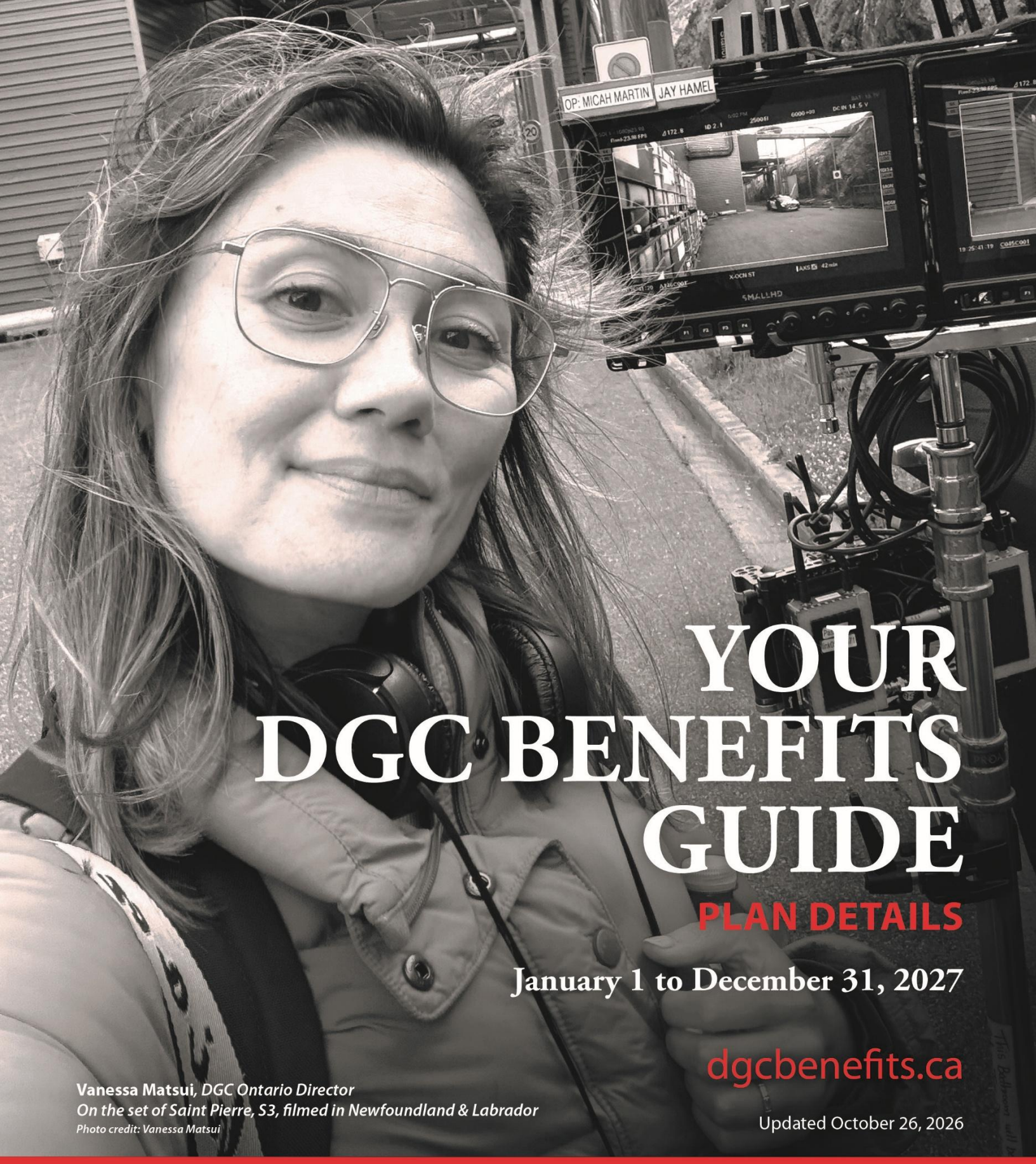


YOUR DGC BENEFITS GUIDE

PLAN DETAILS

January 1 to December 31, 2027

dgcbenefits.ca

Vanessa Matsui, *DGC Ontario Director*
On the set of Saint Pierre, S3, filmed in Newfoundland & Labrador
Photo credit: Vanessa Matsui

Updated October 26, 2026

DGC BENEFITS

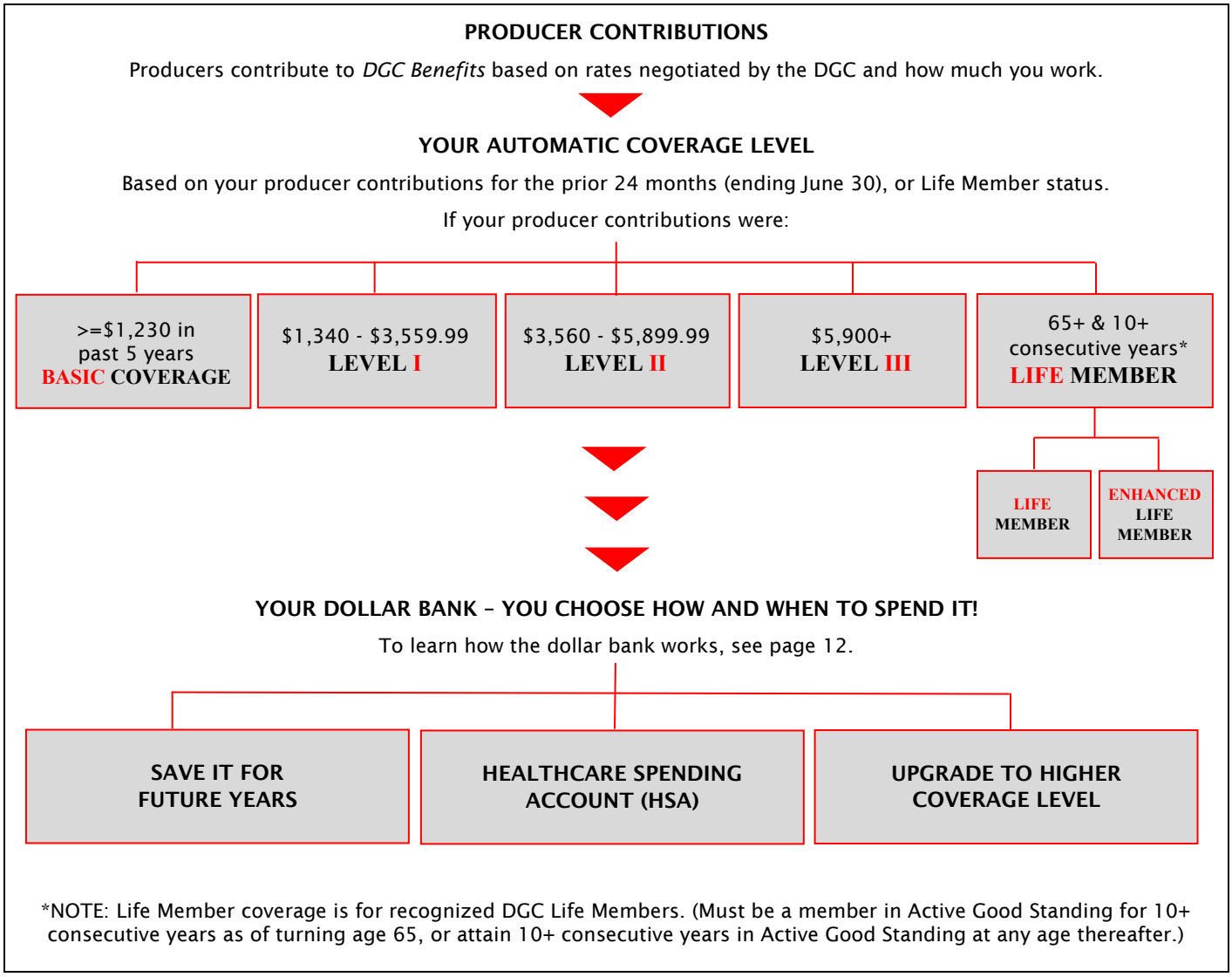
Contents

How DGC Benefits works 3
Coverage at a glance 4
DGC Benefits basics 8
Dollar bank 12
Healthcare spending account (HSA) 14
Health 17
Dental 24
Emergency out-of-province/country medical care 30
Short-term disability 33
Life insurance 39
Accidental Death & Dismemberment (AD&D) 41
Critical Illness insurance 44
Teladoc Medical Experts 52
Consult+ Virtual Healthcare 53
Member & Family Assistance Program (MAP) – and more 55
Making claims 59
For more information 64
Roles and responsibilities 65
The final word 66

PLEASE NOTE: This booklet is intended to provide a reasonable and easy-to-understand summary of *DGC Benefits*, the benefits program provided by the DGC's Health & Welfare Trust. This booklet does not confer any contractual rights or obligations. The full provisions of the individual plans are contained in the official plan contracts and policy documents. If there any discrepancies between those official contracts and this guide, the terms of the contracts will apply in all cases.

How DGC Benefits works

Here's a snapshot of how your plan works.



*NOTE: Life Member coverage is for recognized DGC Life Members. (Must be a member in Active Good Standing for 10+ consecutive years as of turning age 65, or attain 10+ consecutive years in Active Good Standing at any age thereafter.)

Coverage at a glance

The following tables provide a summary of coverage only. Please see the appropriate section in the guide for more complete details.

	BASIC COVERAGE	LEVEL I	LEVEL II	LEVEL III	LIFE MEMBER	ENHANCED LIFE MEMBER
Life insurance	**Member only:** $10,000	**Member only:** $50,000 Reduces to $20,000 at age 80	**Member:** $75,000 Reduces to $20,000 at age 80 **Spouse:** $10,000 **Child:** $5,000	**Member:** $125,000 Reduces to $20,000 at age 80 **Spouse:** $20,000 **Child:** $10,000	**Member only:** $50,000 Reduces to $20,000 at age 80	**Member only:** $50,000 Reduces to $20,000 at age 80
Critical illness insurance	N/A	N/A	**Member:** $25,000 **Spouse:** $5,000 **Child:** $2,500 Coverage ends at age 70	**Member:** $50,000 **Spouse:** $10,000 **Child:** $5,000 Coverage ends at age 70	N/A	N/A
Short-term disability Short-term disability is based on automatic coverage level and not available through upgrade purchase.	N/A	N/A	**Member only:** Up to 26 weeks at $320/week; Coverage ends at age 75	**Member only:** Up to 26 weeks at *up to* $1,400/week; Coverage ends at age 75	N/A	N/A
Accident insurance (AD&D)	**Member only:** $10,000	**Member only:** $50,000 max. Reduces to $20,000 at age 80	**Member only:** $75,000 max. Reduces to $20,000 at age 80	**Member only:** $125,000 max. Reduces to $20,000 at age 80	**Member only:** $50,000 Reduces to $20,000 at age 80	**Member only:** $50,000 Reduces to $20,000 at age 80
Emergency out-of-country medical	N/A	N/A	90-day trip limit	90-day trip limit	90-day trip limit	90-day trip limit
			100%; up to $5 million per person per lifetime, (up to $1 million if age 70-79); Coverage ends at age 80		Same as Levels II, III ←	Same as Levels II, III ←
Teladoc Medical Experts	N/A	Yes	Yes	Yes	Yes	Yes
Consult+ Virtual Healthcare	N/A	Yes – Includes unlimited 24/7 secure online access to Canadian healthcare professionals on demand, for diagnoses and advice, prescriptions (new/refills), lab/imaging orders, specialist referral.				
Member & Family Assistance Plan	Yes – Includes counselling and referral services for member and family, plus up to $10,000 of in/out-patient drug and/or alcohol addiction treatment for members only (lifetime max).					

*If you are a Life Member living outside of Canada (i.e., you are an International Life Member), you are covered for life insurance only. You are not eligible for critical illness insurance, short-term disability, AD&D insurance, emergency out-of-country medical, Teladoc, Consult+ or Member & Family Assistance Plan coverage.

	BASIC COVERAGE	LEVEL I	LEVEL II	LEVEL III	LIFE MEMBER	ENHANCED LIFE MEMBER
DENTAL						
Who's covered	**N/A**	**Member**	**Member & family**	**Member & family**	**N/A**	**Member & family**
Annual combined maximum	N/A	N/A	$1,500/ person/year all dental combined	N/A	N/A	$1,500/person/year all dental combined
Basic dental	N/A	100% of one check-up per calendar year Details on page 25	70%	90%; maximum $2,500/person/year when combined with perio/endo	N/A	70%
Major restorative	N/A	N/A	50%	50%; maximum $2,500/person/year	N/A	50%
Periodontics and Endodontics	N/A	N/A	70%	90%; maximum $2,500/person/year when combined with basic dental	N/A	70%
Orthodontia	N/A	N/A	N/A	50%; lifetime maximum $2,500/person	N/A	N/A

	BASIC COVERAGE	LEVEL I	LEVEL II	LEVEL III	LIFE MEMBER	ENHANCED LIFE MEMBER
HEALTH						
Who's covered	**N/A**	**Member**	**Member & family**	**Member & family**	**Member & family**	**Member & family**
Reimbursement (unless otherwise stated below)	N/A	70% $250,000 maximum/year	75% $250,000 maximum per person/year	90% $250,000 maximum per person/year	100% $100,000 maximum per person/year	75% $100,000 maximum per person/year
Prescription drugs (drug card supplied) Different rules apply for Quebec residents – see page 17/18	N/A	70% of the lowest priced alternative drug	75% of the lowest priced alternative drug 100% after you have paid $1,000 per person/year	80% of the lowest priced alternative drug 100% after you have paid $1,000 per person/year	N/A	75% of the lowest priced alternative drug 100% after you have paid $1,000 per person/year
Ambulance service	N/A	70%	70%	80%	70%	70%
Hospital	N/A	70% semi-private	75% semi-private	100% semi-private	100% semi-private	100% semi-private
Home nursing care	N/A	$10,000 maximum/year	$10,000 maximum per person/year	$10,000 maximum per person/year	$10,000 maximum per person/year	$10,000 maximum per person/year
Medical supplies	N/A	70%	75%	90%	N/A	75%

* A "drugs-only" option is available for Quebec members who do not qualify for drug coverage under their automatic coverage level and who do not wish to upgrade their coverage level to get it. See *Drug coverage for Quebec members* on page 17/18 for details.

	BASIC COVERAGE	LEVEL I	LEVEL II	LEVEL III	LIFE MEMBER	ENHANCED LIFE MEMBER
Vision care Eye exams	N/A	100% up to $100 per 24 months	100% up to $100 per person/24 months	100% up to $100 per person/24 months	100% up to $100 per person/24 months	100% up to $100 per person/24 month
Glasses, contacts	N/A	100% up to $400 per 24 months	100% up to $400 per person/24 months	100% up to $500 per person/24 months	100% up to $400 per person/24 months	100% up to $400 per person/24 months
Laser eye surgery	N/A	N/A	N/A	$2,000 lifetime max	N/A	N/A
Psychology	N/A	70% Up to $3,000/year	70% Up to $3,000 per person/year	75% Up to $3,000 per person/year	N/A	70% Up to $3,000 per person/year
Paramedical services	N/A	N/A	65% up to $1,500 per person/year for all services combined	75% up to $1,500 per person/year for all services combined	N/A	65% up to $1,500 per person/year for all services combined
Hearing aids	N/A	$1,000/5 years	$1,000 per person/ 5 years	$1,000 per person/ 5 years	$1,000 per person/ 5 years	$1,000 per person/ 5 years

DGC Benefits basics

- Eligibility
- Continuing coverage
- Producer contributions
- Determining coverage levels
- Life Member coverage
- Eligible life status change
- Upgrading my coverage
- Eligible dependants

ELIGIBILITY

Coverage under *DGC Benefits* is available to all members of the DGC who:

- are members in Active Good Standing or Life Members,
- can provide DGC with a Canadian primary residential address, and
- qualify for/have access to their provincial health plan.

Coverage is subject to age limits as described in this booklet and in the provisions in the *Upgrading your coverage* section and *Costs to upgrade if you do not qualify for coverage* section. (See pages 10 and 11 for details)

If you are a new member of the DGC – or a member returning to Active Good Standing – your coverage under the *DGC Benefits* program will begin as of the date you became a member in Active Good Standing. (For members upgrading coverage, Critical Illness coverage begins on the date you register and pay for coverage with AGA Benefit Solutions.)

CONTINUING COVERAGE

If you're on parental leave, your coverage will continue at the level of your default coverage at:

- the date of birth of your child, for birth parents, or
- the date of legal guardianship, for adoptive parents.

Your coverage will continue for two enrolment cycles starting January 1st after the date of birth of your child or date of legal guardianship.

If you've been approved to receive disability benefits beyond a three-month period, your coverage will continue at the level of your default coverage at the date of disability. Your coverage will continue for up to two enrolment cycles starting January 1st following the date of your disability leave.

If you've been approved to receive provincial workers' safety and compensation plan benefits beyond a three-month period due to an injury sustained while working under a DGC deal memo, your coverage will continue at the level of your default coverage at the date of your injury. Your coverage will continue for up to two enrolment cycles starting January 1st following the date of your disability leave.

To qualify:

- your injury must have occurred while you were working under a DGC deal memo;
- you must be receiving provincial workers' safety and compensation plan benefits for more than three months; and
- once you have received three months of benefits, you must provide proof of provincial

workers' safety and compensation plan benefits (such as a workplace compensation board statement) to AGA Benefit Solutions (dgc@aga.ca).

PRODUCER CONTRIBUTIONS

DGC Benefits is funded by producer contributions (and contractually obligated member contributions from some Quebec-based collective agreements), as well as any premiums you pay to upgrade your coverage level. Producers contribute to *DGC Benefits* based on contribution rates negotiated by the DGC.

DETERMINING COVERAGE LEVELS

Each year, you'll receive an "automatic" coverage level based on the producer contributions remitted on your behalf during the prior 24 months (ending June 30). For the 2027 plan year, this means your producer contributions from July 1, 2024 to June 30, 2026 (including contributions made in the two years prior to becoming a member).

If you just joined the DGC and don't have a contribution history, your automatic coverage level will be determined differently. It will be based on contributions received up to June 30th in the year you joined.

You get at least Basic Coverage in the year you join and the following year.

There are three automatic coverage levels. The higher the producer contributions, the higher (and more generous) your coverage level. The table below shows which level you will qualify for based on your producer contributions.

If your producer contributions for 2024-2025 and 2025-2026 total…	Your automatic coverage level for 2027 will be…
$1,340 – $3,559.99	Level I
$3,560.00 – $5,899.99	Level II
$5,900 or more	Level III

If you have less than $1,340 in producer contributions in the last two years of membership, consideration will be given to the producer contributions in the last five years and, if they are at least $1,230, you will receive Basic Coverage.

It's important to note that the producer contributions used to determine your automatic coverage level do not necessarily reflect the actual cost of your coverage level.

LIFE MEMBER COVERAGE

You are eligible for Life Member coverage if you are a recognized DGC Life Member. You must be a DGC member in Active Good Standing for at least 10 consecutive years as of turning age 65, or attain 10+ consecutive years in Active Good Standing at any age thereafter. Life Members are not required to have producer contributions, and you can choose to use dollar bank funds or pay to upgrade your coverage level, including to Enhanced Life Member coverage, if desired.

If you're a Life Member who has been working, then you'll of course qualify for the automatic coverage level based on your producer contributions. If your automatic coverage is Level I, you will receive Life Member coverage instead with the option of moving to Level I, if you prefer. If you decide to move to Level I during the annual re-enrolment period, there will be no additional cost.

UPGRADING YOUR COVERAGE

There are two times when you can upgrade your coverage level.

1. During the annual re-enrolment period.
2. If you have an eligible life status change. You must apply within 31 days of your status change. If you do not apply within 31 days, you will have to wait until the next re-enrolment period to upgrade.

The table below shows what it would cost to upgrade, depending on your automatic coverage level and what level you want to upgrade to.

If you qualify for:	Level I	Level II	Level III	Enhanced Life Member	Quebec drugs only (under age 65)	Quebec drugs only (age 65+)
Basic Coverage	$1,880	$5,100*	$8,400*	–	Single: $840 Family: $1,680	Single: $1,050 Family: $2,300 ($1,680 family if spouse under 65)
Level I	–	$3,210	$6,510	–	Family: $1,000	Family: $1,260
Level II	–	–	$3,310	–	-	-
Life Member	–	$3,970	$6,960	$2,210	Family: $1,840	Single: $1,050 Family: $2,300

*Dollar bank credits must cover the full upgrade cost. If you have Basic Coverage, you cannot make a personal payment to upgrade to Levels II or III.

Upgrade costs are subject to applicable provincial sales tax in Manitoba, Ontario and Quebec.

If you make personal payments, you can pay them in full or on a quarterly basis. Payments can be made by major credit card. Your coverage upgrade will not take effect until your credit card payment has been processed.

COSTS TO UPGRADE IF YOU DO NOT QUALIFY FOR COVERAGE

If you do not qualify for any of the above coverage levels, the table below shows what it would cost to upgrade but only if you have sufficient credits in your dollar bank:

Level I	Level II	Level III	Quebec drugs only (under age 65)	Quebec drugs only (age 65+)
$2,210*	$5,410*	$8,720*	Single: $840* Family: $1,840*	Single: $1,050* Family: $2,300*

*Dollar bank credits must cover the full upgrade cost.

Upgrade costs are subject to applicable provincial sales tax in Manitoba, Ontario and Quebec.

ELIGIBLE LIFE STATUS CHANGE

An eligible life status change can include:

- a marriage, separation or divorce
- the birth or adoption of a child
- the death of a spouse or child
- your child(ren) no longer qualifying as a dependant
- the involuntary loss of coverage under your spouse's benefit plan.

If you wish to upgrade your coverage, you must inform AGA Benefit Solutions, the administrator of *DGC Benefits*, within 31 days of your life status change. There is no additional premium required to add dependants if you already have Level II or Level III, which provide family coverage.

ELIGIBLE DEPENDANTS

For the purposes of *DGC Benefits*, eligible dependants are defined as follows:

Dependant child – The unmarried natural or adopted child, stepchild or legal ward of you and/or your spouse who is:

- under age 21 and working less than 30 hours per week (unless a full-time student); or
- under age 26 and a full-time student (attending at least 15 hours of classes or labs per week); or
- any age, if unable to support themselves due to a physical or psychological disorder (provided they qualified prior to age 21, or before age 26 if they were a full-time student).

Spouse – This is the person of the same or opposite sex who is either:

- legally married to you, or
- has been living with you in a conjugal relationship for at least 12 months, or if you live in Quebec, until the birth or adoption of a child, if earlier.

Only those eligible family members who you registered as a dependant when you enrolled (or re-enrolled) will be eligible for health, dental, emergency out-of-country medical, critical illness and life insurance coverage – unless you experience an eligible life status change and advise AGA Benefit Solutions.

Keep in mind that if you qualify for Level II, Level III, Life Member or upgrade to Enhanced Life Member coverage, you must declare (list) all of your dependants when you enrol or re-enrol. If you do not identify dependants at enrolment, they will not be added to the plan and will not be eligible for coverage, unless you have an eligible Life Status Change.

Dollar bank

The dollar bank is a special account designed to maximize the flexibility and tax-effectiveness of your benefits plan.

It can be considered a "holding tank" for excess producer contributions now – until you decide to upgrade your coverage level, allocate dollars to your HSA, or save for the future when you may be working less or not at all.

- How the dollar bank works
- Three options for using your dollar bank
- Tax advantages

HOW IT WORKS

Each year, the Trustees assess overall producer contributions against how much it costs to operate the plan. Any revenue that is not needed to fund future obligations is distributed mostly to members who have generated the most producer contributions to the plan. This is a discretionary process that can vary from year to year. For the 2027 plan year, there will be no dollar bank allocation due to lower-than-usual producer contributions. These lower contributions are a direct result of the industry work levels since 2023.

Your dollar bank account is designed to help you pay for the benefits coverage you need – now or in the future – that is not provided under your automatic coverage level.

THREE OPTIONS FOR USING IT

You have three options for using the credits in your dollar bank. You can:

1. **Use it to upgrade your coverage level.** For example, if you have Level I automatic coverage, which provides member-only coverage, but you want family coverage, you can use the money in your dollar bank to upgrade. Credits from your dollar bank can be used to upgrade your coverage only during the annual re-enrolment period or within 31 days of an eligible life status change.
2. **Move some or all of it to your healthcare spending account (HSA).** The credits in your HSA can be used to pay medical, prescription drug or dental expenses that are not covered – or not fully covered – under your benefit level. The HSA not only saves you out-of-pocket expenses, it also offers some important tax advantages.

   Keep in mind that credits can only be transferred from your dollar bank to your HSA during the annual re-enrolment period, or when you have an eligible life status change. It cannot be transferred throughout the plan year.
3. **Leave the credits in your dollar bank,** so you can use it in future re-enrolment periods. The credits in your dollar bank can be used to pay for coverage:
   - during periods when you are not working, or
   - when you are retired (or easing into retirement).

Although you can carry forward credits in your dollar bank for as long as you want, keep in mind that:

- interest will not be paid on these credits;
- you cannot withdraw these credits – it must be used to provide you with *DGC Benefits* coverage; and
- you must be a member in good standing to use these credits (they will be forfeited if your membership ends).

TAX ADVANTAGES

The credits allocated to your dollar bank account is pre-tax money in most provinces. In other words, income tax is not deducted from this money. This means you have more money to spend.

If you transfer your dollar bank credits to your HSA then different tax rules apply to the HSA. See page 16 for details.

SURVIVOR BENEFITS

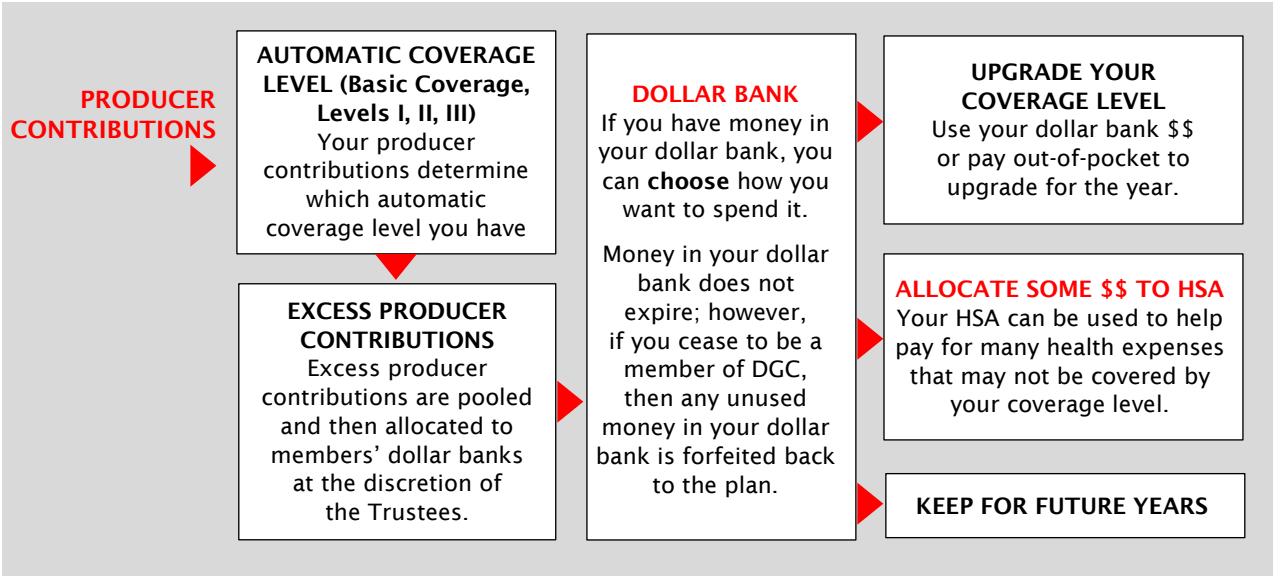
If you die while a member in Active Good Standing, your surviving spouse may transfer any funds remaining in your dollar bank to a Healthcare Spending Account (HSA) for the following year. This HSA can then be used by your surviving dependant(s) for a period up to the survivor extension of Health and Dental benefits. (See pages 23 and 28 for details.)

YOUR DOLLAR BANK AND HSA – THEY WORK *TOGETHER*

Think of **your dollar bank** as a wallet, where you store money.

Your Healthcare Spending Account (HSA) is an added benefit that you can choose to spend your dollar bank money on.

Here's a simplified overview.



Healthcare spending account (HSA)

A key part of *DGC Benefits* is the HSA. It's like a tax-effective bank account. You decide how much money to put in from your dollar bank, and then you spend it to help pay for healthcare expenses not otherwise covered by *DGC Benefits*.

- How it works
- Eligible dependants
- Eligible expenses
- HSA claims
- Tax advantages

HOW IT WORKS

During each annual re-enrolment period, you can choose to transfer money from your dollar bank to your HSA. How much you transfer each year, if anything, is up to you – as long as you have the money available in your dollar bank to transfer. Keep in mind, however, that:

- You can only transfer money to your HSA during the annual re-enrolment period, or when you have an eligible life status change.
- Money in your HSA must be used to pay for eligible health and dental expenses – it cannot be withdrawn as cash.
- Use it or lose it. When you transfer money into your HSA, you must use it within two years (a Canada Revenue Agency rule). Any unused amounts are forfeited back to the *DGC Benefits* plan.

You can spend HSA money as you see fit. The only requirement is that you spend it on medical, prescription drug and dental-related expenses that are not covered under *DGC Benefits* (or any other private or government healthcare plan), but that are allowed under the Income Tax Act.

For example, if you buy a $500 pair of prescription glasses and the plan covers $400, you'd be able to claim the remaining $100 from your HSA – provided, of course, you have allocated that much to your HSA.

When deciding how much money to move to your HSA, keep in mind:

- **Your HSA can be used to offset the cost** of a wide range of medical, drug and dental expenses not covered (or not fully covered) under your coverage level.
- **It may be more cost-effective to use your HSA to pay for uncovered expenses** than it is to upgrade to a higher coverage level, depending on your benefit needs.
- **You can use your HSA to cover eligible expenses for you and your dependants** – even if you do not have family coverage. Even better, when it comes to your HSA, the definition of eligible dependants is expanded.
- **Any money you deposit in your HSA in one plan year must be used by the end of the following plan year** – otherwise it will be forfeited. For example, if you move money from your dollar bank into your HSA for the 2027 plan year, you must spend that money by December 31, 2028.
- **You cannot carry forward an expense from one plan year to the next.** In other words, if you incur an expense in one year, you cannot use money deposited in your HSA for the next year to cover that expense.

For example, if you incurred an expense in October 2026, but don't have enough money left in your HSA from your 2026 deposit to cover that expense, you cannot use money deposited in your HSA for the 2027 plan year to pay for it.

Deadlines for using money in your HSA	
Any money deposited in your HSA for the plan year…	**Must be used by…**
2026	December 31, 2027
2027	December 31, 2028
2028	December 31, 2029
2029	December 31, 2030
Any funds not used by the deadline will be removed from your HSA and used to offset plan costs. This use-it-or-lose-it rule is a Canada Revenue Agency requirement.	

ELIGIBLE DEPENDANTS

When it comes to your HSA, the definition of eligible dependants is expanded. It includes your spouse and dependent children, as well as anyone who is recognized as your dependant by the Canada Revenue Agency. For example, a grandchild, parent, grandparent, brother, sister, aunt, uncle, niece or nephew of you or your spouse will qualify, provided they:

- are dependent on you for support, and
- normally live with you in Canada (unless away at school).

ELIGIBLE EXPENSES

The HSA covers a long list of eligible expenses as defined under the Income Tax Act. There are literally hundreds of eligible expenses, such as:

- dental work – everything from root canals to braces;
- hearing aids – including repairs;
- paramedical services – including the services of a massage therapist, chiropractor, acupuncturist, and physiotherapist;
- vision care – such as contact lenses, laser eye surgery, and even prescription sunglasses;
- deductibles and co-payments under your health and dental coverage.

Keep in mind, however, that to qualify as an eligible expense, the service, procedure or supply in question must be provided or prescribed by a medical practitioner who is licensed according to the laws of the province in which they are practicing.

For a complete list of covered expenses, refer to subsection 118.2(2) of the Income Tax Act. Additional information on many of these expenses can be found in the Income Tax Folio S1-F1-C1: Medical Expense Tax Credit.

If you can claim an expense under another plan (such as *DGC Benefits*, your spouse's benefits plan or a government drug plan), you may want to do that first before submitting your claim under the HSA.

HSA CLAIMS

Eligible HSA expenses must be received by Canada Life within 180 days following the end of the plan year in which the expense was incurred (or, if earlier, within 90 days of your final day of coverage under *DGC Benefits*). The plan year runs from January 1 to December 31.

For example, if you incurred an eligible expense in October 2026, you must submit your claim by June 30, 2027. Only money deposited in your HSA for the 2025 and/or 2026 plan year can be used to pay that claim – money deposited for the 2027 plan year cannot be used.

Keep in mind that the deadlines for HSA claims are different (and shorter) than the claim deadlines for *DGC Benefits* health and dental coverage.

Year expense incurred	This expense can be paid using money deposited in your HSA in…	The deadline for submitting the expense to Canada Life is…
2026	2025 & 2026	June 30, 2027
2027	2026 & 2027	June 30, 2028
2028	2027 & 2028	June 30, 2029

TAX ADVANTAGES

In addition to reducing your out-of-pocket expenses, using the HSA can help reduce your tax hit (see example below).

This is because you don't pay income tax on the money when it is deposited or when it's claimed from your HSA. That can make a huge difference in how much money you have available to spend on health and dental-related expenses.

For those of you who live in Quebec, the tax rules are a bit different. Any amounts claimed from your HSA will be considered a taxable benefit. You'll sidestep the federal tax hit, but provincial income tax will apply.

The bottom line is that the HSA offers you a clear tax advantage regardless of where you live in Canada.

Example: The HSA tax advantage

Let's say the dentist tells you that you have two cavities that will cost $500 to fill. If you have Level I coverage, the cost of filling those cavities won't be covered under the plan. That means you have two options:

1. You can pay the cost using $500 in pre-tax money from your HSA.
2. You can pay the cost out of your own pocket. If you pay out of pocket, you'll be using after-tax dollars. Assuming a 22% marginal tax rate, you would have to earn $640 to have enough after-tax dollars to pay the $500 dentist bill.



TIPS FOR YOUR HSA

- Target specific expenses when deciding how much to move to your HSA during re-enrolment each year.
- When you submit other claims, select the box to cover any uncovered amount through your HSA.
- Always check your unused amount before allocating more next year, then use it before it expires.
- Be sure to take advantage of coordination of benefits before using your HSA.

Health

There are few things in life as important as good health. *DGC Benefits* is designed to help ensure you get the medical care you need… when you need it.

- Coverage levels
- Coverage limits
- Maximums and deductibles
- Drug coverage for Quebec members
- Eligible expenses
- What's not covered
- When coverage ends
- Survivor benefits

COVERAGE LEVELS

DGC Benefits provides three distinct levels of coverage, plus Life Member and Enhanced Life Member coverage, as summarized on pages 6 and 7.

Each year, during the re-enrolment period, you'll be assigned an automatic coverage level for the upcoming plan year based on your producer contributions. If your automatic coverage level doesn't meet your benefit needs, you may be eligible to upgrade your coverage. If you upgrade your coverage, keep in mind that your new coverage level will apply to all of your *DGC Benefits*. For eligibility details about upgrading your coverage, see pages 10 and 11.

Remember, you can use your healthcare spending account (HSA) to offset the cost of those services and procedures not covered (or not fully covered) under your coverage level.

COVERAGE LIMITS

If you have Level I, II or III coverage, there is a $250,000 per person per calendar year coverage limit for all healthcare coverage (excluding out-of-province/country emergency medical insurance). If you have Life Member or Enhanced Life Member coverage, there is a $100,000 per person per calendar year coverage limit for all healthcare coverage (excluding out-of-province/country emergency medical insurance).

MAXIMUMS AND DEDUCTIBLES

Benefit maximums and deductibles run on a calendar year (January 1 to December 31), with the exception of eye exams and vision care, which run on a 24-month cycle, based on the date of your last claim.

DRUG COVERAGE FOR QUEBEC MEMBERS

If you've been issued a health insurance card by the Régie de l'assurance-maladie du Québec (RAMQ), the Quebec government requires that you must have basic prescription drug insurance from either:

- a private plan, or
- the Quebec prescription drug insurance plan (but only if you are not eligible for coverage under a private plan).

Private plan coverage must meet the minimum RAMQ requirements.

DGC Benefits Quebec Drugs Only covers 75% of eligible prescription drug expenses for you and your eligible dependants. Once you have paid $800 out-of-pocket, the plan will reimburse you at 100% for the balance of the plan year. A drug card is provided. Quebec Drugs Only coverage is available only if you are a resident of Quebec, as required by provincial legislation.That said, you do not need to add Quebec Drugs Only, or upgrade if have drug coverage through another source (e.g., your spouse's plan).

If you **do not** qualify for coverage under the DGC Benefits Plan, ***and*** you don't have enough money in your dollar bank to cover the full cost, ***and*** you are not eligible for coverage under another private plan, you must register for the Quebec prescription drug insurance plan (RAMQ). As a result, if you qualify for coverage under the DGC Benefits Plan, here's what you must do:

Basic Coverage
You must upgrade your coverage to Level I, or to Level II or III (to get family drug coverage if you have dependants), or at least add Quebec Drugs Only coverage for yourself and your dependants. If you have Basic Coverage, you may upgrade to Level II or III if you have enough funds in your dollar bank. Upgrade options are also subject to the coverage rules; see pages 10 and 11 for more details.

Level I coverage and have dependants
Individual drug coverage is included in Level I coverage. If you have dependants, you must upgrade your coverage to Level II or III (to get family drug coverage), or at least add Quebec Drugs Only coverage for your dependants.

Life Member coverage and your spouse is under 65
You must upgrade your coverage to Level II, III or Enhanced Life Member coverage (to get family drug coverage), or at least add Quebec Drugs Only coverage for you and your dependants.

Life Member coverage and your spouse is 65+
You have the option to upgrade your coverage to Level II, III or Enhanced Life Member coverage (to get family drug coverage), or add Quebec Drugs Only coverage for you and your dependants. Or, you can continue to have Life Member coverage and choose to be covered under the (RAMQ) drug plan (from age 65, you have the choice).

At age 65, you are automatically covered under the (RAMQ) drug plan unless you advise them that you do not need it. RAMQ charges a premium which you pay through your income tax return. You have the option to purchase Quebec Drugs Only for yourself or your family at the rates outlined on page 10.

ELIGIBLE EXPENSES

The following services and supplies are covered *(based on your coverage level, as well as applicable deductibles and reimbursement rates)*, provided they are:

- reasonable and customary (R&C),
- medically necessary, and
- proven to be effective.

All services and supplies covered under *DGC Benefits* must represent reasonable treatment – meaning they must be accepted by the Canadian medical profession, proven to be effective, and of a form, intensity, frequency and duration that is essential to diagnose or manage a disease or injury.

R&C limits are the normal range of fees for services and supplies in a given geographical area. You can check with Canada Life about R&C limits for your area before any service or treatment.

Accidental dental (Levels I, II, III)

Treatment for an accidental injury to sound, natural teeth, provided:

- the injury occurs while you have health coverage under *DGC Benefits*;
- the treatment is performed by a licensed dentist, oral surgeon, or denturist; and
- the treatment begins within 90 days of the accident (unless treatment is delayed due to 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.

Only treatment that is completed within 12 months of your injury will be covered.

Ambulance services (Levels I, II, III, Life Member & Enhanced Life Member)

Transportation by a licensed ambulance service (including air ambulance) to the nearest medical facility where adequate treatment is available. If transportation is to a facility other than the closest one, alternative benefits will be provided, based on the cost of transportation to the nearest centre where essential treatment is available.

Convalescent care (Levels I, II, III & Enhanced Life Member)

Room and board in a convalescent care facility for a condition that will significantly improve as a result of continuing care. Convalescent care must begin immediately following three or more days of confinement in an acute care facility.

Diagnostic tests and x-rays (Levels I, II, III & Enhanced Life Member)

The cost of eligible diagnostic tests and x-rays (excluding administration fees), when coverage is not available under your provincial health plan.

Drugs and drug supplies (Levels I, II, III & Enhanced Life Member)

Prescription drugs and drug supplies, as described below, that are prescribed by a physician or other qualified health professional (as allowed by law) and are provided in Canada.

- Drugs that require a written prescription, including oral contraceptives.
- Injectable drugs, including vitamins, insulin, and allergy extracts.
- Extemporaneous preparations or compounds, provided at least one of the ingredients is a covered drug.
- Certain other life sustaining drugs that do not require a prescription – provided they are prescribed.
    - Diabetic supplies, including:
        - insulin and insulin syringes,
        - test strips,
        - blood-letting devices (including platforms and lancets),
        - blood-glucose monitoring machines (once every four years),
        - disposable needles for use with non-disposable insulin injection devices, and
        - insulin infusion sets (excluding infusion pumps).

Reimbursement will be based on the lowest cost alternative (usually a generic drug). Generic drugs typically **cost 75-80% less** than their brand name counterpart – even though they have the same active ingredients and are equally effective.

- If you submit a claim for a brand-name drug that has a lower-cost alternative, you will be reimbursed based on the price of the alternative.
- Brand-name drugs will be reimbursed based on their full price only if there is a medical reason why you cannot use a lower-cost alternative. In this case, your doctor must complete a *Request for Brand-Name Drug Coverage* form (it's not enough for your doctor to simply write "no substitution" on your prescription).
- If you take a brand-name drug, talk to your pharmacist or doctor about switching to a generic equivalent, if one exists.

If a drug is covered under a provincial drug plan, coverage under DGC Benefits is limited to any deductible and co-insurance you are required to pay under the provincial plan.

Drug purchases must be limited to what can reasonably be used within 34 days. The exception is maintenance drugs (e.g., antiasthmatics, anticoagulants, cardiac agents, oral contraceptives, etc.). Purchases for maintenance drugs should be limited to what can reasonably be used within 100 days. Pre-approval is required by the FACET Prior Authorization program for some drugs. You will be advised if pre-approval is required when you present your prescription to the pharmacist. Alternatively, you can find out which drugs require pre-approval by checking Canada Life's Drug Coverage Search Tool, or by calling FACET at 1-844-492-9105.

Cubic Health, an independent third-party organization, manages drug prior authorization (pre-approvals) through its FACET Prior Authorization program. Their team of clinical pharmacists takes an evidence-based approach to reviewing prior authorization requests, with an intentional focus on patient care and outcomes.

***Hearing aids* (Levels I, II, III, Life Member & Enhanced Life Member)**

Hearing aids (including, tubing and ear molds provided at the time of purchase) when prescribed by a doctor. Up to $1,000 per person every five years.

***Home nursing care* (Levels I, II, III, Life Member & Enhanced Life Member)**

The home nursing services of a registered nurse, licensed practical nurse or registered nursing assistant, based on the level of skill needed to provide essential acute, convalescent or palliative care. The nurse cannot be a member of the patient's family. A pre-care assessment by Canada Life is required to determine the appropriate level of care. Coverage is limited to a maximum of $10,000 per person in a calendar year.

***Hospital (semi-private)* (Levels I, II, III, Life Member & Enhanced Life Member)**

The difference between the public ward allowance under your provincial health plan and the cost of semi-private accommodation, provided you are confined to a licensed hospital.

***Medical supplies* (Levels I, II, III & Enhanced Life Member)**

The following medical supplies are covered when prescribed by a doctor:

- Breathing equipment, including: oxygen; the equipment needed to administer oxygen; apnea monitors for respiratory dysrhythmia; mist tents; and nebulizers
- Orthopedic equipment, including:
    - braces and cervical collars,
    - custom-made foot orthotics (certain rules apply: please contact Canada Life before ordering orthothics), and custom-fitted orthopedic shoes (up to $750 per year, combined with shoes attached to a splint),
    - casts,
    - external electrospinal stimulators for the correction of scoliosis,
    - non-union bone stimulators,

- prone standers,
- splints, including shoes attached to a splint (up to $750 per year, combined with foot orthotics and orthopedic shoes).

- Prosthetic equipment, including:
  - artificial eyes,
  - cleft palate obturators,
  - external breast prosthesis (once a year),
  - myoelectric arms, including repairs (up to a lifetime maximum of $10,000),
  - standard artificial limbs, including repairs, stump socks, and shoulder harnesses,
  - surgical brassieres (twice a year).
- Mobility aids, including:
  - canes, walkers, crutches and parapodiums,
  - mechanical or hydraulic patient lifters (once every five years, up to $2,000/lifter),
  - outdoor wheelchair ramps (once per lifetime, maximum of $2,000),
  - wheelchairs, including rechargeable batteries and repairs.
- Other, including:
  - catheters and catheterization supplies,
  - colostomy and ileostomy supplies,
  - custom-made pressure supports for lymphedema,
  - elevated toilet seats, shower chairs, bathtub rails, and standard commodes,
  - extremity pumps for lymphedema or severe postphlebitic syndrome (once per lifetime, maximum of $1,500),
  - food substitutes for tube feeding and feeding pumps,
  - hospital beds, bed rails, trapeze bars, head halters, and traction apparatus,
  - intrauterine devices (up to two per year),
  - intraocular lenses following cataract surgery,
  - one pair of eyeglasses or contact lenses following non-refractive eye surgery,
  - transcutaneous nerve stimulators for control of chronic pain (up to $700 per lifetime),
  - wigs for cancer patients undergoing chemotherapy (up to $200 per lifetime).

For supplies available on a rental basis, Canada Life may, at its discretion, cover the rental cost only.

Paramedical services (Levels II, III & Enhanced Life Member)*

Up to $1,500 per person per calendar year for all services combined. Services must be provided by a qualified and licensed practitioner. Covered services include:

- acupuncturist
- massage therapist
- speech therapist
- chiropractor
  (includes diagnostic x-rays)
- naturopath
- osteopath
  (includes diagnostic x-rays)
- physiotherapist
- podiatrist
  (includes diagnostic x-rays).

Benefits for these services are paid only after the maximum annual benefit has been paid under your provincial health plan. No benefits are paid for podiatric treatments eligible for any reimbursement (partial or full) under your provincial health plan.

Psychology (Levels I, II, III & Enhanced Life Member)*

Expenses for registered/licensed practitioners, including: psychologists and social workers, psychotherapists in BC, ON and QC only, and registered clinical counselors in BC only, are eligible at the paramedical reimbursement rate for your coverage level, up to a combined maximum of $3,000 per person per year.

- 70% for Level I,
- 70% for Level II,
- 75% for Level III,
- 70% for Enhanced Life Members.

**Contact Canada Life to confirm coverage if using a practitioner for the first time. To be eligible for reimbursement, each of the above practitioners must be licensed by their respective provincial governing bodies that regulate the services they provide. Governing bodies and eligible practitioners are not consistent in every province.*

Smoking cessation (Levels I, II, III *& Enhanced Life Member*)

Expenses for smoking cessation drugs prescribed by a licensed medical practitioner are covered up to $500 per person per lifetime. Non-prescribed medications are not covered.

Vaccinations (Levels I, II, III & Enhanced Life Member)

The drug portion of the vaccine is covered under the plan. Any additional admin fees or lab fees are not covered.

Vision care

- *Eye exams (Levels I, II, III, Life Member & Enhanced Life Member)*

  Expenses for eye examinations (including refractions) are covered when performed by a licensed ophthalmologist or optometrist and coverage is not available under your provincial plan. You have up to $100 per person every 24 months for Levels I, II, III and Life Member and Enhanced Life Members.

- *Eyeglasses and contact lenses (Levels I, II, III, Life Member & Enhanced Life Member)*

  Expenses for prescription eyeglasses and contact lenses are covered at up to $400 per person per 24 months for Levels I, II, Life Member and Enhanced Life Member coverage; and up to $500 per person per 24 months for Level III coverage.

- *Laser eye surgery (Level III only)*

  Expenses for laser eye surgery performed by a licensed ophthalmologist are covered up to a $2,000 lifetime maximum per person.

WHAT'S NOT COVERED

Regardless of your coverage level, *DGC Benefits* will not pay any benefit or accept liability for any claims relating to expenses such as (but not limited to) the following:

- Expenses covered under a government health plan.
- Expenses covered under another policy (e.g., under another group plan).
- Expenses a private insurer is not permitted to cover by law.

- Services and supplies you are entitled to at no charge.
- Charges that are made only because you have insurance coverage.
- Services or supplies that are considered unreasonable.
- Extra medical supplies that are not spares or alternates.
- Treatment performed for cosmetic purposes only.
- Expenses arising from war, insurrection, or voluntary participation in a riot.
- Drugs dispensed by a dentist, clinic or non-accredited hospital pharmacy.
- Drugs dispensed in a hospital during treatment as an inpatient or outpatient.
- Fertility drugs.
- Allergy extracts.
- Drugs used for cosmetic purposes (e.g., sunscreen), or erectile dysfunction.
- Vision care services and supplies required by an employer as a condition of employment.
- Accidental damage to dentures.

WHEN COVERAGE ENDS

Your coverage will continue as long as you earn sufficient producer contributions, use money from your dollar bank, or pay out of your pocket to buy coverage (provided you are a member in Active Good Standing). For more information about continuing coverage, see *Upgrading your coverage levels* on pages 10 and 11.

If you are a Life Member – your coverage will continue as long as you remain a DGC member.

Your spouse's coverage ends when your coverage ends, or if you move to Level I coverage, which does not include family coverage. Coverage for a dependant child ends when your coverage ends, you move to Level I, or the child no longer qualifies as a dependant… whichever is first.

SURVIVOR BENEFITS

If you die while a member in Active Good Standing, your surviving dependant(s) will continue to receive coverage, as noted in the table below.

Coverage level at the member's death	Survivor's coverage level
Level I	Level II – Single or Family
Level II	Level II – Single or Family
Level III	Level III – Single or Family
Life Member – Single or Family	Enhanced Life Member – Single or Family
Enhanced Life Member – Single or Family	Enhanced Life Member – Single or Family

Your surviving dependants' coverage will continue for a period of time based on your years of membership in the DGC, as noted in the table below.

Years of membership in the DGC	Period of continuing coverage
Less than 25 years	2 years
25+ years	3 years

Dental

We all need dental care. But how much we need can vary dramatically depending on our teeth and dental history. With that in mind, *DGC Benefits* offers a range of preventative, routine and restorative procedures designed to keep you and your family smiling.

- Coverage levels
- Maximums and deductibles
- Eligible expenses
- What's not covered
- When coverage ends
- Survivor benefits

COVERAGE LEVELS

DGC Benefits provides three distinct levels of coverage, as summarized on page 5.

Each year, during the re-enrolment period, you'll be assigned an automatic coverage level for the upcoming plan year based on your producer contributions. If your automatic coverage level doesn't meet your benefit needs, you may be able to upgrade your coverage.If you upgrade your coverage, keep in mind that your new coverage level will apply to all of your *DGC Benefits*. For eligibility details about upgrading your coverage, see pages 10 and 11.

Dental expenses will be reimbursed *(based on your coverage level and reimbursement rates)*, provided they are:

- for reasonable and customary treatment;
- within the amounts specified in the current general practitioner's fee schedule (as approved in your province of residence); and
- for services performed or prescribed by a dentist or denturist.

Charges above those shown in the current general practitioner's fee schedule will not be covered. If a reimbursement amount is not shown in the applicable fee schedule, the insurer will determine a reasonable amount.

MAXIMUMS AND DEDUCTIBLES

Benefit maximums and deductibles run on a calendar year, with the exception of orthodontics, which has a lifetime maximum.

Remember, you can use your healthcare spending account (HSA) to offset the cost of those services and procedures not covered (or not fully covered) under your coverage level.

ELIGIBLE EXPENSES

The following services and supplies are covered (based on your coverage level and reimbursement rates):

Basic dental coverage	**LEVEL I**	**LEVEL II, III & Enhanced Life Member**
Diagnostic services include:		
• Complete oral examination	–	1x every 3 years
• Emergency, oral pathology, periodontal, surgical, prosthodontic and endodontic examinations	–	As required
• Limited oral examinations	1x per calendar year	2x per calendar year, but 1x in years when you have a complete oral exam
• Limited periodontal examinations	1x per calendar year	2x per calendar year
• Complete series of x-rays	–	1x every 3 years
• Intra-oral x-rays – up to 15 images	–	1x every 3 years
• Panoramic x-ray	–	1x every 3 years, except when provided in same year as complete series
• Sialography	–	√
• Extra-oral x-rays (other than panoramic and sialography)	–	√
• Radiopaque dyes used to pinpoint lesions	–	√
• Interpretation of x-rays	–	√
• Microbiological, histological, cytological, and pulp vitality tests	–	√
• Laboratory reports	–	√
Preventative and routine services include:		
• Preventative scaling (one time unit = 15 mins)	1unit per calendar year	Scaling units included in "periodontal"
• Polishing	1x per calendar year	2x per calendar year
• Fluoride treatments	1x per calendar year	2x per calendar year
• Bitewing x-rays	1x per calendar year	–
• Oral hygiene instruction	1x per lifetime	
• Pit and fissure sealants on bicuspids and permanent molars	–	1x every 5 years
• Space maintainers	–	For missing central or lateral teeth
• Appliances for the control of harmful habits	–	√
• Finishing restorations	–	√
• Interproximal disking	–	√
• Recontouring of teeth	–	√

- Minor restorative services, including:
    - amalgams and tooth-colored fillings (replacement fillings are covered only if the existing filling is at least two years old or was not covered under this plan)
    - cavities, trauma and pain control
    - pins and posts for fillings
    - pre-fabricated crowns for primary teeth.
- Denture maintenance, including:
    - relining dentures that are at least six months old, once every three years
    - rebasing dentures that are at least two years old, once every three years
    - resilient liner (at least three months after denture insertion), once every three years.
- Oral surgery, including:
    - palatal obturators
    - removal of teeth
    - remodeling and recontouring oral tissue (minor alveoloplasty, gingivoplasty and stomatoplasty)
    - surgical exposure of teeth
    - surgical excision of tumors, cysts, and granulomas
    - surgical incisions
    - treatment of fractures
    - treatment of maxillofacial deformities
- Adjunctive services, including:
    - pain relief (emergency basis only)
    - therapeutic injections
    - anesthesia required in relation to covered services.

Major restorative

- Crowns and onlays when a tooth has extensive structural loss that cannot be adequately restored using other procedures (the cost for crowns on molars is limited to the cost of metal crowns; the cost of tooth-coloured onlays on molars is limited to the cost of metal onlays). If a crown or onlay is provided when a tooth could have been restored using other procedures, alternative coverage will be provided.
- Replacement crowns and onlays when the existing restoration is at least five years old and cannot be repaired.
- Standard complete or partial dentures to replace teeth extracted while insured under this plan.
- Implantology.
- Complete overdentures or bridgework to replace teeth extracted while insured under this plan when standard complete or partial dentures are not a viable treatment option. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics.
- Replacement of any denture or bridge that is:
    - temporary,
    - at least 5 years old and unserviceable, or
    - less than five years old, but unserviceable due to the placement of an opposing appliance or the extraction of additional teeth. If additional teeth are extracted, but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

- Appliance maintenance, including:
    - denture remakes, once every three years,
    - denture adjustments, once a year,
    - denture repairs and additions,
    - tissue conditioning,
    - resetting of denture teeth,
    - removal, repairs and recementing of bridgework,
    - denture-related surgery for remodeling and recontouring oral tissue.

Periodontal services

- Scaling and root planing, up to eight "time units" (combined) per calendar year. One time unit equals 15 minutes.
- Periodontal surgery.
- Occlusal adjustment and equilibrium, up to four "time units" (combined) per calendar year.
- Periodontal appliances, including adjustments, relines and repairs.

Endodontics

- Treatment of the pulp chamber.
- Root canal therapy for permanent teeth, limited to one course of treatment per tooth (repeat treatment is covered only if the original therapy fails after the first 18 months).
- Apexification.
- Periapical services.

Orthodontics (Level III only)

- Diagnostic services, including:
    - orthodontic examinations,
    - cephalometric x-rays,
    - diagnostic photographs,
    - orthodontic diagnostic casts.
- Fixed and removable orthodontic appliances, including related charges for observations, adjustments, repairs, alterations, removal, and retention.

TREATMENT PLAN

Find out how much reimbursement you can expect – before your treatment begins.

For anything other than routine dental care, it is highly recommended that you ask your dentist to provide Canada Life with a treatment plan before the treatment begins. A treatment plan is simply a description of the proposed procedure and its related cost. Canada Life will review the plan and report what portion of the cost (if any) is covered.

WHAT'S NOT COVERED

Regardless of your coverage level, *DGC Benefits* will not pay any benefit or accept liability for any dental claims relating to expenses such as (but not limited to) the following:

- Duplicate x-rays
- Custom fluoride appliances
- Audio-visual oral hygiene instruction and nutritional counselling
- Root canal therapy for primary teeth
- Isolation of teeth
- Enlargement of pulp chambers
- Endosseous intra coronal implants
- Desensitization
- Topical application of antimicrobial agents
- Subgingival periodontal irrigation
- Charges for post-surgical treatment
- Periodontal re-evaluations
- Cleft palate obturators
- Hypnosis
- Alveoloplasty or gingivoplasty performed in conjunction with extractions
- Acupuncture
- Veneers
- Recontouring of existing crowns
- Staining porcelain
- Inlays (except when provided as an alternative benefit)
- Crowns or onlays if the tooth could have been restored using other procedures
- Overdentures or initial bridge if a standard complete or partial denture would have been a viable treatment option
- Expenses covered under another policy (i.e., under another group plan)
- Expenses a private insurer is not permitted to cover by law
- Services and supplies you are entitled to, by law, at no charge
- Charges that are made only because you have insurance coverage
- Services or supplies that are considered unreasonable
- Treatment performed for cosmetic purposes only
- Treatment for temporomandibular joint (TMJ)
- Expenses arising from war, insurrection, or voluntary participation in a riot

WHEN COVERAGE ENDS

Your coverage will continue as long as you earn sufficient producer contributions, use money from your dollar bank, or pay out of your pocket to buy coverage (provided you are a member in Active Good Standing). For more information about continuing coverage, see *Upgrading your coverage levels* on pages 10 and 11. Your spouse's coverage ends when your coverage ends, or if you move to Level I coverage, which does not include family coverage. Coverage for a dependant child ends when your coverage ends, you move to Level I, or the child no longer qualifies as a dependant… whichever comes first.

SURVIVOR BENEFITS

If you die while a member in Active Good Standing, your surviving dependant(s) will continue to receive coverage, as noted in the table below.

Coverage level at the member's death	Survivor's coverage level
Level I	Level II – Single or Family
Level II	Level II – Single or Family
Level III	Level III – Single or Family
Life Member – Single or Family	Enhanced Life Member – Single or Family
Enhanced Life Member – Single or Family	Enhanced Life Member – Single or Family

Your surviving dependants' coverage will continue for a period of time based on your years of membership in the DGC, as noted in the table below.

Years of membership in the DGC	Period of continuing coverage
Less than 25 years	2 years
25+ years	3 years

Emergency out-of-province/country medical care

Medical emergencies can happen anywhere, any time. With that in mind, *DGC Benefits* offers important insurance to help protect you and your family when you travel outside your home province.

- Coverage levels
- Eligible expenses
- When coverage ends
- Survivor benefits

COVERAGE LEVELS

Your out-of-province/country emergency medical insurance is based on your coverage level, as outlined on page 4.

ELIGIBLE EXPENSES

In addition to covering medical emergencies, out-of-province/country coverage also provides emergency travel assistance.

Emergency medical care

The plan covers the cost of medical care if you experience a sudden, unexpected injury or acute illness while traveling outside of your province of residence for vacation, business or education. If you are covered under your provincial health plan, the plan will cover reasonable and customary expenses for:

- a bed in a semi-private ward,
- the services of a doctor,
- diagnostic services,
- hospital services and supplies,
- treatment for a dental injury, and
- out-patient services.

If you are in Level II or III and under age 80, the plan will cover expenses incurred within 90 days of your departure from Canada, unless you are still hospitalized at the end of the 90 days, in which case coverage will be extended until your release from hospital. The maximum benefit is $5 million per lifetime (up to $1 million if age 70-79).

Life Members who are under age 80 are covered for trips up to 90 days. The same dollar limits as above apply.

If your medical condition permits a return to Canada, your coverage will be the lesser of:

- the cost of continued treatment outside of Canada, and
- the cost of comparable treatment in Canada, plus return transportation.

Limitations

Exclusions listed under your Health coverage also apply for emergency medical care.

In addition, emergency medical care services or supplies received out-of-province but in Canada, are not covered unless:

- the person is covered by the government health plan in their home province or the government coverage replacement plan sponsored by the planholder; and
- this plan would have paid benefits for the same services or supplies if they had been received in the person's home province.

Emergency travel assistance

While you and your eligible dependants are traveling for vacation, business or education, you will have access to Global Medical Assistance (GMA), a world-wide communications network. If you have a medical emergency, GMA can help you locate medical services and obtain approval from Canada Life for covered services – at any time of the day or night.

Subject to prior approval from Canada Life, covered services include:

- Medical evacuation to the nearest suitable hospital.
- Onsite hospital payment when required for admission up to a maximum of $1,000.
- Medical evacuation if suitable local care is not available. If traveling within Canada, you will be moved to the nearest suitable hospital. If traveling outside of Canada, you will be moved to: the nearest hospital equipped to provide treatment, or to a hospital in Canada.
- Lodging, expenses, and return transportation, as well as custodial services, for children left unattended due to the death or hospitalization of the covered person with whom they are traveling.
- Round-trip economy transportation and lodging for one family member joining a covered person who was traveling alone and who has been hospitalized for more than seven days.
- Lodging and expenses for a family member who remains with a covered person who is hospitalized and whose return trip has been delayed.
- The cost of comparable return transportation for a covered person and one traveling companion if a prearranged, prepaid return trip is missed because the covered person is hospitalized. A rental vehicle is not considered pre-arranged, prepaid return transportation.
- Up to $1,000 towards getting your vehicle home or to the nearest rental agency if a covered person dies or is hospitalized. This benefit is not payable if the cost of comparable return transportation is paid.
- Preparation and return transportation for the body of a deceased person who is covered under the plan.

Lodging benefits are limited to moderate quality accommodation and $1,500 per confinement. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home.

Limitations

Out-of-province/country coverage does not include trip cancellation insurance, trip interruption insurance, or coverage for lost or stolen baggage.

WHEN COVERAGE ENDS

Out-of-country emergency medical insurance coverage ends when you turn 80 or no longer qualify as a member in Active Good Standing… whichever comes first.

Your spouse's coverage ends when your coverage ends or your spouse turns 80… whichever comes first.

Coverage for a dependant child ends when your coverage ends or the child no longer qualifies as a dependant… whichever comes first.

SURVIVOR BENEFITS

If you die while a member in Active Good Standing, your surviving dependants will continue to receive coverage, as noted in the table below.

Coverage level at the member's death	Survivor's coverage level
Level I	Level II – Single or Family
Level II	Level II – Single or Family
Level III	Level III – Single or Family
Life Member – Single or Family	Enhanced Life Member – Single or Family
Enhanced Life Member – Single or Family	Enhanced Life Member – Single or Family

Your surviving dependants' coverage will continue for a period of time based on your years of membership in the DGC, as noted in the table below.

Years of membership in the DGC	Period of continuing coverage
Less than 25 years	2 years
25+ years	3 years

Short-term disability

If you're unable to work due to a non-work-related/non-motor vehicle accident, illness or injury, *DGC Benefits* may offer you important financial protection.

- Eligibility
- STD benefits
- Definition of "disabled"
- How the short-term disability process works
- Your responsibilities
- Recurring disabilities or new disability
- Confidentiality
- Your options, if a claim is declined
- Benefit offsets
- Limitations and exclusions
- When disability payments stop
- When disability coverage ends

ELIGIBILITY

Starting January 1, 2027, eligibility for Level II or Level III short-term disability (STD) income benefits requires at least 14 days of work under one or more DGC deal memos or participation agreements, with contributions made on your behalf, in the 12 months before the date of your disability.

Eligibility note:
You must submit your claim within 90 days of the date of your illness or injury.

At each annual re-enrolment, your eligibility and benefit coverage is determined based on your producer contributions for the past two years. **You cannot upgrade your coverage level to qualify for STD,** or increase the amount of your benefit coverage.

Examples:

- If you qualified for Level II coverage and then upgraded to Level III, you will be covered for disability at Level II.
- If you qualified for Level I coverage and then upgraded to Level II or III, you are not eligible for STD benefits.

The following are not eligible:

- Members with Basic Coverage or Level I,
- Members with Life Member or Enhanced Life Member coverage and members over age 75,
- Members on Honourable withdrawal,
- Members' dependants, at any coverage level.

To qualify for disability benefit payments, you must be deemed totally disabled by Canada Life (as defined below). You must also be participating in:

- an appropriate care and treatment program prescribed or performed by a licensed physician (including a certified specialist, where appropriate);
- an approved addiction treatment program that is supervised by a qualified medical specialist (if alcohol, drug and/or substance abuse, or other addiction is a factor in your disability); or
- a rehabilitation program recommended by Canada Life.

See "*Limitations and exclusions*" on page 37 for more details.

STD BENEFITS

After a 14-calendar-day waiting period, the plan provides the following benefits for up to 26 weeks:

- **Level II:** $320 per week
- **Level III:** Minimum $320, *up to* $1,400 per week

Weekly benefits paid to disabled plan members in Level III will be limited to 100% of the member's pre-disability average weekly earnings, with a minimum of $320. All payments from the disability plan are taxable as regular income.

Pre-disability average weekly earnings
=
Earnings during the previous 24-month period ending June 30 of the year before your disability, averaged over the number of weeks in that period (i.e., 104 weeks).

Example:

If you were injured on January 1, 2027, your gross earnings from July 1, 2024 to June 30, 2026 would be used. (Same period used to calculate your default coverage level.)

Scenario 1 — Your gross earnings: $59,000
Benefit calculation: $59,000/104 weeks = **$567.31 per week**

Scenario 2 — Your gross earnings: $146,000 or more
Benefit calculation: $146,000/104 weeks = $1,403.85 per week
Therefore, you would receive the maximum of **$1,400 per week**

If you begin a claim late in the year and your disability period extends into the new benefits plan year, the same coverage level for disability will continue until your disability claim is closed, even if your benefits coverage level changes for the new plan year.

DEFINITION OF "DISABLED"

You will be considered disabled if:

- disease or injury prevents you from performing the essential duties of your regular occupation; and
- you are not employed in any occupation that is providing you with income equal to or greater than the income benefit available under this plan (except for any employment under an approved rehabilitation plan).

HOW THE SHORT-TERM DISABILITY PROCESS WORKS

If you have a disability claim, AGA Benefit Solutions and Canada Life will both help support you through the process. Here's how it works.

1. AGA Benefit Solutions will provide you with access to the disability application forms, including an *Employee Statement* which includes an *Authorization Form* and an *Attending Physician Statement* to take to your doctor for completion. Refer to the *"Making claims"* section on page 59.
2. AGA Benefit Solutions will provide a separate completed form for Canada Life to assist in the review of the claim and to confirm your eligibility to apply for this benefit.
3. The completed forms provide the Canada Life Case Manager with information to help determine eligibility for financial support and the best way to approach your health condition.
4. Your Case Manager will contact both you and AGA Benefit Solutions to discuss the disability management process and obtain any additional information Canada Life requires in order to complete their assessment.

5. If approved, your Case Manager will remain in contact with you and your physician to clarify the expected recovery date and whether or not additional support is required to assist you in recovering your health and preparing to be work-ready.
6. Additional support might include some of the following:
    - consultation with your treating physician,
    - independent evaluations to facilitate a clearer understanding of your health,
    - facilitation of treatment support through a Medical Coordinator, or
    - facilitation of return to work support through a Rehabilitation Consultant.

YOUR RESPONSIBILITIES

During a period of disability, you are expected to make reasonable efforts to:

- provide acceptable proof of your disability within 90 days of the date of disability;
- participate fully in the disability management process, in particular by seeking appropriate treatment and care;
- recover from your disability and be work-ready;
- maintain ongoing communication with the Canada Life Case Manager and AGA Benefit Solutions as required;
- advise the Case Manager if you return to work;
- advise the Case Manager if your medical condition changes; and
- be actively involved in plans to help you become work-ready.

Failure to make such reasonable efforts may result in benefits being modified, delayed, withheld, or discontinued.

RECURRING DISABILITIES OR NEW DISABILITY

There are a number of examples below that outline the claims process if you experience either a recurring disability or a new disability after receiving benefits for an initial claim. The examples are based on:

1. Whether you received benefits for the full 26-week maximum for your initial claim, and
2. Whether your recurring or new disability is *within 30 days* or *after 30 days* of returning to work (or being deemed ready by Canada Life to return to work, even if there is no available work), after the initial claim.

Examples to consider

a) You applied for disability benefits and received payment for six weeks. You recover (may or may not return to work but cease being disabled) but then become disabled again due to the *same or related* cause *within 30 days* of the closure of the prior claim. Your prior claim may be re-opened with no waiting period and you may continue to receive benefits for the remaining 20 weeks (up to the 26-week maximum).

b) You applied for disability benefits and received payment for six weeks. You recover but then become disabled again *more than 30 days* after the prior claim closed. Regardless if your illness or injury is the same or related to the first claim, you can only re-apply after you have worked for at least 14 days within 12 months after your original claim closes (assuming you continue to be eligible). If your claim is approved, you will need to satisfy a new 14-day waiting period and you may be entitled to receive benefits for up to 26 weeks.

c) You applied for disability benefits and received payment for the full 26-week maximum. You recover but then become disabled again – due to the *same or related* cause – *within 30 days* of the closure of the original claim. Even though you're *within the 30-day* recurrence period, you are not eligible for a continuation of the prior claim because the full 26 weeks were paid out and the claim is terminated.

d) You applied for disability benefits and received payment for the 26-week maximum. You recover but then become disabled again *more than 30 days* after the prior claim is closed. Regardless if your illness or injury is the same or related to the first claim, you can only re-apply after you have worked for at least 14 days within 12 months after your original claim closes (assuming you continue to be eligible). If your claim is approved, you will need to satisfy a new 14-day waiting period and you may be eligible to receive benefits for up to 26 weeks.

YOUR MEDICAL INFORMATION IS CONFIDENTIAL

Medical information is always considered confidential and will not be shared with the DGC. Throughout the disability process, Canada Life will provide status updates regarding your limitations and your ability to return to work – without sharing the medical details.

Medical information is used only by Canada Life to ensure a comprehensive understanding of your condition. You are asked to provide written consent (using the Authorization Form) allowing Canada Life to begin the process of assessing your claim, contacting your physician and/or providing status updates to AGA Benefit Solutions as appropriate.

YOUR OPTIONS IF A CLAIM IS DECLINED

You have the right to appeal a denial of a claim with Canada Life. The declination letter will outline the necessary information that is required to review the appeal. It is recommended that you submit your appeal information to Canada Life as early as possible to ensure a timely decision. Contact AGA Benefit Solutions for help.

BENEFIT OFFSETS

Disability benefits will be offset by:

- any benefits you are entitled to receive on your own behalf (for the same disability) from the Canada/Quebec Pension Plan, Employment Insurance or similar government plans;
- any retirement benefits you are entitled to receive from the Quebec Pension Plan because you are already receiving Quebec Pension Plan disability benefits; or
- a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan.

If you do not receive a disability benefit reduction because it has not been awarded or received by you, Canada Life will have the right to estimate it according to the terms of any plans or legislation involved.

Disability benefits are also reduced by the earnings you receive from an approved rehabilitation plan.

LIMITATIONS AND EXCLUSIONS

Disability benefits will not be paid for any period before you are first treated by a legally licensed doctor of medicine, or for any period of employment, except in an approved rehabilitation plan or program.

Benefits will also not be paid if:

- your disability is the result of a motor vehicle accident;
- you do not participate or cooperate in a reasonable and customary treatment program;
- you are receiving unemployment, maternity, parental or compassionate care benefits under the *Employment Insurance Act* (except as required by provincial regulations, and/or if your disability is caused by a complication of pregnancy);
- your disability is the result of any accident or disease that is covered by Workers' compensation programs;
- you are lawfully imprisoned;
- you are receiving disability benefits from elsewhere for a recurring disability;
- your disability is the result of war, insurrection or voluntary participation in a riot;
- your disability is the result of, or associated with, treatment performed for cosmetic purposes; or
- your disability occurs while committing or attempting to commit a criminal offense;

WHEN DISABILITY PAYMENTS STOP

Disability payments will stop at the earliest of:

- your recovery (when you are no longer deemed totally disabled, as defined above);
- the end of the 26-week maximum benefit period;
- you fail to participate or cooperate in a medical coordination program or rehabilitation plan or program that has been recommended or approved by Canada Life;
- if you are receiving disability payments and work for even one day – unless the work time is part of an approved rehabilitation program with Canada Life.
- termination of your membership with DGC; or
- your death.

WHEN DISABILITY COVERAGE ENDS

Your disability coverage will end at the earliest of:

- if you haven't earned enough contributions to achieve Level II or III coverage for the plan year;
- termination of your membership with DGC;
- your 75th birthday; or
- your death.

Keep in mind:

- You will not receive disability payments during any leave of absence (except as required by provincial regulation).
- If you have been on disability leave for more than three months, your *DGC Benefits* coverage will be continued at the minimum level of your default coverage for up to two enrolment cycles.

  However: STD coverage will not be included as part of your guaranteed coverage unless you've worked and earned enough contributions to qualify for Level II or Level III.

Life insurance

DGC Benefits provides life insurance coverage as an important part of ensuring financial protection for your family.

- Coverage levels
- Beneficiaries
- If your coverage level changes
- Coverage reduction at age 80
- When coverage ends

COVERAGE LEVELS

Life insurance coverage for you and your family is based on your coverage level and age limits, as outlined on page 4.

No evidence of insurability is required for coverage under *DGC Benefits*. In other words, you will not be required to provide proof of good health, complete a medical questionnaire or undergo any medical exams.

BENEFICIARIES

You will be the automatic beneficiary of any death benefits paid due to the death of a spouse or eligible dependant child. You can name one or more beneficiary for any benefits paid in the event of your own death. When naming a beneficiary (or beneficiaries), keep the following in mind:

Multiple beneficiaries – If you appoint more than one beneficiary, each will receive an equal share, unless otherwise specified.

Minor beneficiaries – If you name a minor as a beneficiary, they will not have access to any insurance payment until reaching the age of majority – unless you take the necessary legal steps. Those steps vary from province to province. Before naming a minor as your beneficiary, we recommend that you get legal assistance.

If you live in Quebec – If you name your legally married or civil union spouse as your beneficiary, you must check the "revocable" box if you want to be able to change your beneficiary in the future without the consent of your spouse. To change an "irrevocable" designation, you must have the consent of your spouse.

If you do not appoint a beneficiary – Death benefits will be paid to your estate.

IF YOUR COVERAGE LEVEL CHANGES

Keep in mind that life insurance coverage amounts for you and your dependants may change if your coverage level changes. For example, if you move from Level III coverage to Level II coverage, your life insurance coverage will be reduced. If you move to Level I coverage or Basic Coverage, your life insurance coverage will be reduced, and coverage for your dependants will end.

COVERAGE REDUCTION AT AGE 80

If you have Levels I, II, III, Life Member or Enhanced Life Member coverage, or are an International Life Member, your coverage will be reduced automatically to $20,000 when you turn age 80. If you have Basic Coverage, your coverage will remain at $10,000 when you turn age 80.

WHEN COVERAGE ENDS

Coverage for you ends when you are no longer a member in Active Good Standing.

Coverage for your spouse ends when you no longer have Level II or III coverage.

Coverage for a dependant child ends when you no longer have Level II or III coverage, or when that child no longer qualifies as a dependant… whichever comes first.

If you're a Life Member – whether in Canada or internationally – your coverage will continue for as long as you are a DGC member.

Accidental Death & Dismemberment (AD&D)

For most of us, staying out of harm's way is a top priority. But, despite our best efforts, accidents can happen. And when they do, it's good to know that you have some extra protection.

DGC Benefits' accident insurance pays a benefit if you're injured or die because of an accident either on or off the job. Payments are tax-free to your beneficiary and are paid in addition to your life insurance.

- Coverage levels
- What's covered
- What's not covered
- Coverage reduction at age 80
- When coverage ends

COVERAGE LEVELS

AD&D coverage is based on your coverage level and age limits, as outlined on page 4.

No evidence of insurability is required for coverage under *DGC Benefits*. In other words, you will not be required to provide proof of good health, complete a medical questionnaire or undergo any medical exams.

WHAT'S COVERED

The insurer will pay the benefit shown below if you suffer an injury which results in any one of the following specific losses within one year from the date of accident. Only one benefit (the largest) will be paid for a loss with respect to all injuries resulting from one accident.

For loss of		% of coverage
• Thumb and Index Finger of Same Hand • Hearing in One Ear	• Use of Thumb and Index Finger of Same Hand • All Toes of Same Foot	50%
• One Hand or One Foot • Use of One Hand or One Foot	• Entire Sight of One Eye • Four Fingers of Same Hand	75%
• One Arm or One Leg	• Use of One Arm or One Leg	80%
• Life • Entire Sight of Both Eyes • One Hand and One Foot • One Hand and Entire Sight of One Eye	• One Foot and Entire Sight of One Eye • Speech and Hearing in Both Ears • Brain Death • Coma	100%
• Both Arms, Both Hands, Both Legs or Both Feet • Use of Both Arms, Both Hands, Both Legs or Both Feet • Quadriplegia • Paraplegia • Hemiplegia		200%

Other accident benefits

In addition to cash payouts, *DGC Benefits'* accident insurance may also help to cover some costs for the following items. Please contact AGA Benefit Solutions for details on coverage.

- Emergency Transportation
- Home Health Care
- Occupational Retraining
- Spousal Occupational Training
- Repatriation
- Rehabilitation
- Family Transportation
- Alternate Transportation
- Psychological Therapy
- Home Alteration and Vehicle Modification
- Day Care
- Post Secondary Education
- Bereavement
- In-hospital Confinement Monthly Income
- Workplace Modification & Accomodations
- Disability Fitness
- Personal Mobility
- Cosmetic Disfigurement
- Seat Belt & Air Bag
- Occupational HIV
- Occupational Hepatitis
- Critical Disease
- Funeral & Burial
- RESP Contribution
- Parental Care
- Criminal Assault
- Common Carrier
- Identification
- Exposure and Disappearance

WHAT'S NOT COVERED

This policy does not cover loss caused by or resulting from any one or more of the following scenarios, including (but not limited to):

a) Suicide or attempted suicide, or any intentionally self-inflicted injury;

b) Declared or undeclared war;

c) While the insured is on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

d) Death from natural causes;

e) Sickness, disease, or bodily infirmity, whether the loss or claim results directly or indirectly from any of these except as specifically set out in: the critical disease benefit, the occupational HIV benefit, or the occupational hepatitis benefit.

With respect to air travel, this policy includes injuries while riding as a passenger in or on, boarding or alighting from any aircraft not owned or leased by the insured or the policyholder, or a member of the insured'shousehold. Air travel is excluded in the following circumstances:

a) While flying or learning to fly as a pilot, operator, or member of the crew;

b) while being used for any test or experimental purpose;

c) while the insured person is operating, learning to operate or serving as a member of the crew thereof; or

d) while being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Canadian Armed Forces Air Transport Command or

the similar air transport service of any other country; or

e) while being used for firefighting, pipeline inspection, power line inspection, aerial photography or exploration.

COVERAGE REDUCTION AT AGE 80

If you have Levels I, II, III, Life Member or Enhanced Life Member coverage, your coverage will be reduced automatically to $20,000 when you turn age 80. If you have Basic Coverage, your coverage will remain at $10,000 when you turn age 80.

WHEN COVERAGE ENDS

Coverage for you ends when you are no longer a member in Active Good Standing.

If you're a Life Member, your coverage will continue for as long as you are a DGC member.

Critical Illness insurance

Critical Illness insurance helps guard against the financial burden of a serious, life-altering illness. If you're diagnosed with a covered critical illness, you can apply to receive a full lump-sum benefit, which you are then free to use as you see fit.

The benefit can help you cover expenses such as: loss of income, medical costs and care, home modifications, career changes, mortgage or line of credit payments, time off work taken by your spouse during treatment, or transportation costs associated with treatments.

- Coverage levels
- What's covered
- Additional illnesses covered for dependant children
- Partial benefit in case of certain illnesses
- Waiting period
- Living benefits
- Pre-existing conditions
- Cancer recurrence benefit
- Multiple occurrence coverage
- What's not covered
- When coverage ends
- Conversion privilege
- Geographic limitations

COVERAGE LEVELS

Critical Illness coverage for you and your family will be based on your coverage level, as outlined below. Only Level II and Level III coverage are eligible for Critical Illness insurance. Basic Coverage, Level I and Life Members are not covered.

Level II	Level III
Member $25,000 Spouse $5,000 | Dependant Child $2,500	Member $50,000 Spouse $10,000 | Dependant Child $5,000

WHAT'S COVERED

The following critical illnesses are covered – subject to a number of limits, exclusions and definitions outlined in the contract. Please contact AGA Benefit Solutions for more specific policy details.

Each illness must meet certain criteria before a claim can be paid.

For example, if you experience hearing loss, no benefit would be paid unless you have total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The rules for determining whether a particular illness is covered are strictly applied by the insurer, Desjardins Insurance, and in all cases, Desjardins will make the final decision on whether or not a claim is paid. If you do experience a critical illness and have questions about your condition or would like a second opinion, remember that *DGC Benefits* also provides Teladoc Medical Experts service for this advice (see page 52 for details).

These 31 illnesses are covered for Level II and III (member, spouse and child) level coverage.		
Alzheimer's disease Aortic surgery Aplastic anemia Bacterial meningitis Benign brain tumour Blindness Cancer (life-threatening) Coma Coronary artery bypass surgery Deafness Dilated cardiomyopathy	Fulminant viral hepatitis Heart attack Heart valve replacement Kidney failure Liver failure of advanced stage Loss of independent existence Loss of limbs Loss of speech Major organ failure (on waiting list) Major organ transplant Motor neuron disease	Multiple sclerosis Muscular dystrophy Occupational HIV infection Paralysis Parkinson's disease Primary pulmonary hypertension Progressive systemic sclerosis Severe burns Stroke
Level III also includes 7 more covered illnesses for dependant children Cerebral palsy, Congenital heart disease requiring surgery, Cystic fibrosis, Down's syndrome, Serious cerebral lesion, Serious mental deficiency, and Spina bifida cystica		
In addition, the plan provides: Payment of 10% of the amount of insurance (up to $25,000) for Coronary angioplasty, Prostate cancer, Skin cancer or Breast cancer Cancer recurrence Multiple occurrence coverage Conversion privilege		

Alzheimer's disease – a progressive degenerative disease of the brain, resulting in a significant reduction in mental and social functioning, as demonstrated by:

- a loss of intellectual capacity and cognitive functioning;
- impairment of memory and judgement; and
- a need for a minimum of 8 hours of daily supervision.

Aortic surgery – surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Aplastic anemia – a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion. Treatment includes at least one of the following: marrow stimulating agents, immunosuppressive agents, or bone marrow transplantation.

Bacterial meningitis – a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

No benefit will be payable under this condition for viral meningitis.

Benign brain tumour – a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The medical information required must be reported to the Insurer within 6 months of the date of the diagnosis.

Blindness – a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes, or by the field of vision being less than 20 degrees in both eyes.

Cancer (life-threatening) – a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The medical information required must be reported to the Insurer within 6 months of the date of the diagnosis.

Coma – a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 4 days.

No benefit will be payable under this condition for the following: a medically induced coma, a coma which results directly from alcohol or drug use, or a diagnosis of brain death.

Coronary artery bypass surgery – heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

No benefit will be payable under this condition fornon-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

Deafness – the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Dilated cardiomyopathy – a condition of impaired ventricular function resulting in significant physical impairment. Impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Fulminant viral hepatitis – means a definite diagnosis of a submassive to massive necrosis of the liver caused by any virus leading precipitously to liver failure.

No benefit will be payable under this condition for chronic hepatitis or liver failure caused by alcohol, toxins and/or drugs.

Heart attack – the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Heart valve replacement – surgery to replace any heart valve with either a natural or mechanical valve.

No benefit will be payable under this condition for heart valve repair.

Kidney failure – chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

Liver failure of advanced stage – liver failure due to cirrhosis and resulting in permanent jaundice, ascites, and encephalopathy.

No benefit will be payable under this condition for liver disease secondary to alcohol or drug use.

Loss of independent existence – a total inability to perform, by oneself, at least two of the following six Activities of Daily Living or Cognitive Impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of Daily Living

1. Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting – the ability to get on and off the toilet and maintain personal hygiene.

4. Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of Cognitive Impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Loss of limbs – complete severance of two or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation.

Loss of speech – total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

No benefit will be payable under this condition for all psychiatric-related causes.

Major organ failure (on waiting list) – irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, where transplantation is medically necessary.

To qualify, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or in the United States, that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of diagnosis is the date of the Insured Person's enrolment in the transplant centre.

Major organ transplant – irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow.

Motor neuron disease – means one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

Multiple sclerosis – means at least one of the following:

1. two or more separate clinical attacks of the nervous system, confirmed by magnetic resonance imaging (MRI), showing multiple lesions of demyelination; or,
2. well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
3. a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Muscular dystrophy – hereditary muscle disorders in which slow, progressive deterioration occurs, leading to increasing weakness and disability. Diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

Occupational HIV infection – infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV- contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the date coverage began, or the effective date of the last reinstatement of insurance.

Payment under this condition requires satisfaction of all of the following:

1. the accidental injury must be reported to the Insurer within 14 days of the accidental injury;
2. a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
3. a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
4. all HIV tests must be performed by a duly licensed laboratory in Canada or in the United States;
5. the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

No benefit will be payable under this condition if you have elected not to take any available licensed vaccine offering protection against HIV; or a licensed cure for HIV infection has become available prior to the accidental injury; or the HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis – a total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Parkinson's disease – idiopathic and degenerative Parkinson's disease diagnosed by a duly qualified neurologist. The diagnosis must be based on two or more of the following: rigidity, tremors, or bradykinesia.

Primary pulmonary hypertension – primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization), resulting in permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment. Class IV means the inability to engage in any physical activity without discomfort. Symptoms may be present even at rest.

No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

Progressive systemic sclerosis – progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The diagnosis must be unequivocally supported by biopsy and serological evidence.

No benefit will be payable under this condition for localized scleroderma (linear scleroderma or morphea), eosinophilic fasciitis, or CREST syndrome.

Severe burns – third-degree burns over at least 20% of the body surface.

Stroke – an acute cerebrovascular event caused by intra-cranial thrombosis or hæmorrhage, or embolism from an extra-cranial source, with:

1. acute onset of new neurological symptoms; and
2. new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

No benefit will be payable under this condition for transient ischæmic attacks, intracerebral vascular events due to trauma, or lacunar infarctions which do not meet the definition of Stroke as described above.

ADDITIONAL ILLNESSES COVERED FOR DEPENDANT CHILDREN

If you have Level III coverage, your dependant children are covered for the full list of critical illnesses outlined above, plus the following seven additional illnesses.

Cerebral palsy – a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

Congenital heart disease requiring surgery – any serious cardiac malformation present at birth for which corrective surgery has been performed.

Cystic fibrosis – a genetic disease affecting the sweat and mucous glands, particularly in the lungs and digestive system, and characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.

Down's syndrome – a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present.

Serious cerebral lesion – any lesion that is characterized by an invasive development problem or serious intellectual deficiency, that prevents an individual from performing the basic activities of daily living and requires professional specialized services for his treatment, rehabilitation, re-education or schooling on a daily basis.

Serious mental deficiency – a deficiency which, when evaluated through standard testing, demonstrates that an individual has an IQ under 70.

Spina bifida cystica – a congenital defect, diagnosed by a licensed specialist physician, caused by failure of the spine to close properly, allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following: hydrocephalus, paralysis, bowel and bladder problems.

No benefit will be payable under this condition for Spina Bifida Occulta.

PARTIAL BENEFIT IN CASE OF CERTAIN ILLNESSES

If you are diagnosed with of one of the following four illnesses, you may qualify for a benefit equal to 10% of the amount of insurance specified in the Benefit Schedule, up to $25,000.

1. **Coronary angioplasty** – the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.
2. **Ductal carcinoma in situ of the breast** – non-invasive breast cancer originating in the ducts of the breast. The diagnosis must be confirmed by biopsy.
3. **Stage A (T1a or T1b) prostate cancer** – a clinically unapparent malignant tumour localized in the prostate that is neither palpable nor visible by imaging. The diagnosis must be confirmed by pathological examination of prostate tissue.
4. **Stage 1A malignant melanoma** – a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis must be confirmed by biopsy.

WAITING PERIOD

No benefit will be paid if you die within 30 days of being diagnosed with a critical condition.

LIVING BENEFITS

A benefit will be paid to you provided satisfactory medical proof is received within 365 days of your 30-day waiting period ending. The benefit amount will be paid once for covered conditions resulting from the same or related illness or disease. See also "Multiple Occurrence" coverage, below.

PRE-EXISTING CONDITIONS

A pre-existing condition is a condition or symptom(s) that you (or your eligible dependants) experienced within 24 months before your insurance coverage began or was reinstated, for which:

- medical expenses were incurred, treatment was received, drugs or medicine was prescribed or a physician or healthcare practitioner was consulted; or
- an ordinarily prudent person would seek diagnosis, care or treatment.

If you become ill due to a pre-existing medical condition within 24 months of the start of your coverage, no benefits will be payable. Also, keep in mind that if you drop to Level I coverage or Basic Coverage after qualifying for coverage of a pre-existing condition and then later resume coverage under Level II or III, you will once again have to wait two years to re-qualify for coverage of a pre-existing condition.

CANCER RECURRENCE BENEFIT

If you experience a cancer recurrence, the full benefit amount may be paid again. While covered, if you receive a life-threatening Cancer diagnosis after receiving a previous cancer diagnosis, you may be eligible to receive an additional benefit if:

- more than 60 months have passed since the first cancer diagnosis; and
- no treatment relating directly or indirectly to cancer has been received within that 60-month period (treatment does not include preventative medications and follow up visits to the physician).

MULTIPLE OCCURRENCE COVERAGE

With multiple occurrence coverage, if you suffer a critical illness and are then diagnosed with another critical illness, you may be eligible to receive another benefit. Contact AGA Benefit Solutions for details and exclusions.

Sample benefit payments for a $50,000 policy	
Critical illness Phillip has a serious heart attack	**Payment** $50,000
He is later diagnosed with skin cancer	One lifetime payment of $5,000
Shortly thereafter, he finds out he has Parkinson's disease	$50,000
Phillip then has a stroke	$0 Not eligible because a stroke (and other illnesses) is considered related to his heart attack.

WHAT'S NOT COVERED

No benefit is payable for:

1. any critical illness resulting directly or indirectly from:
    - intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane;
    - war, whether declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
    - committing, or attempting to commit a criminal offence;
    - alcohol abuse;
    - the use of any medication narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a physician;
2. any cancer that manifests itself before the insurance coverage starts, when the same cancer either recurs or metastasizes after the insurance coverage began, unless all the requirements of the Cancer Recurrence Benefit have been met; or
3. any critical illness resulting directly or indirectly from a pre-existing condition.

Exclusion period for certain illnesses

No benefit will be payable for certain illnesses if the diagnosis occurs within the first 90 days of the start of the insurance coverage or the last reinstatement of the insurance. Please contact AGA Benefit Solutions for further details.

Note: More details on exclusions and limitations are available from AGA Benefit Solutions.

WHEN COVERAGE ENDS

Your coverage ends when you turn 70 or are no longer a member in Active Good Standing with the Guild… whichever comes first.

Your spouse's coverage ends when your coverage ends or your spouse turns 70… whichever comes first.

Coverage for a dependant child ends when your coverage ends or the child no longer qualifies as a dependant… whichever comes first.

CONVERSION PRIVILEGE

If you have not reached age 70 and lose your Critical Illness coverage under this benefit because you are no longer a member in good standing with DGC, or if you have dropped to Level I coverage or Basic Coverage – you may apply to convert your coverage to an individual critical illness policy within 31 days of cessation or termination, and without evidence of insurability. This privilege does not apply where loss of coverage is due to termination of this policy or benefit.

GEOGRAPHIC LIMITATIONS

If a critical illness is diagnosed outside Canada following an accident or illness, the insurer will only assess the claim once you (or your eligible dependant) have returned to Canada and obtained a medical assessment of the previously made diagnosis.

Teladoc Medical Experts

Teladoc Medical Experts (formerly called *Best Doctors*) allows you or your doctor to connect with world-renowned medical specialists to confirm a diagnosis and treatment plan if you, your spouse, an eligible dependant child, or your parents or parent-in-law who are under your care are faced with a serious illness.

- Services
- What's covered
- When coverage ends

SERVICES

Using this unique service you can:

- get a complete explanation of your medical condition;
- get answers to your questions;
- verify a diagnosis;
- confirm the best treatment options;
- identify the specialists and medical institutions best qualified to meet your medical needs; and
- ensure your treatment is monitored by experts.

For additional detail, you or your doctor can go to the Teladoc Medical Experts website at teladoc.ca/canadalife/ or call 1-877-419-2378. **The policy number is 159947.**

WHEN SHOULD I GET ADVICE FROM TELADOC MEDICAL EXPERTS?

- I see little improvement in my current treatment plan
- My pain won't go away
- I'm looking for a local specialist
- My tests came back, now what?
- I'm considering a surgery
- My diagnosis or chronic pain is affecting my mental health
- I have medical questions and need answers

Note that this service is not insured and limited to persons where their physician has made a diagnosis of a physical or mental illness or condition, either with objective evidence or where it is suspected. Travel and treatment are not covered by this service.

WHEN COVERAGE ENDS

Your coverage ends when you are no longer a member of the *DGC Benefits* health plan, or a member in Active Good Standing with DGC.

Your spouse's, parent's or parent-in-law's coverage ends when your coverage ends. Coverage for a dependant child ends when your coverage ends or the child no longer qualifies as a dependant… whichever comes first.

Consult+ Virtual Healthcare

Consult+ is a virtual physical and mental healthcare service that is available at no additional cost to *DGC Benefits* members in Active Good Standing (Levels I, II, III and Life Member & Enhanced Life Member), including your spouse and dependant children.

Consult+ provides you with 24/7 secure online access to Canadian healthcare professionals on demand. **Get care through your mobile device or computer – when and where you need it.**

These services are especially helpful for those who travel a lot or who work hours that may make it difficult to get – or keep – an appointment with your primary healthcare provider. It's all part of supporting the overall wellbeing of you and your family.

- Services
- Accessing Consult+
- Continuing coverage

SERVICES

You and your eligible family members can register and have **unlimited use** of Consult+ for many of the same things you would usually go to your primary healthcare provider for, including:

- Allergies, colds and flu
- Depression and anxiety
- Skin and eye issues
- …and more

The Consult+ clinicians can provide:

- Diagnoses and advice
- Prescriptions (new and renewals)
- Lab orders
- Specialist referrals

Learn more > Watch the Consult+ demo

Consult+ can be a great addition to your regular healthcare team. With your consent, medical notes from your virtual consults can even be shared with your family doctor. Of course, your medical information will never be shared with *DGC Benefits* or with Canada Life.

ACCESSING CONSULT+

You can enroll yourself and add any eligible dependant family members to get access to **Consult+** care, and it just takes a couple of minutes.

To create your account, have your benefits card handy; you'll need your plan number and member ID.

- Just sign in to *My Canada Life at Work*, select the Benefits plan, then go to Benefits and to *Coverage & Balances,* select *Health* and scroll down to *Other benefits*.
- In *Virtual Healthcare*, click on Consult+ and follow the instructions to *Get Started*.

Get the App: You'll also want to **download the Consult+ app** from **Google Play** or the **Apple App Store** to make it easy to access any time.

If you have dependant family members, use the drop-down box beside your name to select *Family*. Add dependants under age 14 to your account. You can also send an email invite to your spouse and eligible dependants age 14 or over to create their own accounts.

CONTINUING COVERAGE

Your coverage will continue for as long as you remain a member of the *DGC Benefits* health plan (except for Basic Coverage) and are a DGC member in Active Good Standing.

If you are a Life Member or Enhanced Life Member – your coverage will continue as long as you remain a DGC member.

Your spouse's coverage ends when your coverage ends. Coverage for a dependant child ends when your coverage ends, or the child no longer qualifies as a dependant… whichever is first.

Member & Family Assistance Program (MAP) – and more

The Member and Family Assistance Plan (MAP), provided by TELUS Health, is a confidential counselling and referral service available to members who qualify for Basic Coverage or Levels I, II, III, Life Member or Enhanced Life Member coverage. Your spouse and dependant children are also eligible for the MAP's support and services.

The MAP's professional and confidential support and customized resources are available to help you deal with a wide array of personal and work-life issues… before they spiral out of control.

In addition to providing your member and family assistance program, TELUS Health provides you access to online resources and an app – which offers lots of wellbeing tools and perks to motivate, energize and inspire you to be healthy and happy.

- Services
- Accessing TELUS Health's resources
- Continuing coverage

SERVICES

Professional counselling

You can access confidential short-term professional counselling to help you manage:

- **Personal well-being** – this includes dealing with stress, depression, grief, anger, anxiety, aging issues, suicidal risk, abuse, and post-traumatic stress, and abuse.
- **Relationship issues** – such as relationship conflict, separation, divorce, domestic abuse, communications, intimacy issues, and family planning.
- **Family issues** – including issues around parenting, blended families, extended family relationships, single parenting, eldercare and childcare.
- **Addictions** – this includes addictions to alcohol, drugs, smoking, gambling and other addictions.
- **Workplace challenges** – such as workplace conflict, work-related stress, work performance, career planning, retirement planning, workplace violence or harassment, and work-life balance.

Work-life support

Timely professional assistance is available to help you manage life's many complexities.

- **Legal support services** – assistance and support with civil litigation, criminal law, consumer information, separation, divorce, child custody and support, landlord tenant issues, property law, real estate, wills, and estate planning.
- **Family support services** – assistance and support with adoption, daycare, special needs, eldercare, community programs, residential care options, new and expecting parents, and parenting resources.

- **Financial support services** – assistance and support with bankruptcy, credit and debt management, insurance, investment planning, real estate, mortgage, employment transition, retirement, and taxes.
- **Nutritional support** – information on disease state management, healthy eating, weight gain/loss, developing a well-balanced vegetarian diet, regulating diabetes, accommodating shift work, and preventing heart disease.
- **Health coaching** – assistance and support with condition management, health risk reduction, weight management, healthy eating, responsible alcohol use, and stress management.
- **Naturopathic services** – information on physiology, diet, lifestyle, and mental and emotional wellbeing.

Addiction treatment

In addition to other MAP services and support, when a TELUS Health counsellor recommends in/out-patient treatment for alcohol and/or drug addiction, *DGC Benefits* offers financial support, with up to a lifetime maximum of **$10,000 of coverage** for eligible expenses. This benefit is offered for members only. Family members are not eligible for this program.

If you need help, you must start by contacting the TELUS Health Care Access Centre at 1-833-366-1602 (toll free), or through any of their other access options.

Online wellbeing resources

Get tips and tools for everyday life. TELUS Health's online resources makes it easy to find answers to tough questions. Browse hundreds of articles, toolkits, audio recordings and more, based on your interests. There's expert wellbeing content that covers areas related to Family, Health, Life, Money and Work.

> Log in to one.telushealth.com. If you're a first-time user, you will need your invitation to log in – please contact dgcbenefits@dgc.ca to request an email invitation and access code.

Snackable wellbeing

Get daily, bite-sized personalized content from experts, delivered directly to you through the News Feed when you log in to one.telushealth.com or access TELUS Health's One app. Customize your content for your interests, across Body, Mind, Personal Finances, Relationships and Work. If you're a first-time user, you will need your invitation to log in – please contact dgcbenefits@dgc.ca to request an email invitation and access code.

CareNow

Get the flexibility you need to choose your own path when it comes to care – from participating in exercises and taking assessments, to listening to podcasts and watching videos – all focused on positive behavioural change. You have access to a range of programs designed to help with Anxiety, Depression, Stress and more.

> Log in to one.telushealth.com, click on *Care Path* and select *CareNow Programs.* Then scroll to *CareNow.* If you're a first-time user, you will need your invitation to log in – please contact dgcbenefits@dgc.ca to request an email invitation and access code.

Total wellbeing assessment

This easy-to-use assessment helps you understand your strengths and improvement opportunities across the four pillars of wellbeing: Mental, Physical, Social and Financial.

- Understand your current state of health across the four pillars
- Improve your health with personalized wellbeing content and tips
- View your total health score, and then make improvements

> Log in to one.telushealth.com, click *Care Path*, and select *Assessments.* If you're a first-time user, you will need your invitation to log in – please contact dgcbenefits@dgc.ca to request an email invitation and access code.

Perks & Savings

Through TELUS Health, you can save money on daily purchases and other important things in life. Planning a family vacation, doing some shopping, or moving? Exclusive Perks can help you save in every area of your life, and make your money go further with exclusive offers, cashback and gift cards.

> Log in to one.telushealth.com, go to *Perks* and browse the *Cashback* or *Gift Cards* sections. If you're a first-time user, you will need your invitation to log in – please contact dgcbenefits@dgc.ca to request an email invitation and access code.

ACCESSING TELUS HEALTH'S RESOURCES

Choose the option you feel most comfortable with, and get **access** to support and resources.

***IMPORTANT:** Members who are first-time users require an invitation from the DGC to set up a TELUS Health account.

If you cannot find the invitation that was sent to you, please contact dgcbenefits@dgc.ca, and you'll receive a new invitation within 1 business day.

- **Toll-free telephone** – Simply call the confidential TELUS Health Care Access Centre at 1-800-387-4765, at any time, 24/7. Specialists are available to provide crisis counselling and risk assessment, and to guide you to the appropriate services and resources. Specialists are fully bilingual in English and French.
- **Face-to-face** – You can arrange to meet one-on-one with a counsellor. To set up a confidential meeting, call the toll free number.
- **Online** – You have access to one.telushealth.com with all the services listed above, and more.
- **Get the App** – You can download TELUS Health's One app to get fast and easy access to the full range of support and information. Get the app free from **Google Play** or the **App Store**.

CONTINUING COVERAGE

Your access to TELUS Health's services and online resources and app will continue as long as you are a member in Active Good Standing and remain a member of the *DGC Benefits* health plan. Your spouse's coverage ends when your coverage ends. Coverage for a dependant child ends when your coverage ends or the child no longer qualifies as a dependant… whichever comes first.

Confidentiality is key – Any communication you have with a TELUS Health counsellor will be completely confidential (within the limits of the law).

Making claims

It's good to know your *DGC Benefits* plan provides valuable coverage, but to make the most of that coverage, you need to submit your claims – so you can be reimbursed quickly and efficiently.

Here's how…

- Hospital claims
- Prescription drug claims
- Other health and dental claims
- Out-of-province/country health claims
- Making an HSA claim
- Short-Term Disability claims
- Life insurance claims
- Critical illness insurance claims
- Coordinating your claims

HOSPITAL CLAIMS

When you are admitted to hospital, advise the admitting clerk that you are covered under Canada Life, Group Policy number **50553**. The hospital should invoice Canada Life directly.

PRESCRIPTION DRUG CLAIMS

Present your drug card to your pharmacist when you fill your prescriptions. The pharmacist will process your drug claim on the spot. All you pay is the portion that is not covered by the plan.

Did you know? If you have money in your Healthcare Spending Account (HSA), you can submit a claim to your HSA for the portion not covered by the plan.

If you forget or misplace your card, submit your claim online or on paper, using the Healthcare Expenses Statement form. See the "Other health and dental claims" section below for details.

Plan number
When submitting paper claims, you will need to provide the **plan number 50553** and your ID number (which is your DGC member number).

These numbers are on your *DGC Benefits* card from Canada Life. A digital version of this card is available on the mobile app. You can also reprint this card any time from *My Canada Life at Work*.

OTHER HEALTH and DENTAL CLAIMS

Submit your health and dental claims online by logging in to *My Canada Life at Work*. It's quick and easy, and you can usually receive payment within a few days through direct deposit into your bank account.

For dental claims, your dentist may be able to submit your claims on your behalf. Check with your dentist.

If you prefer to use a paper claim form, you can print out a paper copy of the "Healthcare Expenses Statement" or "Dental Expenses Statement" through *My Canada Life at Work*. **The health and dental policy number is 50553.**

If you submit a paper form, attach all original receipts (or the original Explanation of Benefits if you have already submitted this claim under another plan).

Paper forms should be mailed to:

- **For members in Quebec** –
  Canada Life, Benefit Payments Montreal,
  P.O. Box 4592 Station A
  Toronto, ON M5W 0L5
- **For members outside of Quebec** –
  London Benefit Payments
  P.O. Box 5160 Station B
  London, ON N6A 0C6

Whether you submit a claim online or on paper, be sure to:

- Check the box indicating whether you want any unpaid portion of your claim processed through your HSA – assuming you have money in your HSA.
- Keep a copy of the claim form and receipts (and Explanation of Benefits) for your own records.

Keep in mind that non-HSA health claims must be submitted within 18 months of the date the expense occurred (or within 90 days of your final day of coverage under the *DGC Benefits* plan).

EMERGENCY OUT-OF-PROVINCE/COUNTRY MEDICAL CLAIMS

(for Levels II, III, Life Member & Enhanced Life Member)

Make sure you take your Canada Life Travel Assistance or benefits card with you whenever you are travelling outside your home province. **The Travel Assistance policy number is 159947.**

If you or a family member is hospitalized, contact Travel Assistance (Global Excel) within 24 hours of the emergency.

- In Canada or the U.S.: 1-855-222-4051
- From within Cuba: 1-204-946-2946*
- From all other locations: 1-204-946-2577*
- If you use a TTY machine: 1-800-990-6654

*Submit long-distance charges to Canada Life for reimbursement.

The phone number is also on the back of your Travel Assistance or benefits card. (Failure to contact Travel Assistance within 24 hours may jeopardize your coverage.)

In most cases, Global Excel will co-ordinate direct payment of the service with the provider. If you have to pay for a covered medical expense yourself:

- Keep the receipt(s).
- Obtain a fully itemized bill for any hospital treatment.
- Within 30 days of your return home, go to *globalexcel.com/canadalife* and click “Start a Claim”.

Approved claims are paid in Canadian dollars based on the exchange rate in effect when the expense was incurred.

MAKING AN HSA CLAIM

You have three payment options. You can:

1. Pay using your *Health SolutionsPlus* Visa® payment card.
2. Submit your claim online.
3. Submit a paper claim form.

Easy and convenient! The *Health SolutionsPlus* Visa® payment card provides a way to pay for eligible medical/dental products and services using the money in your HSA.

- Simply present your card at the time of your purchase and the money will be drawn automatically from your HSA.
- Keep receipts for purchases made using your card for 12 months.
- Keep your card! Each year, if you transfer money from your dollar bank, your new balance will automatically be put on your card.

Use the card with approved providers only. Keep in mind that your *Health SolutionsPlus* Visa® payment card can be used to make purchases from pharmacies, dentists, vision care centres and paramedical practitioners who are part of Canada Life's approved network. Check with your provider.

CAUTION! Your *Health SolutionsPlus* Visa® payment card may be declined if:

- your purchase is for an amount that is more than you currently have in your HSA,
- the expense is ineligible, or
- your provider is not an approved provider.

Also keep in mind the following:

- **Use your *Health SolutionsPlus* Visa® card** to pay only for expenses not covered under your *DGC Benefits* health and dental plan, such as deductibles and co-payments – otherwise the full amount will be deducted from your HSA.
- **Do NOT use your *Health SolutionsPlus* Visa® card** if you can coordinate your claim through another benefits plan (e.g., your spouse's plan). If you use your card, the entire expense will be deducted from your HSA and you will not be able to coordinate coverage.

You need to activate your card before you can use it. If your card is declined, if you forget your card, or you decide not to use your card, you can submit your HSA claim online by logging in to *My Canada Life at Work*, or submit a paper "Healthcare Expenses Statement". See the instructions in "Other health and dental claims."

- To submit your claim online, follow the easy steps outlined on *My Canada Life at Work*.
- If you submit a paper form, attach all original receipts (or the original Explanation of Benefits if this claim was first submitted under another plan).
- Be sure to keep a copy of your claim form and receipts (and Explanation of Benefits) for your own records.

HSA claims must be received by Canada Life within 180 days following the end of the calendar year in which the expense occurred (or within 90 days of your final day of coverage under *DGC Benefits*).

If you can claim an expense under another plan (such as your spouse's benefits plan), you may want to do that first before submitting your claim under the HSA.

Paper forms should be mailed to:

- **For members in Quebec** –
  Canada Life, Benefit Payments Montreal,
  P.O. Box 4592 Station A
  Toronto, ON M5W 0L5
- **For members outside of Quebec** –
  London Benefit Payments
  P.O Box 5160 Station B
  London, ON N6A 0C6

SHORT-TERM DISABILITY CLAIMS

Contact AGA Benefit Solutions as soon as reasonably possible to begin the claims process. You must apply within 90 days of your disability. As our plan administrator, AGA Benefit Solutions will provide you with the forms you will need, and then support you and work together with Canada Life if needed, to help complete your claim. You can reach AGA Benefit Solutions at 905-477-7088 (or toll free at 1-800-218-7018) or dgc@aga.ca. **The Short-Term Disability policy number is 59307.**

LIFE INSURANCE CLAIMS

Upon your death, your executor, beneficiary or family member should contact AGA Benefit Solutions, the plan administrator, as soon as reasonably possible to obtain the necessary claim forms. **The Life Insurance policy number is 159947.** You can reach AGA Benefit Solutions at 905-477-7088 (or toll free at 1-800-218-7018) or dgc@aga.ca.

CRITICAL ILLNESS INSURANCE CLAIMS

Contact AGA Benefit Solutions, the plan administrator, as soon as reasonably possible to obtain the necessary claim forms. You can reach AGA Benefit Solutions at 905-477-7088 (or toll free at 1-800-218-7018) or dgc@aga.ca.

Claims should be submitted to Desjardins Insurance as soon as possible, but no later than one year following the date you (or a covered family member) are diagnosed with an eligible critical illness. **The Critical Illness policy number is 541477.**

COORDINATING YOUR CLAIMS

If both you and your spouse have health and/or dental coverage under a group benefit program, you can coordinate your claims. In other words, you may be able to claim payment for health or dental expenses under both plans (provided you have Level II, III, Life Member or Enhanced Life Member coverage, which includes family coverage).

- Any personal claims for yourself must be submitted through *DGC Benefits* first. Any unpaid expenses can then be submitted through your spouse's plan.
- Your spouse must submit personal claims through their company plan first. If that plan doesn't cover the full cost of the service or procedure, you can claim the remaining expense through *DGC Benefits.*
- Claims for dependant children should be submitted first to the plan of the parent whose birthday falls earlier in the year. For example, if you were born in March and your spouse was born in July, you would submit claims to *DGC Benefits* first. Again, any uncovered expenses could, in turn, be submitted to your spouse's plan as a secondary payer (assuming your spouse has family coverage).

In situations where you and your spouse are separated or divorced you should make claims for children in the following order:

- the plan of the parent with custody of the child,
- the plan of the spouse of the parent with custody,
- the plan of the parent without custody,
- the plan of the spouse of the parent without custody.

In situations where you belong to two or more different group plans (e.g., you are an employee at two organizations and have coverage at both), your claims should be submitted in the following order:

- the plan where you are an active full-time employee,
- the plan where you are an active part-time employee,
- the plan where you are a retiree.

If you have the same status (i.e., full-time employee, part-time employee, retiree) in two group plans, the order of payment should be:

- the plan where you have had coverage the longest,
- the other plan.

In no case can the total reimbursement you (and your spouse) receive exceed 100% of the actual expenses incurred.

For more information

What…	Where…
How *DGC Benefits* works	Visit the DGC Benefits website (dgcbenefits.ca)
Administrative issues and making claims	Contact AGA Benefit Solutions at: • Phone: 905-477-7088 (toll free at 1-800-218-7018) • Email: dgc@aga.ca
Submit and track claims **Get claim forms**	You can find claim forms and submit and track your health and dental claims online at My Canada Life at Work (my.canadalife.com) If a drug prescribed to you requires prior authorization, apply for coverage approval with CUBIC Health's FACET Prior Authorization program: • Call: 1-844-492-9105 OR • Email: claims@facetprogram.ca
Out-of-province/country medical emergency	If you're travelling and need help, contact Travel Assistance at: • From within Canada and the USA: 1-855-222-4051 • From within Cuba: 1-204-946-2946* • From all other locations: 1-204-946-2577* • If you use a TTY machine: 1-800-990-6654 *Submit long-distance charges to Canada Life for reimbursement. For general questions about coverage: 1-855-729-1839.
Member and Family Assistance Plan (MAP)	Contact TELUS Health at 1-800-387-4765, get the TELUS Health One app, or visit https://one.telushealth.com/ Please note: Members who are first-time users require an invitation from the DGC to set up an account. If you cannot find the invitation that was sent to you, please contact dgcbenefits@dgc.ca, and you'll receive a new invitation within 1 business day.
Addiction treatment	Counselling and financial support for in/out-patient treatment for alcohol and/or drug addiction, with up to a lifetime maximum of $10,000 of coverage for eligible expenses. Call 1-833-366-1602 to speak with a dedicated addiction counsellor.
Consult+ **Virtual Healthcare**	Get virtual healthcare 24/7 – sign up and download the Consult+ app. Go to My Canada Life at Work > Benefits, Coverage & Balances, select Health and scroll down to Other benefits. In Virtual Healthcare, click on Consult+ and follow the instructions to Get Started.
Teladoc Medical Experts (formerly called *Best Doctors*)	Call 1-877-419-2378, or visit their website at teladoc.ca/canadalife/
General DGC information	Contact Jessica Maltez at: • Phone: 416-925-8200, ext. 237 (toll free at 1-888-972-0098) • Email: dgcbenefits@dgc.ca In Quebec, contact Anne Arminjon at: • Phone: 514-844-4084, ext. 104 • Email: beneficesdgc@dgc.ca

Roles and responsibilities

Who does what for DGC Benefits

Who	Their role
DGC Health & Welfare Trustees	• Represented by the President, Vice-President and Secretary/Treasurer of the DGC, District Council representatives and the National Executive Director • Set direction, policy, plan design and priorities • Oversee administration of the plan • Responsible for the financial operations of the Trust
DGC National Office	• Oversee day-to-day operations of the plan • Provide plan information to members and staff • Act as liaison with the DGC Health & Welfare Trust and its providers • Receive and process remittances to the DGC Health & Welfare Trust • Assist members with appeals to the Trust • Process participation and reciprocal agreements
AGA Benefit Solutions	• Administer the plan • Answer questions about your coverage • Request new drug cards/Travel Assistance cards • Update your benefit dependants, beneficiaries, and personal information • Assist you with claim and coverage issues
Canada Life	• Provide health, dental, emergency out-of-province/country medical, life, and STD coverage • Pay claims • Answer detailed questions about your benefits coverage
CUBIC Health	• Administer the FACET Prior Authorization program for complex specialty drugs
Desjardins Insurance	• Provide Critical Illness insurance
Chubb Insurance	• Provide Accident (AD&D) insurance
TELUS Health	• Provide the Member and Family Assistance Plan (MAP)
You	• Submit properly completed claim forms within required time limits • Ensure your personal beneficiary and dependant information is up to date and accurate

Privacy

Your privacy is important to DGC.

All providers maintain elements of your personal information that are necessary for administration of your DGC Benefits plan.

If you have any questions about your personal information or how it's used by the insurer, please contact dgcbenefits@dgc.ca.

The final word

This booklet is intended to provide a reasonable and easy-to-understand summary of *DGC Benefits*, the benefits program provided by the DGC's Health & Welfare Trust. This booklet does not confer any contractual rights or obligations.

- The full provisions of the individual plans are contained in the official plan contracts and policy documents. If there any discrepancies between those official contracts and this guide, the terms of the contracts will apply in all cases. Your right to access plan documents, including your enrolment form, evidence of insurability and the plan contracts, is based on applicable provincial and territorial legislation. Contact *DGC Benefits* to determine your access rights.
- Short Term Disability, Health (excluding Travel Assistance), Dental and the Healthcare Spending Account are self-insured by the Trust. All claims, however, are processed by the applicable insurers.
- Life Insurance, Critical Illness, Accidental Death & Dismemberment (AD&D), Emergency out-of-province/country medical, the Member and Family Assistance Program (MAP) and Teladoc Medical Experts are insured by the applicable insurance companies.
- Legal actions: Any legal action or proceedings you take against an insurer for the recovery of insurance money under the *DGC Benefits* program must be initiated within the time limits set out in applicable provincial and territorial legislation.
- Appeals: You may have the right to appeal a denial of all or part of the insurance or benefits described in the contract or policy. An appeal must be in writing and must include your reasons for believing the denial to be incorrect. Contact dgcbenefits@dgc.ca for information on how to appeal a decision. There are time limits to appeal.
- The DGC Health & Welfare Trust reserves the right to change, amend or terminate the benefits program at any point.