists;
  - chiropractors;
  - naturopaths;
  - osteopaths;
  - physiotherapists/athletic therapists (combined);
  - podiatrists/chiropodists;
  - psychologists;
  - registered massage therapists; and
  - speech therapists.
- Treatment of accidental injury to sound, natural teeth is covered when:
  - the accident occurs while the person is covered under this benefit; and
  - treatment starts within 60 days after the accident. This requirement is waived if a medical condition delays treatment beyond 60 days. If treatment is to be received more than 60 days after the accidental blow, you must submit a treatment plan to Canada Life within 60 days of the accident. For details on treatment plans, see the Psst note under Dental care coverage.

  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. Treatment resulting from accidental injury that does not qualify under this provision will be considered under the other dental coverage provisions on the same basis as treatment of dental defect or disease.

  The Plan will not pay for any part of this eligible expense that exceeds the amount recommended in the current Dental Association Fee Guide for General Practitioners in the person's province of residence.

Plan details

Hospital benefit

In your province of residence

- There is **no hospital coverage** provided under the Plan. Your provincial health plan provides hospital coverage.

Outside your province of residence (within Canada)

- The Plan covers the difference between the hospital's standard ward rate and your province of residence's government authorized inter-province allowance, to a lifetime maximum of $10,000.

Psst...

Although the Plan does not provide hospital coverage in your province of residence for semi-private or private accommodations, the provincial plan may cover the cost if preferred accommodations are required due to your medical condition.

Vision care

The Plan pays up to the reimbursement level defined in the Benefits at-a-glance section for your group for the following services:

- prescription glasses and contact lenses;
- eye exams; and
- services for visual training or remedial exercises.

Plan details

Psst...

Did you know that Medical Services Insurance (MSI) provides vision care?

It covers:

- the cost of a routine eye exam once every two years for children under age 10 and for persons age 65 or over; and
- the services of a specialist such as an ophthalmologist, if your doctor refers you to one because of a medical condition.

What's not covered

No health care benefits will be payable under this provision for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- any charges for services, treatment or supplies for which there would otherwise be no charge in the absence of coverage;
- any injury or illness for which a claimant is entitled to indemnity or compensation under any workers' compensation act;
- atomizers, appliances, first-aid kits or equipment, electronic diagnostic monitoring or testing equipment, non-disposable insulin delivery devices, delivery or extension devices for inhaled medications, spring-loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, supplies and accessories, or colostomy supplies;
- batteries for hearing aids;
- braces used for athletic purposes;
- charges of a doctor for time spent travelling, completing forms, missed appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication;
- cosmetic surgery or treatment;
- delivery and transportation charges;
- diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, intrauterine devices or appliances normally used for contraception;

Plan details

- any service or supply that Canada Life has determined is 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.
- drugs on the prior authorization listing maintained by Canada Life, unless otherwise approved by Canada Life for the treatment of the disease or injury on which the individual's claim is based (see the Prior authorization requirements section for more details);
- drugs, serums, injectables and supplies that are not approved by Health Canada or are experimental or limited in use, whether or not so approved;
- examinations required for the use of a third party;
- experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate specialty society;
- health claims incurred outside Canada;
- homeopathic preparations;
- injury resulting from insurrection, war, service in the armed forces of any country or participation in a riot;
- items deemed cosmetic, such as topical minoxidil or sunscreens (even if a prescription is legally required), whether or not prescribed for a medical reason;
- medication covered under a provincial drug benefit plan;

Plan details

- oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition (TPN) solutions, except where a prescription is required by law;
- prescriptions dispensed by a physician, clinic or dentist or in any non-accredited hospital pharmacy, or for treatment as an inpatient or outpatient in any hospital, including emergency status and investigational status drugs, unless otherwise approved by us;
- private-duty nursing;
- proprietary medicines that are registered under Division 10 of the *Food and Drug Act*, Canada and bear a General Public (GP) number on their label;
- supplies that are medically necessary for recreation or sports but not for a person's regular daily living activities;
- travel for health reasons;
- treatment of self-inflicted injuries or illness, whether sane or insane; and
- urinals, raised toilet seats, or standard toilets.

Plan details

Preferred providers

To help you save on out-of-pocket expenses, I.L.A./H.E.A. offers Plan members a preferred provider arrangement for prescription drugs and hearing aids.

Managed Health Care Services Inc. Supplementary Pharmacy Benefit Program

The Managed Health Care Services Inc. (MHCSI) Supplementary Pharmacy Benefit Program provides additional drug coverage of up to $3.00 per prescription when you shop at a participating MHCSI preferred provider pharmacy. Participating pharmacies include Lawtons Drugs, Sobeys Pharmacy, Sobeys Pharmacy by Mail, Foodland Pharmacy, Thrifty Foods Pharmacy, FreshCo. Pharmacy and Safeway Pharmacy.

You also have access to a wide range of pharmacy services and programs offered by the participating MHCSI preferred provider pharmacy network. These additional services and programs complement core prescription dispensing and counseling services to help you manage your medication and health care needs and those of your family.

In addition you will also enjoy discounts on front store purchases at Lawtons Drugs when you use the Lawtons Drugs Partner Discount Card.

For more information or to enrol in the MHCSI Supplementary Pharmacy Benefit Program, contact Mercer (the Plan Administrator) at 902-425-4526.

Plan details

Connect Hearing and EPIC Hearing Healthcare

Connect Hearing has partnered with EPIC Hearing Health to provide savings on hearing care and hearing aids for members of the Atlantic Canada Health Care Coalition Society (ACHCCS). Members can save up to 25% off the manufacturer suggested retail price and 10% off the retail price on name brands manufacturer hearing aids and related professional services.

To take advantage of these discounts, contact Connect Hearing and identify yourself as a member of the ACHCCS to schedule an appointment at one of 120 convenient locations throughout Canada.

A Connect Hearing Professional will evaluate your hearing health status and discuss best treatment solutions based on your unique hearing needs. They will work with you to program your hearing aid(s) to suit your lifestyle and preferences.

For more information visit www.connecthearing.ca or call Connect Hearing at 1-855-714-9491.

Plan details

Dental care

Here's a reason to smile… the Plan offers you and your family preventive dental care coverage. In addition, the Plan helps pay a significant portion of expenses for major services and orthodontics. See the Benefits at-a-glance section of this booklet for your group for the reimbursement level and allowable maximums per benefit.

What's covered

Eligible dental expenses are those that a dentist or doctor considers necessary. They cannot be greater than the amounts for general practitioners and specialists in the current dental fee guide of the province where the treatment is performed.

It is entirely up to you and your dentist to decide which treatment method to use – alternative or otherwise. However, reimbursement will be based on the least expensive treatment method that will provide a professionally adequate result.

This amount is determined by Canada Life, based on published fee guides of various associations and surveys of local practitioners.

Only the following listed treatments are eligible. Please read the What's not covered section for dental care exclusions.

We encourage you to get approval for unusual or large dental expenses beforehand to make sure the Plan covers them.

Plan details

Psst...

If treatment will cost over $500, ask your dentist for a treatment plan.

A treatment plan sets out the proposed treatment (including any x-rays), duration and related costs. Once completed, the treatment plan should be submitted to Canada Life, which will then determine how much the Dental Plan will cover. A treatment plan is not intended to limit you in your choice of dentist or treatment, to tell the dentist what fee to charge, or to guarantee reimbursement after coverage ends. It simply explains the cost implications of the proposed treatment before you start.

Basic dental services

Preventive

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays, fluoride treatment and fillings.

Examinations

Note: A total of four examinations are covered every benefit year.

- Initial or complete examinations: A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment.

  One complete examination is covered per dentist in a lifetime.

- Recall examinations: Include a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient.

  Two recall examinations are covered every benefit year. However, there must be a five-month period between recall examinations.

- Specific examinations: May include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion.

- Emergency examinations: Include checking for pain or infection and pulp vitality tests.

Plan details

X-rays

- Full-mouth series x-rays: A series of at least 16 films including bitewings. One series is covered every 36 months. The covered person must be age 12 or older.
- Panorex x-rays: One view of the entire mouth; covered once every 36 months.
- Periapical x-rays: x-rays of single teeth; 16 periapical x-rays are covered every 36 months.
- Bitewing x-rays: Used to detect decay in molar teeth; four bitewing x-rays are covered in a benefit year.
- Bite x-rays: x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact. Four bite x-rays are covered in a benefit year.

Tests

- Biopsy of oral tissue: A small piece of tissue is removed and sent to a laboratory to be tested for disease. There are no limits.
- Pulp vitality test: The pulp is the soft tissue inside a tooth. This test is performed to see if the pulp is healthy. One pulp vitality test per tooth is covered if the test is done more than 30 days prior to a root canal therapy.

Plan details

Cavity prevention

- Polishing or cleaning teeth: One unit (15 minutes) is covered each visit and up to two visits are covered every benefit year as part of the covered person's recall package. However, there must be a five-month period between visits.
- Recall scaling: One unit (15 minutes) is covered each visit and up to two visits are covered every benefit year as part of the recall package. However, there must be a five-month period between visits. (For periodontal scaling, please see the Treatment of gums section.)
- Fluoride: Two treatments are covered every benefit year. However, there must be a five-month period between treatments.
- Recall package: Includes a recall examination, polishing, scaling, and fluoride for children age 18 or younger. However, there must be a five-month period between each polishing, recall scaling procedure, fluoride treatment or recall examination.
- Oral hygiene instruction: Instruction on how to brush and floss. One instruction is covered in a lifetime.
- Pit and fissure sealants: A coating put on top of any pits or cracks in teeth to prevent cavities from forming. Only children age 18 or younger are covered for up to one for each molar every 36 months.

Space maintainers

- Space maintainers: An appliance that a dentist uses to maintain a space where a tooth has been removed. Only children age 14 or younger are covered for one space maintainer per space in a benefit year.
- Maintenance of space maintainers: Adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed. Only children age 14 or younger are covered.

Plan details

Fillings

Note: These procedures may include local anesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

All restoration done to the same tooth will be covered as a single visit to the dentist.

- Silver fillings: Covered only if 24 months have passed since the last restoration to the same tooth. If a bonded silver filling is installed, only the cost of a non-bonded silver filling will be covered.
- White fillings: Covered only if 24 months have passed since the last restoration to the same tooth.
- Retentive pins: Pins used to make sure that a restoration or filling stays in place. The covered person is covered for the cost of one set of retentive pins per tooth in 24 months.
- Sedative fillings for caries, trauma and pain control: Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anesthesia to reduce pain before a permanent filling is installed.

  Sedative fillings that are applied to reduce pain are covered. This procedure includes local anesthesia, removal of decay and/or removal of existing restoration, bite adjustment (treatment to make sure that the fit between the top and bottom teeth is correct), pulp cap (a sedative placed on an exposed nerve to reduce pain and prevent infection) and placement of a sedative filling (a sedative placed under a filling to reduce pain).
- Stainless steel, plastic and polycarbonate caps: A cap that is installed to cover the whole tooth or teeth. Only children age 14 or younger are covered for this treatment for up to one treatment per tooth every 36 months.

Plan details

Minor oral surgery

Note: These procedures may include local anesthesia, appropriate x-rays, surgery and follow-up care.

- Extractions: Removal of teeth, including an impacted tooth. There is no limit on the number of extractions per year or visit.
- Residual root removal: Removal of tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

Major oral surgery

Note: These procedures may include local anesthesia, appropriate X-rays, surgery and follow-up care.

Treatment for these procedures are unlimited as long as they are not for cosmetic purposes and are not part of any implant (supports for artificial teeth surgically placed in the jaw bone) or part of any orthognathic surgery, remodelling or repositioning of the lower jaw.

- Alveoloplasty, gingivoplasty, stomatoplasty, vestibuloplasty: Alveoloplasty means remodelling, removing or reducing bone. Gingivoplasty means remodelling gums. Stomatoplasty means remodelling the floor of the mouth. Vestibuloplasty involves ridge reconstruction.
- Surgical excision: Includes the removal of cysts or a foreign body.
- Surgical incision: Incision made to an infected area usually to allow drainage.
- Fractures: Treatment of fractures of the upper or lower alveolar bone, which holds the teeth in their sockets.
- Frenectomy: Surgery on the frenum (a thin tissue that connects the lips to the gums and the tongue to the floor of the mouth).
- Sialolithotomy: Partial removal of the salivary duct.

Plan details

- Antral surgery: Surgical removal of a tooth that has been forced up into a sinus cavity.
- Hemorrhage control: Treatment to stop bleeding resulting from an extraction or trauma.
- Postsurgical care: Treatment given by the dentist after surgery until healing is complete.
- Anesthesia: All necessary anesthesia during a dental procedure, including:
  - general anesthesia (total loss of consciousness);
  - deep sedation (where the covered person may be in and out of consciousness during a procedure);
  - intravenous sedation (the injection of a sedative into the blood stream); and
  - inhalation technique (sedation given using a mask).

Maintenance

Some of the procedures that are covered are treatment of gums, root canal therapy, periodontal scaling, bite adjustment, equilibration, appliance and appliance adjustments, and denture maintenance.

Treatment of roots

- Pulpotomy: Removal of dental pulp from the crown portion of the tooth. This procedure may include a treatment plan, anesthesia, the treatment, appropriate x-rays, and follow-up care, and must occur more than 30 days before a root canal therapy.

Plan details

- Root canal therapy: Includes:
  - treatment plan;
  - pulp vitality test;
  - pulpectomy (removing the diseased nerve from inside the tooth to reduce pain);
  - opening and drainage;
  - tooth isolation; and
  - clinical procedure with appropriate x-rays.

One root canal therapy is covered per tooth in a lifetime. Retreatment procedures are not covered.

If dental coverage ends during root canal therapy, coverage will be extended for 30 days to allow for completion of the root canal service. If the dental coverage is replaced by a policy with another insurer before the procedure is completed, the replacing insurer will be responsible for the cost of the entire procedure.

- Apexification: Closing the root of a tooth with hard tissue. This procedure may include a treatment plan, anesthesia, tooth isolation, the treatment with appropriate x-rays, placement of dentogenic media (material that causes a root tip to form in young teeth so that root canal therapy can be done) and follow-up care. The covered person is covered for one apexification procedure per tooth in a lifetime.
- Retrofilling: A filling done through the root end; covered once per tooth in a lifetime.
- Apicoectomy: Surgical removal of a root end after root canal therapy; covered once per tooth in a lifetime.
- Root amputation: Roots from a tooth may have to be removed because of infection. However, the crown and at least one root remains so that the tooth does not have to be removed. Covered once per tooth in a lifetime.
- Hemisection: Removal of a portion of the root(s) and the crown of a tooth, while the other root(s) are left in place; covered once per tooth in a lifetime.
- Intentional removal, apical filling and re-implantation: Intentional removal and implanting of a healthy tooth. For example, a third molar is removed and used to replace a missing first molar. The covered person is covered for one procedure per tooth in a lifetime.

Plan details

Treatment of gums

Note: These procedures may include local anesthesia, surgical dressing, sutures and follow-up care for one month. Post-treatment evaluation is not covered.

- Displacement dressing: Placing a medicated pack on inflamed gums to move gums away from the calculus (deposits on teeth that irritate gums).
- Desensitization: Applying fluoride to reduce sensitivity.
- Gingival curettage: Scraping out damaged tissue inside the gums.
- Gingivectomy: Removing damaged gum tissue.
- Flap surgery: Opening made for bone removal.
- Tissue graft: Transfer of healthy gums to an area where the gums have receded.
- Periodontal scaling and/or root planing (tartar removal): Scaling means removing calcium deposits on teeth. Root planing means the smoothing of rough tooth surfaces and removing any calcium deposits. Covered for up to eight units of scaling and/or root planing every benefit year.

Bite adjustment/equilibration

A procedure to correct the bite problem between the upper and lower teeth when they are in contact. Bite adjustments are covered for up to four units every benefit year.

Appliances and appliance adjustment

- Periodontal appliances: The cost of making the impression and inserting the appliance is covered. One appliance is covered per arch (upper or lower) every 24 months.
- Adjustment of periodontal appliances: Covered for up to four adjustments every benefit year.

Plan details

Denture maintenance

- Denture adjustments: Adjustments are covered and unlimited as long as they are made more than three months after the new dentures were first inserted.
- Denture repairs: Fixing broken or damaged dentures. The covered person is covered for unlimited denture repairs.
- Denture rebasing and relining: Rebasing dentures means fitting dentures with a new base. Relining dentures means adding material so that the dentures fit properly.
- One rebase or reline is covered every 36 months as long as the rebasing or relining is done more than three months after the dentures were first inserted.
- Tissue conditioning: Applying a conditioner to the alveolar ridge that ensures a proper denture fit; covered once every 36 months.

Major dental services

These are procedures used to treat major dental problems. Some of the procedures are dentures, posts and cores, crowns, bridgework, inlays, onlays and veneers.

Caps and tooth coverings

Note: These procedures may include treatment planning, bite records, local anesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary services, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

The cost of inlays, onlays, crowns, veneers and build-up/fillings are covered only if teeth are broken down and it has been more than 60 months since the last crown, inlay, onlay, veneer or build-up/filling was installed on that tooth.

Plan details

If coverage ends after a tooth has been prepared for a crown, inlay, onlay or veneer but before the procedure has been finished, coverage will be extended for 90 days to allow for completion of the procedure even if the dental coverage is replaced by a policy with another insurer.

- Inlay/onlay restorations: Metal or porcelain casts placed on the surface of the tooth.
- Crowns: A cap that covers the whole tooth. A porcelain crown installed on a molar is not covered.
- Laboratory-processed veneer applications: White facings put on a tooth's surface. Veneer applications for cosmetic purposes are not covered.
- Retentive pins in inlays, onlays and crowns: Pins used to make sure that the inlays, onlays or crowns stay in place.
- Build-up/fillings: Restoration of a tooth prior to capping for better adaptation of the cap; covered only if it has been more than 60 months since the last time this treatment was given for that tooth.

Dentures

Note: These procedures may include treatment planning, initial and final impressions, jaw relations records, try-in insertion, bite equilibration (work done to make sure that the fit between the top and bottom teeth is correct), and three month follow-up care.

If coverage ends after preparations have been made for a denture(s) but before the procedure has been finished, coverage will be extended for 90 days to allow for completion of the denture(s), even if the dental coverage is replaced by a policy with another insurer.

If the covered person is covered by this policy on the date that the denture is installed, the cost will continue to be covered even if this policy is replaced by another insurer.

Plan details

- Complete dentures: Dentures that replace either all of the top teeth or all of the bottom teeth. The covered person is covered only if:
  - it has been more than 36 months since the last complete dentures were inserted; or
  - it has been less than 36 months since the last complete dentures were inserted and the existing denture is no longer wearable. Must be approved by Canada Life.
- Transitional dentures: Temporary dentures used for healing purposes due to the extraction of one or more teeth. Permanent dentures must be inserted within 12 months of the date the temporary dentures were inserted.
- Acrylic dentures: Dentures with an acrylic denture base. Acrylic dentures are covered only if it has been more than 36 months since the last acrylic dentures were inserted.
- Partial dentures: Dentures that replace one or more top or bottom teeth. They may be acrylic (plastic), metal or chrome base that can have acrylic, wire or chrome clasps (which hold on to the teeth). Partial dentures are covered only if it has been more than 36 months since the last partial dentures were inserted or additional teeth have been extracted.

Bridges

Note: These procedures may include treatment planning, bite records, local anesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary coverage, splinting, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

- Pontics: An artificial tooth that replaces a missing tooth. Pontic replacement is covered only if it has been more than 36 months since the last pontic was installed in that space. A porcelain pontic installed on a molar is not covered.

Plan details

- Retainers/abutments: The tooth beside a missing tooth, which will be used to support the bridge. The preparation of the tooth is covered only if it has been more than 36 months since the last preparations were made to that tooth.
- Bridgework repairs: Fixing or repairing damaged bridgework.
- Posts in retainers/abutments: Posts and cores used for additional support to the retainer/abutment. Posts and cores are covered only if it has been more than 36 months since the last installation to that tooth.

Orthodontics

These are procedures used to correct crooked or misaligned teeth. This includes all necessary dental treatment to correct this problem, such as examinations, x-rays, models, photographs, reports and surgical exposure of teeth, appliances and adjustments.

A treatment plan prepared by the dentist must be submitted to Canada Life. Up to 30% of the cost will then be paid at the beginning of treatment, minus the diagnostic fee. The remaining payments will be calculated by dividing the rest of the cost by the number of months in the treatment plan. Payments will be made monthly or quarterly, depending on when the dentist bills Canada Life or when Canada Life receives the receipts. No advance payments will be made.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment will be included and covered as if it were an orthodontic service.

Plan details

What's not covered

No dental care benefits will be payable under this provision for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- any cause for which the claimant may apply for and receive indemnity or compensation under any workers' compensation act;
- intentionally self-inflicted injury;
- war, insurrection or hostilities of any kind, whether or not the claimant participated in such actions;
- participating in any riot or civil commotion;
- any group or policyholder-sponsored dental care or treatment;
- any dental care or treatment for which the claimant is not legally obliged to pay;
- any dental care or treatment that is principally for cosmetic purposes;
- any appointments not kept or for the completion of claim forms;
- any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction;
- any endodontic treatment commencing prior to the date on which the claimant became covered under this provision, except as required to be consistent with the terms of the applicable extension of coverage on replacement of this policy section;
- replacement of mislaid, lost or stolen appliances;

Plan details

- any crowns placed on teeth that are not functionally impaired by incisal or cuspal damage;
- any crowns, bridges or dentures for which tooth preparations were made prior to the date on which the claimant became covered under this provision, except as required to be consistent with the terms of the applicable extension of coverage on replacement of this policy section;
- any orthodontic expenses that were incurred prior to the date on which the claimant became covered under this provision;
- any charges incurred for other than metal only crowns or pontics, posterior to the second bicuspid tooth;
- any procedures, appliances, or restorations used to increase vertical dimension, or to repair or restore teeth damaged or worn due to attrition or vertical wear, or to restore occlusion;
- any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants;
- any dental charges not included in the current Dental Association Fee Guide for General Practitioners;
- any treatment related to orthognathic surgery (remodelling or reconstruction of the jaw); and
- experimental treatment or testing.

Plan details

Travel (for Regular benefits – Working members only)

Out-of-province/country emergency medical

The Plan offers emergency travel coverage, which provides financial support in the event of a medical emergency while traveling within or outside Canada, provided you are entitled to Regular benefits – Working members.

Emergency medical travel care is covered if it is required as a result of a medical emergency – i.e. a sudden, unexpected injury or an acute episode of disease – arising while the person is outside Canada for vacation, business, or education, provided that the person remains covered by the government health plan in their home province.

Coverage for trips outside Canada is limited to the first 60 days. You are also covered within Canada, if your trip takes you more than 500kms from home.

Your protection through your emergency travel plan supplements your provincial plan by covering the reasonable and customary costs of medically necessary services or supplies relating to the initial treatment of a medical emergency.

In addition, Travel Assistance provides benefits and services over and above the basics. Through Travel Assistance, you have access to multilingual assistance coordinators who can direct you to the nearest, most appropriate physicians and health care facilities, and help you with travel arrangements.

Plan details

Travel Assistance

Travel Assistance is provided through a worldwide communications network that operates 24 hours a day. The network assists in locating medical care and in obtaining Canada Life's prior approval of covered services. The network can also approve on-site hospital payment when required for admission, to a maximum of $1,000.

The following services are covered subject to Canada Life's prior approval:

- **Medical advisors** – Qualified licensed physicians, under agreement with the assistance company, provide consultative and advisory services as well as second opinions.
- **Courtesy assistance** – The assistance company can help you locate qualified legal advice, local interpreters and appropriate services for replacing lost passports.
- **Admission advance assistance** – The assistance company may make advance payment to the hospital when required for admission.
- **Medical evacuation** (if suitable local care is not available) – If the person is travelling within Canada, coverage is provided for transportation to the nearest hospital where treatment is available. If the person is travelling outside Canada, coverage is provided for transportation to:
  - the nearest hospital outside Canada where treatment is available; or
  - a hospital in Canada.

  When services are covered under this provision, they are not covered under other provisions of this policy.

Plan details

- **Family assistance** – Round trip economy class transportation and lodging for one family member joining a patient who will be hospitalized for more than seven days while travelling on their own. A person is considered to be on their own when no family member is with them.
- **Traveling companion** – Extra lodging costs for one travelling companion when the return trip for the patient and travelling companion is delayed because the patient is hospitalized. No benefits are payable for extra lodging costs for a travelling companion if family assistance benefits are claimed under the previous benefit for the same period of confinement.
- **Transportation reimbursement** – The cost of comparable return transportation home for a patient and one travelling companion if prearranged, prepaid return transportation is missed because the patient is hospitalized. Any amount for which other compensation is available is not covered. A rental vehicle is not considered prearranged, prepaid return transportation.
- **Transportation of remains** – In case of death, preparation of the person's body and its return transportation home.
- **Unaccompanied minor children** – Return transportation home for minor children who had travelled with the patient and who are left unaccompanied because of the patient's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary.
- **Vehicle return** – The cost of returning a patient's vehicle, whether private or rental, home or to the nearest appropriate vehicle rental agency when sickness or injury prevents the patient from driving. The maximum amount payable is $1,000. No benefits will be paid for vehicle return if transportation reimbursement benefits are claimed under the transportation reimbursement benefit for the same period of confinement.

Lodging limitation

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses as well as taxicab and car rental charges are included. Meal expenses are not covered. The maximum amount payable for lodging expenses is $1,500 per confinement.

Plan details

Refund of on-site hospital payments

Where on-site hospital payments exceed Canada Life's liability under this policy for that confinement, the patient must refund the excess to Canada Life. If the hospital confinement is not covered under this policy, Canada Life is entitled to a full refund of the amount advanced.

Special note

Neither the communications network nor Canada Life is responsible for:

- the availability, quantity, quality, or results of any medical treatment a person receives; or
- any unsuccessful attempts by a person to obtain medical services.

Psst...

Did you know that pre-existing medical conditions can affect your coverage under the travel plan?

If you have a pre-existing medical condition and you have an occurrence while you are travelling, your claim may not be paid if you had a pattern of symptoms within the last three months prior to travel.

Canada Life will review your medical history, including the treatments you received and the frequency in which you sought medical attention in Canada, to determine if there was a pattern of symptoms that would indicate that a medical occurrence could be expected while travelling.

If you have a pre-existing condition and are planning to travel outside of Canada, consider calling a Canada Life representative at 1-800-957-9777 to better understand the administration of claims. This will help you make an educated decision about your current health and whether an occurrence would be considered sudden and unexpected. You can also talk with your doctor. Keep in mind that the Canada Life representative is not in a position to determine if coverage would apply.

Remember: Travel coverage is subject to limitations, including pre-existing conditions. As a result, depending on your personal circumstance, you may need to purchase additional healthcare coverage for travel.

Plan details

Diagnostic and treatment support services

Teladoc Medical Experts services

Teladoc Medical Experts services are designed to allow you and your attending physician or specialists access to the expertise of world-class specialists, resources, information and clinical guidance.

If you or your dependents are diagnosed with a serious medical condition for which there is objective evidence, or if your physician or you or your dependent suspect you have this condition, you can access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a medical 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.

You can also use Teladoc Medical Experts for for help finding a local doctor. In addition, it offers Mental Health Navigator that provides expert support and guidance for mental health conditions.

Teladoc Medical Experts is available to you, your dependents, your parents, and your parents-in-law.

How it works

- You or your dependent can access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- You will be connected with a member advocate who will be dedicated to your case and will provide support through the process. The member advocate will take the necessary medical history and answer your questions. Any information provided is not shared with either your employer or the Plan Administrator of your Health Plan.
- Based on the information and questions, the member advocate determines the optimal level of service for you or your dependent.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet your health needs. They can also help identify individual community supports and resources available.

Plan details

If it is appropriate, the member advocate may arrange for an in-depth review of your 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 you and your physician. On average, this process takes six to eight weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If you decide to seek treatment by a different physician, the member advocate can help identify the specialist best qualified to meet your specific medical needs. Expenses incurred for travel and treatment are not covered by this service.
- If you decide to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also access hospital and physician discounts, arrange for forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.

Note: These services are not insured services. Neither the Plan nor Canada Life is responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

Consult+ virtual health care services

Consult+ lets you meet with health care professionals using a secure mobile app or website at a time that fits your schedule. You can download the app or access the website through My Canada Life at Work.

You can use Consult+ to:

- Talk to health care professionals
- Get prescriptions or refills sent to your pharmacy electronically
- Get referrals for lab work, when medically indicated
- Provide help for non urgent health conditions

Plan details

Life and accident insurance

A financial safety net is always necessary if you have loved ones who depend on you for financial security. The Plan helps provide that safety net in the event of your death or a serious injury. Financial protection is also offered in the event your spouse dies. Given the importance of financial protection in the event of death, we encourage you to speak with a financial expert to determine your life insurance needs and how much you may need to supplement your coverage under the Plan.

Life insurance

Benefits

Should you die from any cause, benefits payable to your designated beneficiary or your estate vary according to your category of benefits, as described in your Benefits at-a-glance.

Please note that life insurance coverage is available to active and disabled employees, eligible retirees, but not survivors. Your spouse is only eligible for coverage while you are covered under this policy. Spousal insurance is not payable if you die before your spouse.

Psst...

Coverage conversion option

If you are entitled to Regular benefits and your coverage ends under the group policy, you may convert it to an individual policy.

You may convert your basic life insurance (and your spouse's) to an individual policy. You will not have to provide proof of good health to maintain this coverage as long as you apply for conversion and pay the necessary premium within 31 days of the date coverage terminates.

If you are in good health, you may want to shop around before converting your group coverage. Depending on your situation, you may actually obtain a better rate with another insurer for individual coverage. Of course, you also will be required to provide proof of good health.

For more information on conversion, contact the Plan Administrator.

Plan details

Beneficiary designation

In the event of your death

You may designate a beneficiary or beneficiaries to receive life insurance benefits payable under the Plan in the event of your death.

If you designate more than one beneficiary, benefits will be equally divided among them unless you specify otherwise. If you do not have a beneficiary, benefits will be paid to your estate, in accordance with applicable laws.

If you designate your estate as your beneficiary, you should be sure to make a will to ensure benefits are paid according to your wishes.

Psst...

Is your beneficiary designation up to date?

Make sure to review your beneficiary designation periodically. If you wish to designate a new life insurance beneficiary, you must complete a beneficiary change form. Both you and a witness must sign the form. Afterward, please mail it back to the Plan Administrator.

In the absence of a designated beneficiary or if your beneficiary is deceased, your life insurance proceeds may be paid to your estate. Since this can result in negative tax consequences, we encourage you to consult an estate-planning advisor.

In the event of your spouse's death

You are automatically the beneficiary of spousal life insurance.

Plan details

Accidental death & dismemberment insurance

Benefits

Along with the life insurance protection, the Plan automatically provides you with an extra measure of protection against a number of losses.

Accidental death

Please refer to your Benefits at-a-glance for the amount payable in the event of your accidental death.

Accidental injury

The Plan also pays an amount equal to a percentage of the accidental death benefit in the event of an accidental injury, as follows:

For loss of:	Benefit payable:
Entire sight in one eye	66 2/3%
Speech	66 2/3%
Hearing in one ear	33 1/3%
All toes of one foot	25%
For loss or loss of use of:	
One arm or one leg	75%
One hand or one foot	66 2/3%
Thumb and index finger or at least four fingers of one hand	33 1/3%
For total paralysis of:	
Both upper and lower limbs (quadriplegia)	200%
Both lower limbs (paraplegia)	200%
Upper and lower limbs of one side of body (hemiplegia)	200%

Plan details

Keep in mind that:

- bodily injury must be caused by an accident, directly and independently of all other causes;
- the accident must occur while the insured person is covered under the Plan;
- the loss must occur within 365 days of the accident;
- the full amount payable for all losses resulting from one accident cannot exceed 100% of the accidental death benefit. However, in the event of total paralysis, the full amount cannot exceed 200% or, if death occurs within 90 days after the accident, 100%;
- if as a result of one accident you suffer a number of losses for one limb, payment will be made only for the loss providing the largest amount; and
- if an accident covered under this Plan unavoidably exposes you to the elements and you suffer a covered loss as a result, the Plan will pay benefits. If you have not been found within one year of the disappearance, sinking or wrecking of the conveyance you were in at the time of the accident, under circumstances covered by the Plan, you will be considered deceased.

Loss is defined as follows:

- hand or foot: complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- arm or leg: complete severance through or above the elbow or knee joint;
- thumb: complete severance of one entire phalanx of the thumb;
- finger: complete severance of two entire phalanges of the finger;
- toes: complete severance of one entire phalanx of the big toe and all phalanges of the other toes;

Plan details

- eye: irrecoverable loss of the entire sight;
- speech: complete and irrecoverable loss of the ability to utter intelligible sounds;
- hearing: complete and irrecoverable loss of hearing;
- quadriplegia, paraplegia and hemiplegia: complete and irreversible paralysis of the respective limbs; and
- loss of use: total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Other benefits

The Plan may also pay the following benefits:

In the event of ...	The Plan may provide benefits for ...
Your accidental injury	Family transportation, home/vehicle modifications, hospitalization, and rehabilitation
Your accidental death	Day-care, education, occupational training for your spouse, body identification and repatriation

The Plan may also pay additional benefits if you were wearing a seat belt at the time of the accident.

Certain conditions and limitations apply. For details, please contact the Plan Administrator at 902-425-4526.

Plan details

What's not covered

No accidental death and dismemberment benefits are payable for any loss, fatal or non-fatal, caused by or contributed to by:

- intentionally self-inflicted injury while sane or insane;
- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- riding as a passenger or otherwise in any vehicle or device for aerial navigation, except when:
  - riding as a passenger, and not as a pilot, operator or member of the crew in or on any aircraft having a current and valid certificate of airworthiness and piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft;
  - riding as a passenger, and not as a pilot, operator or member of the crew in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country; or
  - boarding or alighting from or being struck by any aircraft.

Notwithstanding these points, the Plan does not cover injury sustained while and in consequence of riding in or on any aircraft owned, operated or leased by or on behalf of the policyholder.

Plan details

Beneficiary designation

In the event of your death

You may designate a beneficiary or beneficiaries to receive life insurance benefits payable under the Plan in the event of your death. The person(s) you designate for your life insurance benefits will also be entitled to any accidental death and dismemberment insurance benefits payable in the event of your accidental death.

If you designate more than one beneficiary, benefits will be equally divided among them unless you specify otherwise. If you do not have a beneficiary, benefits will be paid to your estate, in accordance with applicable laws.

If you designate your estate as your beneficiary, you should be sure to make a will to ensure benefits are paid according to your wishes.

See the Survivor benefits section for information on additional benefits your survivors may be eligible to receive in the event of your death.

Psst...

Is your beneficiary designation up to date?

Make sure to review your beneficiary designation periodically. If you wish to designate a new life insurance beneficiary, contact the Plan Administrator.

If you do not designate a beneficiary or if your beneficiary has passed away, your estate will receive benefits payable in the event of your death. This can lead to increased taxes for your estate, so please consult a tax advisor.

In the event of your spouse's death

You are automatically the beneficiary of the spousal life insurance benefit.

Plan details

Disability insurance

The Board of Trustees sponsors two different disability benefit plans:

- Short-term disability (STD) benefits – up to 27 weeks; and
- Long-term disability (LTD) benefits – after 27 weeks, up to age 65 (age 60 if you became disabled between August 1, 2009 and March 31, 2012) for members disabled after termination of employment, paid up to 24 months and terminates when you turn age 65.

These two types of benefits involve different levels of coverage, application processes, definitions of disability, and eligibility for benefits. If you are approved for benefits, the amount of your benefit will be influenced by other sources of income, Employment Insurance, workers' compensation benefits, and the Canada or Quebec Pension Plan.

Before you read the details about each of the disability benefit plans, please take note of the following.

Purpose of the disability plans

Disability benefits operate on a very different basis than a pension. Disability is not an early retirement package. If a Plan member is able to work in some capacity, the goal of the disability plan is to return them to work.

This means that Plan members who are claiming disability benefits will be re-evaluated by the insurer during the short-term and long-term phase of their disability and must provide ongoing medical evidence to support their claim. Given the high cost of disability benefits to the Trust and the desire to preserve coverage for Plan members into the future, the Trustees support disability management initiatives by the insurance carrier.

Disability coverage is an important benefit should you become disabled. The level of benefits available compares very favourably with coverage available in comparable industries. But you also need to do your part through personal savings if you wish to maintain your standard of living during a disability. The Trustees encourage you to do some careful financial planning so that you can support your family in the event of a disability.

Plan details

Psst...

You should contact Trustees, the Plan Administrator or the insurer only for information on claims or eligibility. Also note that the insurer and the Plan Administrator serve members normally by telephone or by mail. They do not provide member service on a drop-in basis.

Process and forms

If you become sick, injured or disabled, it is very important that you contact the Plan Administrator as soon as possible to get information on your benefit entitlements and the application processes. Forms are available from the Plan Administrator.

Even if you are applying for workers' compensation benefits or think you will be off work only for a short time, it is very important that you contact the Plan Administrator to understand your rights and responsibilities. Failure to pursue your claim on a timely basis may delay or jeopardize your claim, and may ultimately result in your not being eligible for any benefits under the Halifax Port I.L.A./H.E.A. Health, Welfare & Wellness Benefits Plan.

Short-term disability

The Plan provides Short-term disability (STD) insurance to ensure you receive income during short periods of absence from work caused by illness or injury, provided you are entitled to Regular benefits.

If you become disabled, please contact the Plan Administrator as soon as possible.

What is considered a short-term disability?

If you become totally disabled, unable to work and are under the continuing care of a doctor, you may be eligible to receive weekly STD benefits. You are considered to be totally disabled if you are unable to work for your employer for wages or profit because you are sick or injured.

Plan details

When benefits begin

Benefits, as described in your Benefits at-a-glance, are payable from:

- the eighth day of disability due to illness;
- the first day of disability due to illness, but the member must submit proof of approved EI sickness claim;
- the first day of hospitalization or outpatient surgery.

Duration of STD benefits

STD benefits are payable for up to 27 weeks. The daily benefit is 1/7 of the weekly benefit. All benefits received are taxable.

STD benefits	EI* benefits
Week 1** (EI waiting period)	Weeks 2 – 27
• STD benefits payable equal to the EI maximum	• Payments from EI • STD Benefits are only payable if you are inelgible for EI Sickness Benefits

* EI or Employment Insurance provides benefits if you have worked a certain number of insurable hours. The required number of insurable hours varies according to where you live, the unemployment rate where you live, and your work history. Please contact EI for details.

** STD payments will be issued in week 1 for injury/hospitalization, and will also be issued for illness, but the member must submit proof of approved EI sickness claim.

Effective retroactive to the 2000 taxation year, all claimants who receive EI sickness benefits no longer have to repay those benefits.

Plan details

Psst...

Did you know you may receive benefits from other sources if you become injured by accident?

For certain severe injuries, you may be entitled to accidental death and dismemberment insurance benefits and any additional coverage you may have purchased. Also, in the event of a car accident, talk to your auto insurance company right away. You may be able to receive loss-of-income benefits from your insurer.

Integration with other sources of earnings

The Plan is integrated with the sources of earnings below to ensure that all eligible recipients receive an equitable level of benefits, regardless of whether or not they are entitled to benefits from those sources. As a result, benefits may be reduced or eliminated if you receive disability benefits or payments from:

- another employer;
- Employment Insurance (EI);
- any workers' compensation act or similar legislation with respect to the same disability;
- provincial automobile insurance plan; and
- earnings recovered through another individual or corporation (see Third-party liability section).

Plan details

Psst...

Even if you are applying for workers' compensation benefits or think you will be off work only for a short time, it is very important that you contact the Plan Administrator to understand your rights and responsibilities. Depending on your level of workers' compensation benefits and other factors, you may be eligible to receive LTD benefits in addition to workers' compensation benefits. More importantly, approval of your LTD claim will protect you for the future, even if workers' compensation benefits cease. **However, failure to pursue your LTD claim on a timely basis may delay or jeopardize your claim, and may ultimately make you ineligible for any benefits under the Plan.**

Applying for STD benefits

Application for STD benefits are separate from application for any other benefits. Please talk to your doctor about whether a fee will be charged to complete your application for benefits, as it is your responsibility should there be such a fee.

Third-party liability

If another party owes you income lost as a result of your disability, benefits are payable as specified under the Integration with other sources of earnings section. However, before payment begins, you must agree to reimburse the insurer by completing a *Reimbursement Agreement/Direction* form. The amount to be reimbursed will not exceed the amount of benefits paid.

Please refer to the agreement form available from Canada Life for full details on terms and the calculation of the reimbursement.

Recurring disabilities

If you become unable to work again within 30 days of your return to work as a result of an injury or an illness directly related to the first period of disability, your disability will be considered a continuance of the first disability.

In other words, you do not have to complete another waiting period to qualify, and benefits resume for up to 27 weeks (including the time already taken).

Plan details

When payments end

Benefits are payable until the earliest of the following:

- you recover;
- you reach the maximum 27-week benefit period;
- you refuse to undergo a physical examination or mental evaluation at the insurer's request;
- you refuse to provide the insurer with a completed Reimbursement Agreement/Direction form or fail to comply with the terms of this agreement;
- you reach age 65;
- you retire; and
- you die.

Psst...

What you need to know before using your vacation pay during a disability.

Vacation pay taken during your absence may delay or reduce EI benefits. If you become ill or injured, you should contact EI about the impact of vacation benefits on your EI benefit entitlements (including the impact of accrued vacation benefits that you have not yet received).

If you find that EI is delaying benefits because of vacation pay, please notify the Plan Administrator since you may be eligible for STD benefits during this time.

Plan details

What's not covered

No STD benefits will be payable under this provision with respect to your disability during any of the following periods:

- For any period that EI benefits are payable. If EI does not pay benefits during any part of the 27 week period, the Plan may pay benefits for such period.
- Any period beyond the maximum 27-week benefit period.
- Any period of disability during which you are not under the care of a physician or surgeon legally licensed to practice medicine.
- Any period during which you are not receiving appropriate treatment for such medical condition(s). Both the insurer and your treating physician must agree on the appropriateness of such treatment. If there is a difference in opinion, the insurer reserves the right to seek and accept an independent medical opinion from a physician who is specialized in the treatment of the medical condition(s).
- The period during which you are on maternity leave of absence. If you become disabled while on maternity leave of absence, the maternity leave of absence will be deemed to end on the day before the date on which you are scheduled to return to work.
- Any period while you are either permanently or temporarily outside of Canada and the United States unless approved in advance by the insurer. If you become disabled while you are outside of Canada and the United States, your disability will not be deemed to commence until the date on which you return to Canada or the United States.

In addition, no disability benefits will be payable under this provision for any disability that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- war, insurrection or hostilities of any kind, whether or not the employee was a participant in such actions; and
- participating in any riot or civil commotion.

Plan details

Long-term disability

The Plan also provides financial help should you remain disabled for longer periods than a short-term disability, provided you are entitled to Regular Benefits.

Please contact the Plan Administrator as soon as possible if you will be making an LTD claim or terminating benefits.

Benefits

You can find the monthly amount of LTD benefits payable in your Benefits at-a-glance.

If the period during which you are entitled to receive benefits under this provision is not a complete number of months, the amount of benefit payable for each day that is in excess of a complete number of months will be at the rate of 1/30th of the monthly benefit that is applicable to you.

The term "earnings" is defined as the annual gross earnings shown on the T-4 or T-4A Form(s) from participating employers in the Plan for the calendar year preceding your date of disability.

Duration of benefits

If you are eligible for LTD benefits, the benefits period is broken down as follows:

STD benefits	LTD benefits	LTD benefits
27 weeks	Next 12 months if unable to perform essential duties of your regular occupation	After 12 months if unable to perform the essential duties of any occupation for which you are qualified. Benefits payable until your 65th birthday, recovery or termination. If you were disabled after termination of employment, benefits will only be payable for an additional 12 months (for a total maximum LTD benefit period of 24 months)

Psst...

What happens if I retire? LTD terminates if a retirement option is exercised. A plan member cannot draw LTD and ILA Pension Benefits at the same time.

Plan details

Elimination period

LTD benefits begin after an elimination period of 27 weeks. By elimination period, we mean the continuous period of disability before you may receive benefit payments under this provision. It will not include any period of disability that is described in the Exceptions and limitations section.

What is considered a long-term disability?

First 12 months

You are totally disabled during the elimination period and the succeeding 12 months of a continuous period of disability when you are wholly and continuously disabled due to illness or bodily injury and, as a result, are not physically or mentally able to perform the essential duties of your regular occupation with any employer.

After 12 months

After 12 months, you are considered totally disabled provided you are wholly and continuously disabled due to illness or bodily injury and, as a result, are not physically or mentally fit to perform the essential duties of:

- your regular occupation; and
- any other occupation, jobs or work:
  - for which you are, or become, qualified by your education, training or experience, considered collectively or separately; and
  - for which the current monthly earnings are 75% or more of the current monthly industry earnings. Current monthly industry earnings are based on the average annual earnings for all insured members under the LTD plan in the prior calendar year.

Plan details

In assessing your disability status, no consideration will be given to the job availability of your regular or any other occupation.

Continuous period of disability includes all periods of disability that meet all of the following conditions:

- they commence while you are insured under this provision;
- they are due to the same or a related cause or causes;
- during the elimination period, they are not separated by a period of more than 30 days during which you were not disabled; and
- after the elimination period has been satisfied, they are not separated by a period of more than six consecutive months during which you were not disabled.

Psst...

Did you know that your doctor may charge you a fee to complete your application for disability benefits?

Please talk with your doctor about whether a fee will be charged to complete your application for benefits, as it is your responsibility should there be such a fee.

Plan details

Benefit integration

LTD benefits may be reduced by any amounts that you are entitled to receive from the following sources:

- Any workers' compensation act or similar legislation with respect to the same disability.
- Disability benefits payable under the Canada or Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan. This does not include benefits payable under such plans to another member of your family, due to your disability.
- Any income replacement benefits to which you are entitled to receive under any provincial motor vehicle accident insurance plan if the benefits payable under the employment insurance act are not taken into account when determining the amount of benefits payable under the provincial plan.
- Employment Insurance maternity/parental benefits.

LTD benefits are further reduced so that your total income from all sources does not exceed 85% of your pre-disability monthly earnings. This limit of 85% is indexed according to increases as determined in the collective agreement.

All sources include:

- any disability benefits that are payable to you under this provision;
- any disability benefits resulting from your disability that are payable to you under any workers' compensation act or similar legislation;
- any disability benefits that are payable to you under the Canada or Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan, and any benefits payable under such plans to another member of your family, due to your disability (for the purposes of this offset, the Canada or Quebec Pension Plan award is frozen at the level of the initial award except for changes (i) in the benefit formula of 10% or more, (ii) a change in dependent status, or (iii) an error in determining the benefit amount. Any change due to a cost-of-living increase will not be taken into account.);

Plan details

- any income-replacement benefits to which you are entitled to receive under any provincial motor vehicle accident insurance plan if the benefits payable under the employment insurance act are not taken into account when determining the amount of benefits payable under the provincial plan;
- any indemnity for loss of time that is payable to you under an insured or uninsured plan that covers you on a group basis, including a professional or other association type of plan;
- any continuation of salary from your employer, other than vacation pay or salary earned before the date of disability;
- any benefits that you are receiving under a retirement or pension plan of your employer;
- damages for loss of income recovered from a third party and arising out of the same circumstances that caused your disability;
- earnings or payments from any employer, including severance payments and self-employment earnings, but excluding vacation pay or salary earned before the date of disability; and
- Employment Insurance maternity/parental benefits.

Disability benefits payable under the Canada or Quebec Pension Plan or workers' compensation act will not be taken into account until actual determination of the award is made, provided an agreement to reimburse the insurer, signed by you, is furnished at the time of claim. Otherwise, any government award that has not been determined by the time this benefit is payable will be estimated and deducted from the monthly benefit. Adjustment to correct such payments under this policy will be made after the award has been determined.

If you receive a lump-sum settlement for any of the benefits described above, the disability benefit from the Plan will be reduced by the amount that the Plan calculates you would receive if the payments were being made on a monthly basis.

Plan details

When LTD benefits end

Your monthly LTD payments will cease on the earliest of the following events:

- the date you cease to be disabled as defined in this section;
- the date of your death;
- the date you reach age 65 (age 60 if you became disabled between August 1, 2009 and March 31, 2012), or after 24 months of benefit payments if the disability began after termination of employment;
- the earliest date on which you refuse to participate in a rehabilitation program offered by the insurer, or refuse a rehabilitation job for which you are reasonably suited, unless the disability prevents you from participating in such rehabilitation program or from performing the duties of such rehabilitation job; or
- the date on which you would cease to receive benefits under this LTD income benefit provision.

Third-party liability

If you have a cause of action against a third party for income lost as a result of your disability, the LTD benefit will be payable as specified. However, prior to the commencement of payments, you will be required to complete a *Reimbursement Agreement/Direction* form, agreeing to reimburse the insurer. The amount to be reimbursed will not exceed the amount of benefits paid by the insurer.

Full details concerning terms and calculation of reimbursement are as set out in the *Reimbursement Agreement/Direction* form, which reflect the insurance contract.

Plan details

Periods of disability

Disabilities during the elimination period

If, before completing the elimination period, you return to work and become disabled again, the previous continuous period of disability will be applied toward the elimination period, provided the disability is:

- due to the same or a related cause or causes; and
- not separated by a period of more than 30 days during which you were not disabled.

Admitted disabilities that recur while this policy is in force

Once LTD benefits have become payable under this Plan, the insurer will waive the elimination period if you become disabled again from the same or related causes, within six consecutive months of returning to work. All such recurrences will be considered a continuation of the same disability and the benefit that was payable to you for the previous period of disability will be reinstated.

You will have to submit a new STD claim and satisfy a new elimination period for LTD benefits if:

- the same disability recurs after you have been at work for six consecutive months; or
- you become disabled again due to unrelated causes and after a return to work of at least one day.

Admitted disabilities that recur after this policy is terminated

After the policy is terminated, the insurer will continue to be liable for admitted disabilities for which benefits have become payable and which recur within six consecutive months of your return to work.

Plan details

Admitted disabilities that recur after benefits received under a prior policy are terminated

If your disability recurs within six consecutive months of the termination of your benefits under a prior policy and your benefits were terminated for one of the reasons below, the provisions of the prior policy will govern all of your entitlements with respect to that disability.

The above applies to you only if your benefits were terminated for one of the following reasons:

- you reached the maximum age outlined in the prior policy;
- you accepted a settlement in satisfaction of your rights under the prior policy; or
- you ceased to meet the definition of disability under the prior policy.

To see if you are eligible for coverage following the termination of your benefits under a prior policy, please refer to the section Reinstatement of coverage.

Rehabilitation

LTD benefits are designed to be paid during periods when you are disabled and cannot work. Often, however, there will be a time when, although you are not yet fully recovered, you can work at some type of job and possibly earn an income.

Therefore, you will be encouraged to participate in a rehabilitation program developed by the insurer's rehabilitation counsellors in consultation with your physician, employer and rehab specialists. Rehabilitation program as used in this section means a training or work-related activity that can be expected to help you return to your regular occupation or other gainful employment.

We will pay reduced benefits under this policy while you are participating in a rehabilitation program provided the program has been approved in advance by the insurer, in writing. The elimination period may be satisfied while you are working in an approved rehabilitation program.

If you receive an income under the rehabilitation program, the amount of benefit payable to you under the other terms of this provision will be reduced according to the Return-to-work allowance section.

Plan details

We will stop making benefit payments to you at the earliest of the following dates:

- the earliest date on which you refuse to participate in a rehabilitation program offered by the insurer, or refuse a rehabilitation job for which you are reasonably suited, unless the disability prevents you from participating in such rehabilitation program or from performing the duties of such rehabilitation job;
- the date on which you cease to participate in the program or your 65th birthday, if earlier;
- the date on which you would otherwise cease to be disabled as defined under this LTD income benefit provision; and
- the date on which you would otherwise cease to receive benefits under this LTD income benefit provision.

We will pay expenses that you incur, other than usual employment expenses, for services and equipment associated with an approved rehabilitation program, provided the expenses have been approved in advance by the insurer, in writing.

Return-to-work allowance

If you are able to return to your regular occupation or any other occupation on a part-time basis under a pre-approved program or are participating in the rehabilitation program, you will continue to receive disability benefits until you are able to return to your regular or any other occupation on a full-time basis.

In no event will benefits be paid beyond the maximum benefit payment period.

Plan details

Your disability payment will be reduced under the return-to-work allowance as follows:

- During the first 12 months of your return to work, or participation in an approved Rehabilitation program, your total monthly income from this Plan, the sources described in the Benefit integration section, and the gross income you are receiving each month from your employment, cannot exceed 100% of your pre-disability monthly earnings.
- After you have returned to work or participated in an approved rehabilitation program for 12 months, your total monthly income from this Plan (using the formula below), the sources described in the Benefits integration section, and the gross income you are receiving each month from your employment, cannot exceed 100% of your pre-disability monthly earnings.

$$\frac{(A - B)}{A} \times C = \text{Total monthly return-to-work allowance}$$

A = Your pre-disability monthly earnings

B = Your monthly earnings received while disabled

C = Your benefit as figured above, but not including adjustments under any cost-of-living adjustment

Pre-existing condition

LTD benefits are not payable with respect to any disability that is directly or indirectly related to or results from injury, disease, illness, pregnancy, mental disorder or any other medical condition with respect to which you did any of the following within the 90-day period prior to the date on which you became insured under this provision:

- you visited or consulted a physician or paramedical practitioner; and
- you took tests or received treatment (including but not limited to taking pills, injections or other medication for any condition such as high blood pressure, diabetes, multiple sclerosis, etc.).

This pre-existing condition limitation will apply to any continuous period of disability that commences within one year of your becoming insured under this benefit provision.

Plan details

Exceptions and limitations

No amount of LTD benefit will be payable under this provision:

- For that part of a continuous period of disability that is prior to the later of the following dates:
  - the date on which you have completed the elimination period; and
  - the date on which initial proof that you are disabled is given to the insurer's head office. The proof must be given to the insurer within 90 days after you have completed the elimination period and must be satisfactory to the insurer.
- If during a continuous period of disability, replacement coverage has been obtained with another insurance company and there is legislation or industry guidelines that stipulate that the new insurer should assume liability for such payments.
- With respect to your disability during any of the following periods:
  - any period while you are not under the continuing care of a physician or surgeon legally licensed to practice medicine; and
  - any period while you are either permanently or temporarily outside of Canada and the United States unless approved in advance by the insurer. If you become disabled while you are outside of Canada and the United States, your disability will not be deemed to commence until the date on which you return to Canada or the United States.
- For any disability arising from any medical condition(s) unless you are receiving appropriate treatment for such medical condition(s). The insurer and your treating physician must agree upon the appropriateness of such treatment. If there is a difference in opinion, the insurer reserves the right to seek and accept an independent medical opinion from a physician who is specialized in the treatment of the medical condition(s).
- With respect to your disability if you refuse or fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitative program or substance abuse treatment program, considered beneficial to you as recommended by the insurer and your physician.

Plan details

- For any period that you are incarcerated in a jail, prison, mental institution, or other correctional facility, due to a criminal code offence.
- For any period that you refuse to participate in a rehabilitation program offered by the insurer, or to accept a rehabilitation job for which you are reasonably suited, unless the disability prevents you from participating in such rehabilitation program or from performing the duties of such rehabilitation job.
- For any period that you refuse an alternate job offered by the employer for which you are reasonably suited, unless the disability prevents you from performing the duties of the alternate job.
- For any disability that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:
  - intentionally self-inflicted injury;
  - war, insurrection or hostilities of any kind, whether or not you were a participant in such actions, or service in the armed forces of any country; and
  - participating in any riot or civil commotion.

Reinstatement of coverage

If your disability benefits are terminated under this policy, a prior policy or the I.L.A./H.E.A. Pension Plan, you must contact the Plan Administrator to discuss reinstatement of insurance coverage if you are returning to work.

Extension of coverage

If you have begun a continuous period of disability prior to the time your insurance under this policy would otherwise terminate, your disability income benefit will be continued in force under this provision as long as you are entitled to such benefit with respect to the continuous period of disability. The continuation will be subject to all of the conditions of this provision and in no event will your disability income benefit be continued beyond your 65th birthday.

Plan details

Maternity Leave Supplemental Unemployment Benefit

While you are on maternity leave, the Plan offers the following benefits under the Maternity Leave Supplemental Unemployment Benefit (SUB):

- During the one week Employment Insurance Maternity Leave Benefit waiting period, you are eligible to a flat amount of $721. For current maximum amounts, visit https://www.canada.ca/en/services/benefits/ei/ei-maternity-parental/benefit-amount.html
- Thereafter:
  - If you are medically unable to work and are not eligible for Employment Insurance Maternity Leave Benefit, you are eligible for a flat amount of $721 per week; or
  - If you are receiving Employment Insurance Maternity Leave Benefits, but the weekly benefits are less than $721, you are eligible for a top-up amount from the Maternity Leave SUB that will equal $721 when combined with your Employment Insurance Maternity Leave Benefits.

The maximum benefit period for the Maternity Leave SUB is 16 weeks.

Making claims

Health, dental and travel claims

Getting reimbursed is easy… When you have eligible expenses, just complete the appropriate claim form and submit it directly to the address that appears on the form. After you submit the claim, you should receive a cheque for the amount of your expense, up to the applicable limit.

Health care claim forms

The claim forms that you need to complete vary according to your category of coverage. If you have recently changed categories under the Plan, your old claims forms may no longer be valid. Use the chart below to confirm which claim form you should use.

Regular benefits*		Retiree benefits		Survivor benefits (depends on member's coverage at the time of their death)	
Working members	Disabled members	Transitional retiree benefits	Retiree (age 65 or over)	Working/Disabled or Enhanced (under age 65)	Retirees (age 65 or over)
Claim form for account 432 Policy # 56072		Claim form for account 432 Policy # 56072	Healthcare Spending Account plan claim forms Policy # 56072	Claim form for account 432 Policy # 56072	Healthcare Spending Account plan claim forms Policy # 56072

*Includes involuntary pensioners

If you require new forms or have any questions about which claim form you should be using, contact the Plan Administrator at 902-425-4526. You may also obtain forms at:

I.L.A. Local 269 Hiring Hall
5220 Morris Street
Halifax, N.S.

Making claims

Pay-direct drug card

For drug claims, you can use your pay-direct drug card to cover eligible drug expenses. When you have a prescription filled, present your card to the pharmacist and your claim will be processed on the spot. You will only have to pay the balance.

In addition, when you present your pay-direct drug card 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. The checks done include drug interaction, therapeutic duplication and duration of therapy, which allows the pharmacist to make adjustments prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may decide they cannot to dispense the prescribed drug and will speak with your about other options and their concerns.

Dental care claims

The Canadian Dental Association form, Medavie Blue Cross Dental form, and Canada Life Dental form are all acceptable for dental claims, but you must inform your dentist of:

- the policy number (56072);
- your work card number; and
- your carrier – Canada Life.

Health, dental and travel claims
– Coordination of benefits
Life and AD&D claims

Making claims

Travel claims

To submit a claim related to travel, contact Canada Life when you get home for copies of the applicable forms you need to submit a travel claim.

Complete the forms and submit them directly to Canada Life. Don't forget to include your original receipts. You will also need your policy number for submitting travel claims – 330502 and 56072.

Send your claims directly to:

Canada Life
Out-of-Country Claims Department
PO Box 6000
Winnipeg MB R3C 3A5

In most cases, Canada Life will pay your provincial health plan's share of the claim on the province's behalf. Canada Life will also reimburse you on the balance of expenses covered by your group healthcare plan.

Before you leave the country, Canada Life suggests that you review your provincial health plan to determine the extent of its coverage. Many provincial health plans have time limitations on the submission of claims. These time limits also apply to your Canada Life claims. If your provincial health plan refuses payment, you may be asked to reimburse Canada Life for any amount already paid on its behalf.

Reminder: Eligibility for travel coverage

Travel coverage is only available to members who are entitled to Regular benefits – Working members.

Health, dental and travel claims
– Coordination of benefits
Life and AD&D claims

Making claims

Psst...

Do you know who to call?

See the Who to contact section for details on who to contact if you have questions or for information on claims or eligibility.

Submitting a claim

Paper claims

When completing the paper form, be sure to indicate your union work card number for identification purposes. You must sign the form upon completion and return it to the address indicated on the form.

If you have any questions about completing the form, please contact Canada Life at 1-800-957-9777.

Online claims

Claims for expenses incurred in Canada, for paramedical services, vision care and dental services, may be submitted 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.

Claims must be submitted to Canada Life as soon as possible, but no later than six months for online claims and 15 months for paper claims after you incur the expense.

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

Making claims

Claims payment

You should receive a reimbursement cheque about two weeks after mailing your claim form. Cheques are issued in your name and will be mailed to your address. They cannot be picked up. If you have direct deposit set up with Canada Life, your reimbursement will be deposited into your bank account in about half the time or less.

Psst...

Some rules you need to know about a Healthcare Spending Account

If you are a retiree over age 65 or a survivor, it is important to note the following rules:

- You cannot transfer or carry forward unused balance in your Healthcare Spending Account from one year to the next; however, there is a 90-day grace period for claims submission. Claims received beyond the grace period are not eligible for payment from the prior year.
- If you do not incur expenses up to your annual maximum, the Canada Revenue Agency requires that the remaining balance be forfeited (unused balances will be used to cover administrative expenses). This is known as the “use it or lose it” rule.
- However, you may carry forward unclaimed receipts for one year. If you have submitted a receipt that was partially reimbursed in the prior Plan year, you can carry forward the non-reimbursed portion if you retain your *Explanation of Benefits* form that was attached to your claim cheque.

Health, dental and travel claims
– Coordination of benefits
Life and AD&D claims

Making claims

Coordination of benefits

Did you know that you could receive up to 100% of the cost of your claim? Here's how the coordination of benefits works.

Your benefits Plan coordinates benefit payments with those of other plans.

If you, your spouse or your children are covered under this Plan **and** another plan, you could claim up to 100% of expenses under both plans. So, it is important for you to advise the insurer if your dependents are covered under another plan.

To coordinate your claim:

1. you submit your individual claims to your benefits Plan;

2. your spouse submits his or her claims to his or her employer's plan; and

3. the spouse whose birthday comes first in the year submits the claims for all children to his or her plan first.

Any amount not paid by the first plan should then be submitted to the second plan for reimbursement. This simple procedure benefits everyone: it saves you money and helps ensure that the Plan does not pay for claims that should be paid by another plan.

For prescription drug claims where the I.L.A./H.E.A. Plan is the second payer, any amount that is not fully covered by the first payers plan (e.g. your spouse's plan), will only be reimbursed by Canada Life up to the reasonable and customary amount, instead of the amount submitted. If the expense exceeds the reasonable and customary amount, you'll be responsible for paying the difference.

Note: You must provide the insurer of your Plan with a copy of the reimbursement statement from the other plan and, if possible, copies of the receipts.

Health, dental and travel claims
– Coordination of benefits
Life and AD&D claims

Making claims

Life and AD&D claims

Life insurance claims

For a life insurance claim, contact the Plan Administrator or Canada Life directly. A completed claim form should be submitted as soon as reasonably possible.

AD&D claims

- Notice of claim: Written notice of an injury on which an AD&D claim may be based must be given to the insurer within 30 days after the date of the accident resulting in the injury. Provide notice to the insurer at its Head Office: SSQ Insurance Company Inc., 1200 Papineau Ave., 4th Floor, Montreal, Quebec, H2K 4R5. Failure to provide notice within 30 days will not invalidate the claim if it is shown that it was not reasonably possible to provide notice during that time and that the notice was given as soon as it was reasonably possible, provided it is within one year after the date of the accident.
- Claim forms: The insurer, upon receipt of a notice of claim, will provide the claimant with the applicable forms.
- Proof of loss: Written proof of loss must be given to the insurer within 90 days after the date of the accident resulting in the loss. Failure to provide proof within this time will not invalidate the claim if it is shown that it was not reasonably possible to provide the proof during that time and that the proof was given as soon as it was reasonably possible, provided it is within one year after the date of the accident.
- Physical examination and autopsy: The insurer will have the right and opportunity to examine you, at its own expense.
- Payment of claims: Benefits will be paid after the insurer received satisfactory proof of loss in accordance with the requirements of this Plan.

All benefits payable under this Plan are payable in Canadian currency.

Health, dental and travel claims
– Coordination of benefits
Life and AD&D claims

Who to contact?

For more information on the Plan, here's what you need to do:

For general information (or if you are not certain who to call) or to obtain forms, find out about disability or life insurance coverage, or make changes to personal information, call:	**Mercer** (the Plan Administrator) 902-425-4526 (ILAM)
To find out about coverage and claims concerning health, dental and travel as well as prescription drugs not purchased with the drug card, call:	**Canada Life** 1-800-957-9777 Be sure to mention your policy numbers: Health and dental questions – 56072 Travel questions – 330502 and 56072
To view your benefit details, claims history and more, go online:	Register at canadalife.com (simply click "Sign In" and select "Your benefits and savings through your employer") Be sure to enter your Canada Life policy number 56072
To find out more about accessing Teladoc Medical Experts for diagnostic and treatment support or Mental Health Navigator, call:	**Teladoc Medical Experts (formerly Best Doctors)** 1-877-419-BEST (2378) toll-free Be sure to mention your Canada Life policy number 330502
If your physician or pharmacist has any questions about your drug coverage or how the drug card works, ask them to call:	**Telus Health Solutions** (formerly Emergis) 1-800-668-1608 This number is **not** for members. It is only for physicians and pharmacists
If an AD&D claim, send a written notice of an injury to:	**SSQ Insurance Company Inc.** 1200 Papineau Ave., 4th Floor Montreal, Quebec H2K 4R5 Be sure to mention your SSQ policy number 1FX80
For quick, east access to virtual health care services via secure mobile app or website, visit:	**Consult+ Virtual Health Care** My Canada Life at Work

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Who to contact?

Tools and resources

Canada Life online services for Plan members

As a Canada Life member, you can register for My Canada Life at Work at www.canadalife.com. To access, simply click “Sign In” and select “Your benefits and savings through your employer”. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user-friendly environment 24 hours a day, seven days a week:

- your benefit details and claims history;
- personalized claim forms and cards;
- online claim submission for many of your health and dental claims; and
- extensive health and wellness content.

Who to contact?

GroupNet Text

Canada Life also offers GroupNet Text, where you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed Plan information, including:

- plan and member identification numbers;
- coverage details (details available depend on your Plan design);
- reimbursement amounts; and
- benefit maximums, balances and more.

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab. See the Who to Contact section for details on how to register.

To use GroupNet Text, text keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword. Compatibility of GroupNet Text may vary by mobile device or operating system.

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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.

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Who to contact?

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 your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Protecting Your Personal Information

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

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

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

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Who to contact?

Your employer has an agreement with Canada Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer'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 and 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 employer has entered into an agreement with Canada Life whereby the short term disability, health (excluding Travel Assistance) and dental benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the short term disability, health (excluding Travel Assistance) and dental benefits are:

- an unsecured financial obligation and are payable from your employer'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 employer from the requirements under the Financial Institutions Act (British Columbia).

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Glossary

The following defined terms appear throughout this booklet in blue.

Benefit year	The year that runs from April 1 of a given year to March 31 of the following year.
Children	Your natural or adopted children, grandchildren (provided you are their guardian), and foster children or stepchildren living with you, who reside in Canada and who: • are under age 21; or • are over age 21 but under age 26 on the first day of the benefit year and are full-time students and depend on you for support; or • are age 21 or over on the first day of the benefit year and are incapable of self-sustaining employment and completely depend on you for support and maintenance due to a mental or physical handicap.
Deemed hours	Work hours that are credited to you for health, welfare and wellness benefit purposes while you are receiving benefits from any of the following sources, provided you are a Plan member with regular benefits and not working during that time: • I.L.A./H.E.A. short-term disability benefits; • Employment Insurance sickness benefits; • Employment Insurance maternity or parental benefits; and • Workers' compensation total earnings replacement benefits with respect to the first 27 weeks of disability. You may be credited for 40 deemed hours for every full week that you receive benefits from the above sources for a maximum of 15 weeks per calendar year. Deemed hours will not be credited for partial weeks. Deemed hours are intended to help you maintain your eligibility when you are off work due to a short-term disability. However, in the case of an extended absence (27 weeks or more), **the only way to ensure that you maintain your eligibility under the Plan and protect your entitlement to future benefits over the long term is to be approved for long-term disability benefits**. It is solely your responsibility to pursue this claim and to do so on a timely basis, even if you are off on a work-related disability and/or drawing workers' compensation benefits.

(Continued...)

Glossary

Deemed hours (Continued)	Please note that you must already be a Plan member to be credited for deemed hours. **If you are eligible for deemed hours:** Let the Plan Administrator know if you are receiving Employment Insurance or workers' compensation benefits. **If you are pregnant and plan on taking a maternity leave of absence:** Let the Plan Administrator know when you plan on taking your leave of absence. You may be eligible to receive benefits from the Maternity Leave Supplemental Unemployment Benefit (SUB) plan. It is very important that you **contact the Plan Administrator as soon as possible** in these cases. Failure to do so may result in the **loss of benefits**.
Employee	Any person who is a member of a Local union and who is employed in the industry by an employer.
Employer	Employer members of the Halifax Employers Association, the union and the Trust.
Industry	The longshoring industry in the Port of Halifax, and longshoring work at Autoport and Shearwater.
Plan	Any plan adopted by the Board of Trustees of the Trust to provide health, welfare and wellness benefits, and any amendments to such plan.
Plan Administrator	Mercer – Administrator of the Plan on behalf of I.L.A./H.E.A. You can reach Mercer at 902-425-4526 (ILAM).
Retire or Retired	When a person meets any of the following conditions: • You are drawing early retirement, normal retirement (age 65) or postponed retirement benefits from the Halifax Port I.L.A./H.E.A Pension Plan but not disability retirement benefits. • You have transferred the value of your retirement benefits out of the Halifax Port I.L.A./H.E.A. Pension plan as an early retirement, normal retirement (age 65) or postponed retirement benefit option. • You have attained age 65 while receiving long-term disability benefits from the Plan or disability retirement benefits from the Halifax Port I.L.A./H.E.A. Pension Plan.

Glossary

Spouse	The person who is legally married to you through an ecclesiastical or civil ceremony and who resides in Canada. If no one is legally married to you through an ecclesiastical or civil ceremony, it is the person who cohabits with you in a conjugal relationship, which is recognized as such in the community in which you reside, for at least 12 months at the time a claim is incurred. You may contact the Plan Administrator to cover your divorced spouse for health and dental benefits alone, provided there is no other eligible spouse enrolled in the Plan. Otherwise, the Plan will not be required to provide coverage for a divorced spouse and will not be bound by the terms of a court order or legal agreement. Coverage for your divorced spouse will end on the earlier of: • when you enrol another spouse in the Plan; and • you instruct the Plan Administrator to remove the spouse's coverage from the Plan.
Trust	The Halifax Port I.L.A./H.E.A. Health, Welfare & Wellness Trust Fund.
Union and local union	Any or all of the International Longshoremen's Association, Locals 269, 1341, 1738 and 1825.
Work hours	Hours worked by an employee in his/her capacity as an employee of a participating employer.