Carrier 1

COMPANY 1

Division 1 - All Other Employees

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

BENEFIT DETAILS

Carrier 1™ is a leading Canadian life and health insurer. Carrier 1's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Carrier 1 Online

Visit our website at XXXXXXXXXX for:

- information and details on Carrier 1's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

My Carrier 1 at Work

As a Carrier 1 plan member, you can register for My Carrier 1 at Work™ at XXXXXXXX. Make sure to have your plan and ID numbers available when registering.

With My Carrier 1 at Work you can:

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

Carrier 1's Toll-Free Number

To contact a customer service representative at Carrier 1 for assistance with your medical and dental coverage, please call 1-800-XXX-XXXX

Customer complaints

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

- Toll-free:
  - Phone: 1-866-XXX-XXXX
  - Fax: 1-855-XXX-XXXX • Email: XXXXXX
- In writing:

The Carrier 1

For additional information on how you may submit a complaint, please visit XXXXXX.

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 123456 and 134567. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail to the extent permitted by law.

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

The Plan is underwritten by

and arranged by

This booklet was prepared on: March 14, 2022

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Carrier 1 as evidence of insurability, subject to certain limitations.

Legal Actions

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

Appeals

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

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Carrier 1 sends you a notice of the overpayment, or within a longer period if agreed to in writing by Carrier 1. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Carrier 1’s right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

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

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

Employer Role

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

Protecting Your Personal Information

At Carrier 1, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Carrier 1 or the offices of an organization authorized by Carrier 1. Carrier 1 may use service providers located within or outside Canada. We limit access to personal information in your file to Carrier 1 staff or persons authorized by Carrier 1 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
- Carrier 1's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

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

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

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Carrier 1'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 Carrier 1's Chief Compliance Officer or refer to XXXXXX.

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Benefit Summary

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

Employee Basic Life Insurance	$25,000, reducing by 50% at age 65
Dependent Basic Life Insurance	
Spouse	$5,000
Child	$2,500
Optional Life Insurance	Available in $10,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum
Employee Accidental Death, Dismemberment and Specific Loss (Principal Sum)	An amount equal to your Basic Life Insurance
Long Term Disability Income Benefits	
Waiting Period	120 days
Amount	66.7% of the first $2,500 of your monthly earnings plus 50% of the remainder to a

	maximum benefit of $3,500 or 85% of your pre-disability take-home pay, whichever is less

Healthcare

Covered expenses will not exceed customary charges

Deductibles

In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge
All Other Expenses	Nil

Reimbursement Levels

Chronic Care and Global Medical Assistance expenses	100%
In-Canada Prescription Drugs	80%
All Other Expenses	90%

Basic Expense Maximums

Home Nursing Care	$5,000 for a maximum of 12 months per condition
Chronic Care	$25 per day
In-Canada Prescription Drugs	Included
Hearing Aids	$500 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	$300 combined every 12 months
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months

Surgical Brassieres	2 every 12 months
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	1 in a lifetime to a maximum of $2,000
Blood-glucose Monitoring Machines	1 every 4 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	$4,000 each calendar year
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500
Custom-made Compression Hose	4 pairs each calendar year to a maximum of $250

Paramedical Expense Maximums

Chiropractors, Podiatrists, Naturopaths, Osteopaths, Psychologists/Social Workers/ Psychotherapists, Physiotherapists, Dieticians, Speech Therapists, Massage Therapists, and Acupuncturists	$500 per practitioner to a maximum of $1,000 combined each calendar year

Visioncare Expense Maximums

Eye Examinations - dependent children under age 22	1 every 12 months to a maximum of $50 every 12 months

- all others	1 every 24 months to a maximum of $50 every 24 months
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	80%
Accidental Dental Injury Coverage	100%
Plan Maximums	
Basic Treatment	$1,000 each calendar year
Accidental Dental Injury Treatment	Unlimited

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 6 months of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- You and your dependents will be covered as soon as you become eligible.

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose

spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Carrier 1, you and your dependents may be required to provide evidence of insurability acceptable to Carrier 1 to be covered for health benefits, and may be declined for or offered limited dental benefits.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- Temporary and seasonal employees, and part-time employees who work less than 24 hours per week may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the policy terminates, whichever is earliest.

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

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

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

Survivor Benefits

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

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

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

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

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

BENEFICIARY DESIGNATION

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

EMPLOYEE BASIC LIFE INSURANCE

On your death, Carrier 1 will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

- Your life insurance will not continue past the end of the day before the date you reach age 70.

- If you become disabled while insured, Carrier 1 may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

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

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

DEPENDENT BASIC LIFE INSURANCE

If one of your dependents dies, Carrier 1 will pay you the dependent life insurance benefit. Your employer will explain the claim requirements.

- Your dependent life insurance will not continue past the end of the day before the date you reach age 70.

- If you are disabled and the premiums for your employee life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.

- Your dependent life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not

actively at work because of disease or injury and your employee life insurance is continued, your dependent life insurance will be continued on the same basis.

- If your spouse's insurance terminates on or before their 65th birthday, your spouse may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

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

When you apply for optional life insurance, you must provide proof of insurability, and your application must be approved by Carrier 1. Carrier 1 may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Carrier 1 will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If your spouse dies you will be paid the amount for which your spouse was insured.

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

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

- Your optional life insurance will not continue past the end of the day before the date you reach age 65. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever comes first.

Limitation
No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Carrier 1 refunds the premiums that have been received.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Carrier 1 will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	**Amount Payable**
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at	

least 4 fingers of one hand 1/4 Principal Sum All toes of one foot 1/8 Principal Sum **Loss of Use**

Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

Your AD&D insurance will not continue past the end of the day before the date you reach age 70.

Surgical Reattachment

If you suffer the loss of a limb that is surgically reattached, Carrier 1 will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation

If you die as the result of an accident that is at least 150 kilometres away from your home, Carrier 1 will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation less any amounts paid under this plan's global medical assistance benefit.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Carrier 1 will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled:

- as a full-time student at a post-secondary institution at the time of the accident causing your death, or
- as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Carrier 1 will pay up to 5% of the Principal Sum, or $5,000, whichever is less, for each year of full-time post-secondary school enrolment. Carrier 1 will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

Limitations

No benefits will be paid for tuition expenses incurred before the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Carrier 1 will pay the actual expense incurred less any amount paid for the same expenses under this plan's global medical assistance benefit, up to $2,000, for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

Limitation

Meal expenses are not covered.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Carrier 1 will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Carrier 1 will pay up to 10% of the Principal Sum, or $10,000, whichever is less.

Limitations

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Carrier 1 will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident.
Carrier 1 will pay up to $10,000.

Limitations

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Carrier 1 will pay for alterations to your principal residence to make it wheelchair

accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Carrier 1 will pay the actual expense incurred less any amount paid for the same expenses under this plan's healthcare benefit, up to $10,000 for all home and vehicle modifications combined.

Limitations

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

General Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions

- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed

- Any form of illness or physical or mental infirmity
- Medical or surgical treatment, except surgical reattachment

- War, insurrection or voluntary participation in a riot

- Service in the armed forces of any country

- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

- To claim benefits for yourself, ask your employer for a claim form. Complete it and return it to your employer.

- If you die accidentally, your employer will explain the claim requirements to your beneficiary.

- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 65, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, **and**, except for any employment under an approved rehabilitation plan, you are **not** employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the Benefit Summary.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

- Loss of any license required for work will not be considered in assessing disability.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

- Because you pay the entire cost of LTD coverage, benefits are not taxable.

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

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan
- benefits under any Workers' Compensation Act or similar law
- employer sponsored short term disability or sick leave benefits
- loss of income benefits under an automobile insurance plan, to the extent permitted by law
- 50% of earnings received from an approved rehabilitation plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan
- benefits another member of your family is entitled to on the basis of your disability under the Canada Pension Plan or Quebec Pension Plan that are paid directly to you
- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability
- the wage loss portion of any criminal injury award

- disability benefits under a plan of insurance available through an association

- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

The balance of any earnings received from an approved rehabilitation plan is not used to further reduce your LTD benefit unless that balance, together with your income from this plan and the other income listed above, would exceed your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Vocational Rehabilitation

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Carrier 1. In considering whether to recommend or approve a rehabilitation plan, Carrier 1 will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination

Medical coordination is a program, recommended or approved by Carrier 1, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Carrier 1 will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

Survivor Benefit

If you die while LTD income benefits are being paid, Carrier 1 will pay 3 times your monthly LTD benefit to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Carrier 1's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your employer for details.

Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Canada Life.

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

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

- Any period after you fail to participate or cooperate in a required medical or vocational assessment.

- The scheduled duration of a leave of absence.

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

- Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Carrier 1 pre-authorized the absence prior to your departure.

- Any period of incarceration, confinement, or imprisonment by authority of law.

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

How to Make a Claim

- To submit claims online, go to XXXXXX

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

  You can get this form from your employer, or online from the Carrier 1 corporate website. To access the form online, go to XXXXXX

Please ensure that your claim is submitted to Carrier 1 as soon as possible, but no later than 3 months after proof of your claim has been requested.

HEALTHCARE

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

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

Covered Expenses

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

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

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

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

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

  Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable

- only as provided under the out-of-country emergency care provision.

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

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

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

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

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

  Unless medical evidence is provided to Carrier 1 that indicates why a drug is not to be substituted, Carrier 1 can limit the covered expense to the cost of the lowest priced interchangeable drug.

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

- Rental or, at Carrier 1's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

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

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

- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible

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

- Blood-glucose monitoring machines prescribed by a physician

- Flash glucose monitoring machines prescribed by a physician

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

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

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

- Out-of-hospital treatment of nutritional disorders by a registered dietician

Out-of-hospital treatment of movement disorders by a licensed physiotherapist

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- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital treatment by a registered psychologist, or a qualified psychotherapist or social worker
- Out-of-hospital treatment of speech impairments by a qualified speech therapist
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital services of a licensed naturopath

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Carrier 1's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Carrier 1's prior approval:

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

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

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

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

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

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

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

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

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

  Limitation

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

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

Limitation

Meal expenses are not covered.

Out-Of-Country Emergency Care

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

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

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

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

  Limitation

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

Other Services and Supplies

Carrier 1 can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Limitations

Carrier 1 can decline a claim for services or supplies that were purchased from a provider that is not approved by Carrier 1.

Carrier 1 can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

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

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

  In this limitation, government plan does not include a group plan for government employees

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- Services or supplies that do not represent reasonable treatment
  Services or supplies associated with:

  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility
  - contraception, other than contraceptive drugs and products containing a contraceptive drug

- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Carrier 1 to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Carrier 1 would have paid benefits for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid

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

Services or supplies that Carrier 1 has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, Carrier 1 may take any factor into consideration including, but not limited to, the following:

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

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

• Drugs or drug supplies that appear on an exclusion list maintained by Carrier 1. Carrier 1 may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. Carrier 1 may add or remove a drug or drug supply from an exclusion list at any time.

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

- Carrier 1 determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or

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  - Carrier 1 determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

  Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment

- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices

- Delivery or extension devices for inhaled medications

- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions

- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances

- Smoking cessation products

- Fertility drugs

- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada

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

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

- Non-injectable allergy extracts

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- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Preventative immunization vaccines and toxoids
- Drugs used to treat erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Carrier 1 maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to XXXXXX

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

If the use of a lower cost alternative service or supply represents reasonable treatment, Carrier 1 may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Carrier 1 may contact you to participate in health case management. Health case management is a program recommended or approved by Carrier 1 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, Carrier 1 may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for

objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Carrier 1 can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Carrier 1 has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Carrier 1 at its discretion. Expenses claimed under this provision must be pre-authorized by Carrier 1.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Carrier 1 has recommended or approved health case management, Carrier 1 can require that a service or supply be purchased from or administered by a provider designated by Carrier 1, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Carrier 1 to the cost of the service or supply had it been purchased from or administered by the provider designated by Carrier 1; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Carrier 1.

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, Carrier 1 can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Carrier 1 requires participation, Carrier 1 can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Out-of-country claims (including those for XXXXXXX expenses)** should be submitted to Carrier 1 as soon as possible after the expense is incurred. It is very important that you send your claims to the Carrier 1 Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access My Carrier 1 at Work to obtain a personalized claim form or obtain form (Statement of Claim Out-of-Country Expenses form) from your employer. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Carrier 1 Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Carrier 1 Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government’s share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or

for assistance in completing any of the forms, please contact Carrier 1's Out-of-Country Claims Department at 1-800-XXX-XXXX.

- **You may submit all Healthcare claims online**. To use this online service you will need to be registered for My Carrier 1 at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Carrier 1 as soon as possible, but no later than 12 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Carrier 1 as a record of the transaction, and you must submit it to Carrier 1 on request.

- **We also accept paper claims for all Healthcare expenses.** Access My Carrier 1 at Work to obtain a personalized claim form or obtain form from your employer. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Carrier 1 Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

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

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

VIRTUAL HEALTH SERVICES

Virtual health services are available to you and your dependents by downloading the service provider's application specified by Carrier 1 from time to time. These services include the following:

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

DENTALCARE

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

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

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

Treatment Plan

- Before incurring any large dental expenses, ask your dental service provider to complete a treatment plan and submit it to Carrier 1. Carrier 1 will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
    - one complete oral examination every 36 months

- limited oral examinations once every 9 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed

- limited periodontal examinations once every 9 months

- complete series of x-rays every 36 months

- intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

• Preventive services including:

- polishing and topical application of fluoride each once every 9 months

- scaling, limited to a maximum combined with periodontal root planing of 6 time units every 12 months

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

- pit and fissure sealants on bicuspids and permanent molars every 60 months

- space maintainers including appliances for the control of harmful habits

- finishing restorations

- interproximal disking

- recontouring of teeth

• Minor restorative services including:

- caries, trauma, and pain control

- amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan

- retentive pins and prefabricated posts for fillings

- prefabricated crowns for primary teeth

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months

- Periodontal services including:

  - root planing, limited to a maximum combined with preventive scaling of 6 time units every 12 months

  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

- Denture maintenance, including:

  - denture relines for dentures at least 6 months old, once every 36 months

  - denture rebases for dentures at least 2 years old, once every 36 months

  - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months

- Oral surgery

- Adjunctive services

Accidental Dental Injury Coverage

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

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

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions
- Hypnosis or acupuncture
- Crowns (other than prefabricated crowns), bridgework, dentures or repairs to bridgework or dentures
- Orthodontic treatment

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

- Expenses private plans are not permitted to cover by law

- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

- Congenital defects or developmental malformations in people 19 years of age or over

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access My Carrier 1 at Work to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Carrier 1 at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Carrier 1 as soon as possible, but no later than 12 months after the dental treatment.

You must retain your receipt for 12 months from the date you submit your claim to Carrier 1 as a record of the transaction, and you must submit it to Carrier 1 on request.

- **For all other Dentalcare claims**, access My Carrier 1 at Work to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Carrier 1 Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

COORDINATION OF BENEFITS

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

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

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

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

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (Teladoc Medical Experts)

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

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

How it works

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

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

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

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

- If it is appropriate, the member advocate may arrange for an indepth review of the person’s medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written

report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes several weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

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

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

Limitations

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

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

These services are not insured services. Carrier 1 is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.