Frequently Asked Questions

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MODULES/COVERAGE SELECTION

1. Can I select a different module for Health and Dental Care?

Yes. You can select a different module for Health and Dental Care.

2. Can I select a different status (single or family coverage) for Health and Dental Care?

No. You can't select a different status for Health and Dental Care.

3. Will I be able to change my Health and Dental Care modules after I have made my selection?

You will not be able to change the modules selected until the next enrolment period, unless you experience a life event. You must keep your selection until the next enrolment period. When you will be able to change your module you can only move up or down one module for each component.

4. Can I change my modules if I experience a life event?

Yes. You have 31 days to make a change, but you can only move up or down one module for each component. Life events are defined in the Decision Guide, which has been posted on the Intranet or is available from your human resources department.

5. Can I change my status from single coverage to family coverage or vice-versa during the enrolment period?

During the enrolment period, you are only electing the module under which you wish to be covered. In order to change your status (single/family), you must meet some conditions. For more information, please consult the Plan Brochure. To complete the action in Workday, please watch the capsule "Adding or Removing Dependants" in the Employee's Toolbox on workday.ia.ca.

6. Can I opt out of Health Care and/or Dental Care, or re-enrol during the enrolment period?

During the enrolment period, you are only electing the module under which you wish to be covered. In order to change your status (single/family), you must meet some conditions. For more information, please consult the Plan Brochure. To complete the action in Workday, please watch the capsule "Adding or Removing Dependants" in the Employee's Toolbox on workday.ia.ca.

7. Am I eligible under option 2 for long-term disability insurance?

If you chose option 1 for long-term disability insurance for the period before January 1st, 2020 and have received benefits in the last 24 months or if you are currently receiving Short Term Disability benefits, you are not eligible under Option 2. You must continue choosing option 1.

If you chose option 2 for long-term disability insurance for the period before January 1st, 2020, you can continue choosing option 2 or change to option 1, regardless of whether you received benefits in the last 24 months.

8. Do I need to submit evidence of insurability to be covered for long-term disability (LTD)?

No evidence of insurability is required:
- for employees who choose option 1, or
- for employees who choose option 2 whose insurable annual salary is less than $231,435.

If you choose option 2 and your insured annual salary is greater than $231,435, you must provide evidence of insurability for the portion of monthly coverage between $10,000 and $15,000 per month.

9. Can I change my LTD coverage before the next enrolment period (January 1, 2021) if I experience a life event?

No. Your choice of LTD coverage cannot under any circumstance be changed prior to the next enrolment period.

10. Can I opt out of Health Care, Dental Care or both (outside the enrolment period)?

Yes you can but only if you have similar coverage under your spouse's plan. You will have to file an exemption request and proof of your coverage through your Workday portal. For more information, please consult the capsule " Changing Benefits - Life Event" in the Employee's Toolbox on workday.ia.ca.If you are single, you must elect both Health Care and Dental Care coverage. If you have dependents, you may opt out of the coverage for yourself and/or your dependents, provided that there is similar coverage available under your spouse's plan. In this case, you may opt out of Health and Dental Care, Health Care only, or Dental Care only. If you opt out of Health and Dental Care for your dependents only, you will be treated as a single person for the coverages under the plan.

11. My spouse has a Health and Dental Care plan. If I opt out of Health Care only or Dental Care only, how does this affect my Health Spending Account (HSA)?

If you opt out of Health Care or Dental Care, or both, you will receive an HSA credit:
- If you opt out of both coverages, the HSA credit will be equal to $350.
- If you opt out of health care only, the HSA credit will be equal to $250. This amount would be added to the HSA credit you would be entitled to from your dental coverage.
- If you opt out of dental care only, the HSA credit will be equal to $100. This amount would be added to the HSA credit you would be entitled to from your health coverage.

12. If I opted out of the plan because I had coverage under my spouse's plan and later decide that I would like to re-enrol in our plan (other than due to a life event), do I have to provide evidence of insurability?

Yes. You must file a request through your Workday portal first. For more information, please consult the capsule "Changing Benefits - Life Event" in the Employee's Toolbox on workday.ia.ca. You must complete the form entitled "Evidence of Insurability" and send it to the Human Resources Department. If enrolment is approved, Dental Care will be subject to a maximum of $100 per insured person for the first 12 months of coverage.

13. What information do I need to keep up to date with Human Resources?

It is important to verify that the information available in your file is up to date at all times. For example, if the student status of your dependents changes or in event of a divorce, it is your responsibility to notify Human Resources. This could have an impact on the cost of your coverage.

14. How long does the premium paid by the employee (the cost per pay, as shown in the Excel Premiums Calculator) remain valid?

The premium will be reviewed after a one-year period. Therefore, the cost per pay, as shown in the Excel Premiums Calculator, is valid from January 1, 2020 to December 31, 2021 (except for changes required upon salary modification).

15. When may I modify my optional life insurance protections?

You may obtain the optional life insurance without evidence of insurability, if you elect it within 31 days of the date you are first eligible to elect the insurance, or if you elect it within 31 days of either of the following events occurring:
- the date on which a spouse qualifies; or
- the date on which you have a new child.

If you elect the optional life insurance at any other time, evidence of insurability will be required.

You can only elect the Dependents' Optional Life Insurance if you elect it within 31 days of the date you are first eligible to elect the insurance, or if you elect it within 31 days of either of the following events:
- the date on which you a spouse qualifies; or
- the date on which you have a new child.

Evidence of insurability will not be required for the Dependents' Optional Life Insurance.

CLAIMS AND COVERAGES

1. How do I submit a claim for Health Care and Dental Care benefits?

Details of the procedure to follow are available on the Intranet or from your human resources department.

2. What do I do about claims incurred before January 1, 2020?

You have 90 days after the end of 2019 to submit claims for reimbursement under the module that was in effect prior to January 1, 2020.

3. Which orthodontic expenses will be covered if I select Module 3?

The covered orthodontic expenses are as follows:

- Oral examination
- Observation and diagnosis
- Cephalometric x-rays
- Diagnostic casts - unmounted
- Removable active appliances for tooth guidance
- Fixed or cemented appliances
- Appliances to control harmful oral habits
- Retention appliances
- Comprehensive treatment

4. I started receiving orthodontic treatment in 2019 when I was covered under Module 2. Will the expenses incurred be eligible for reimbursement if my orthodontic treatment continues in 2020 and I opt for Module 3?

Only the services provided on or after January 1, 2020 will be eligible for reimbursement. Therefore, even if you paid for all the treatment in 2019, the expenses related to services provided in 2020 are eligible for reimbursement. You will, first of all, have to submit to the Claims Department the payment agreement reached with your dentist. As the treatment proceeds, you will have to submit the receipts showing payment corresponding to the period for which you are claiming reimbursement.

5. I have selected Module 3 as of January 1, 2020 and want to begin receiving orthodontic treatment in 2020. What do I have to do?

We suggest you to submit a treatment plan to the Claims Department to make sure that your claim is not declined. After it has been accepted, you have to submit the payment agreement reached with your dentist. Then, as your treatment proceeds, you have to submit the receipts showing payment corresponding to the period for which you are claiming reimbursement.

6. How is the maximum of $2,000 applied for orthodontic care if I select Module 3?

This amount constitutes the lifetime maximum that can be reimbursed for each individual (adult or child) covered under the plan.

7. When do I have to provide a treatment plan to the insurer for dental care?

It is recommended that whenever the cost of the treatment is to be greater than $500, a treatment plan be submitted to the insurer.

8. **How often are expenses for dental cleanings subject to reimbursement?**

   Dental cleanings are covered once every six (6) months, regardless of the module you have selected.

   For example, if you had your last dental cleaning on October 1, 2019, the earliest date for which you can book your next appointment is April 1, 2020, if you want it to be eligible for reimbursement.

9. **Does the modular plan have the "generic drug" provision?**

   Yes. If the drug is a brand name product that has a generic equivalent, the amount payable will be based on the lowest priced similar product. However, if the health care provider who prescribed the drug has included the notation "DO NOT PRODUCT SELECT," "NO SUB," or "NO SUBSTITUTION," the amount payable will be based on the cost of the drug prescribed.

10. **Does the paramedical services maximum apply separately to each covered individual?**

    Yes. The maximum amount is applied separately to each individual covered under your plan.

11. **Is there a limit to the number of trips per year that are covered by trip cancellation insurance under Modules 2 and 3?**

    No. The plan does not limit the number of trips that are covered. However, in the event of a claim, you are reimbursed 100%, up to a maximum of $5,000 per insured person, subject to a limit of four people for the same trip, including yourself.

12. **Does trip cancellation insurance cover lost luggage?**

    No. Expenses associated with lost luggage are not covered.

13. **What is the procedure for submitting a trip cancellation claim?**

    When a covered event such as sickness or death forces you to cancel your trip prior to the date of departure, you have to contact the travel agency or the transportation company within 48 hours of the event in order to cancel your trip. You must also call the Group Insurance Department within the same timeframe at 1 877 422-6487. The insurer will ask you to submit supporting documentation in order to reimburse you for expenses not covered by the travel agency or transportation company. Details are available from your human resources department or in the employee booklet.

14. **What coverage is offered for diagnostic services, preventive care and screening tests?**

    Coverage of diagnostic services includes all the expenses associated with lab tests and medical imaging services (X-rays, scan, ultrasound) that are performed under medical recommendation and used for diagnostic purposes. Diagnostic services are not covered under module 1.

    Coverage of preventive care (prescribed or not prescribed by a doctor) includes expenses incurred for health checkups. A health checkup may include a complete physical examination, identification of personal and family health history, cardiovascular evaluation, a complete blood test and measurement of bone density. Note that a maximum depending on your module is to be applied for health checkups.

    Screening tests are not covered.

15. What coverage is offered for home care insurance?

The coverage offered includes the following services provided by a recognized home care service provider following hospitalization or day surgery which results in a period of convalescence:
- Assistance with basic daily activities;
- Home maintenance;
- Regular maintenance outside the home (snow removal, lawn mowing);
- Preparation of meals;
- Accompanying the insured to medical appointments.

Relief also covers:
- Expenses exceeding those normally incurred for child care, up to a maximum of $25 per day;
- Transportation fees to receive medical care or to attend medical follow-ups, up to three outings per week, for a global maximum of $30 per day.

The services provided by a supplier must be dispensed at your home and the provider must not be a member of your immediate family and must not live with you.

The coverage does not cover the following fees:
- Any expenses incurred while you are able to perform the basic activities of daily living or after your have returned to work;
- Any expenses incurred following a hospitalization for childbirth, except where you remained in hospital for a period of 7 days or more after delivery on the recommendation of the attending physician;
- Any expenses for services that are rendered more than 30 days (module 2) or 40 days (module 3) after you were released from the hospital or underwent day surgery, whichever is applicable.
- Any expenses following a third period of convalescence (or more) in the same calendar year.

16. What preventative vaccines are covered?

All vaccines administered for preventative purposes are covered. They include vaccines that are recommended for travel to certain areas (e.g. vaccines for hepatitis) and influenza vaccines.

17. Is the per visit maximum for massage therapy, acupuncturist, naturopath and osteopath included in the combined maximum for paramedical care coverage?

Yes. Each of your sessions to these specialists will be subject to a maximum per visit, which is determined based on your module selection. These reimbursements are also subject to the combined maximum to which you are entitled for the paramedical care coverage. In addition, you are entitled to a limited number of visits to all these specialists depending on your module.

DIRECT PAYMENT DRUG CARD

1. **Will I receive a new card as at January 1st, 2020 for the change from deferred payment to direct payment?**

   No, the card you currently hold will be used for direct payment starting January 1st, 2020.

2. **Will a Direct Payment Drug Card be sent to each of my registered dependents upon my enrolment in the plan?**

   If you have family coverage, two Direct Payment Drug Card in the primary insured's name will be sent to you. Please refer to question 4 to have more information about how to obtain additional cards.

3. **How are benefits coordinated when both spouses have an extended health care plan?**

   - **For you:**
     The refundable portion of your prescription drug will be automatically paid by your group insurance plan with the Direct Drug Card. Any expenses that are not covered under IA's plan may then be submitted to your spouse's plan.
   - **For your spouse:**
     Your spouse should continue to first submit his or her claims to his or her benefits provider. Any refundable expenses may then be submitted to IA's plan by means of a paper claim.
   - **For your dependent children:**
     If you have dependent children, their claims must first be submitted to the plan of the parent whose birthday comes earlier in the calendar year.

4. **If I lose my Direct Payment Drug Card, what do I have to do to get a replacement one?**

   You can log onto My Client Space (CyberClient) and print a copy of your card or contact the Group Insurance department by email at hr@ia.ca to order one. You should receive your replacement card within ten business days.

5. **Does the Direct Payment Drug Card eliminate the need for paper claims?**

   The Direct Payment Drug Card eliminates the need for paper claims with respect to prescription drugs only. When submitting claims for all other expenses, such as vision care or paramedical expenses, you will still have to submit an electronic or a paper claim form.

HEALTH SPENDING ACCOUNT (HSA)

1. Am I covered under the Company's HSA?

You will be covered under the HSA if you are enrolled in module 1 or 2 for Health Care or Dental Care benefits. If you are eligible to group insurance benefits for permanent employees and opt out of either Health Care or Dental Care or both, you will be covered as well under the HSA.

2. What are the advantages of an HSA?

Your HSA adds significant value to your benefits plan and provides you with many advantages. Your HSA provides you flexibility to cover a much wider range of medical and dental benefits than the coverage you have under the Health Care and Dental Care benefits. In addition, it can provide reimbursement of the premiums paid by you for Health Care and Dental Care and any other medical and dental expenses that are not fully covered.

3. Who is considered an eligible dependent under my HSA?

Eligible dependents include not only your spouse and children but also any other person for whom you claim an eligible tax deduction on your annual income tax return.

4. Do I have a separate HSA for Health and one for Dental, or is it combined?

The HSA is combined for Health and Dental Care and can be used for reimbursement related to health or dental.

5. To what amount of HSA will I be eligible in the year of my enrolment?

The amount deposited in your HSA is pro-rated based on the number of full months of coverage under the plan in the year of your plan enrolment.

6. What types of medical expenses are eligible under my HSA?

All expenses recognized by the Canada Revenue Agency are eligible for reimbursement under the plan, provided that they are not reimbursable under a provincial health insurance plan or any other benefits plan (including your spouse's plan, if applicable). You will find a list of eligible expenses in the Health Spending Account brochure that has been posted on the Intranet or is available from your human resources department.

7. Are laser treatments to stop smoking eligible for reimbursement under the HSA?

If they are recommended by a physician for medical purposes and performed by a medical practitioner, then they will be considered eligible under the HSA.

8. Is my HSA considered a taxable benefit by the Canada Revenue Agency?

The amount credited to the account or reimbursed from the account is taxable **only for those residing in Quebec**. For Quebec residents, the money used to reimburse you for eligible expenses (and the related administration expenses of 4%) is taxable and must be declared in your provincial annual income tax return only. The taxable benefit, if any, will be reflected on the last pay of the year.

9. Can I claim reimbursement of the premiums paid by source deduction for the Health Care and Dental Care benefits?

Yes. You can submit a claim to your HSA for reimbursement of the premiums paid by you for Health Care and Dental Care benefits. The claim can be submitted on a quarterly, semi-annual or annual basis. Please refer to question 16 in this section for information on the procedure to follow.

10. Can I submit my provincial health insurance premium to my HSA for reimbursement?

No. The HSA cannot be used to pay public health insurance premiums. It can only be used to reimburse you for private health insurance premiums.

11. I would like to save my HSA credits to pay for a particular expense. How would I manage this?

If you are contemplating a specific expense, you may carry your HSA balance forward for a maximum of one year. So in the second year, you will have the maximum amount available to assist in the payment of a certain expense.

Example: You decide to have laser eye surgery at a cost of $1,200 in year two. You do not claim against your HSA during the first year. In year two, you proceed with the surgery and submit the expense for reimbursement to the amount that is available in your account. Your account balance will then be $0 until the next year's allocation.

12. Can I carry forward expenses if I have used up my HSA amount for the year in which the expenses were incurred?

The HSA does not allow for expenses incurred in one year to be carried forward into the next calendar year for reimbursement.

13. How will I know the balance of my HSA?

Each time you submit a claim under your HSA, the Explanation of Benefits you receive shows the balance remaining. You can also find your HSA balance through the Member Access site of My Client Space (CyberClient), which you already use to access your other group benefits.

14. Can my health service provider be paid directly from my HSA so that I do not have to pay money out of my pocket?

No. The Canada Revenue Agency stipulates that you – not a service provider – must be the recipient of reimbursement from your HSA.

15. How do I submit a claim under my HSA?

You will have to complete an HSA claim form (Form # F54-383-A), attach a copy of your receipt and submit it the same way you do for a Health or Dental Care claim. You can obtain a copy of the HSA claim form by going to the Intranet or My Client Space (CyberClient) where you will be able to print a copy.

16. How do I submit a claim under my HSA for reimbursement of the premiums paid by source deduction for the Health Care and Dental Care benefits?

To submit a claim:

1. Complete a HSA claim form (available on the Intranet or via My Client Space (CyberClient)).

2. Indicate the premium amount for which you are claiming a reimbursement and specify the corresponding period (e.g. January, February, March 2020). (*Please note that the deducted amount shown on your payroll statement includes all contributions, even the LTD insurance premiums, which cannot be reimbursed from your HSA).*

3. Submit your claim for reimbursement as you would with any other Health or Dental Care claim. No supporting documentation is required, as the amount will be verified at source from your payroll deductions.

17. Can I submit claims dated prior to the opening of my HSA?

No. Only claims for expenses incurred after the HSA effective date and while you were covered as an employee may be submitted for reimbursement.

18. What is the deadline for submitting claims?

You must submit your receipts for any expenses within three months (90 days) of the end of the year in which the expenses were incurred. This means that, by March 31 of each year, you must have submitted your expense claims for the previous year. We strongly recommend that you send in receipts immediately after you incur the expenses.

It is important to note that claims are applied to the HSA balance in the order in which they are submitted. They will be reimbursed first from the amount of your HSA balance that was carried forward from the previous year. This ensures that you do not forfeit the amount carried forward from the previous year at the end of the current year. As expenses incurred one year cannot be reimbursed from the new amount added to your HSA at the beginning of the following year, we recommend that you submit all of your expenses for the previous year before submitting expenses for the current year.

Example: (the example is based on an annual HSA credit of $190)

2019	**December 31:**	You have a balance of $50 in your account.
2020	**January 1:**	The sum of $190 is credited to your account. The total amount is now $240 ($50 + $190).
	June 1:	You incur a claim for $150, which is reimbursed under your HSA.
	December 28:	You incur a claim for $75, but you do not submit it before the end of the year.
	December 31:	You have a balance of $90 in your account.
2021	**January 1:**	The amount of $190 is credited to your account. The total amount is now $280 ($90 + $190).
	January 15:	You incur a claim for $250, and you submit it for reimbursement on January 20. To reimburse the claim, the $90 carried forward from 2018 will be used first. The next $160 of the claim will be reimbursed from the $190 added to the HSA on January 1, 2021.
	February 1:	You submit the claim incurred on December 28, 2020. The claim will not be reimbursed, as the funds from 2020 ($90) have already been used to pay the claim submitted on January 20. The claim cannot be reimbursed from the new amount added on January 1, 2021.

In order for the December 28, 2020 claim to be reimbursed in whole or in part under the HSA, you have to submit it before the January 15, 2021 claim but no later than March 28, 2021.

19. When do I claim from my HSA if I have co-ordination of benefits (i.e. I am covered under my spouse's group benefit plan for Health Care only or for Dental Care only)?

The HSA are designed to complement your current benefit coverages. You must therefore access all other group benefit plans before submitting expenses to your HSA for payment. Once your claims have been processed by both plans, you attach your Explanation of Benefits statements from Industrial Alliance or the other insurance company and submit them with an HSA claim form for the balance that you wish to be paid.

20. If I opted out of coverage for my spouse because he is covered under his employer's plan, can I get reimbursed for his medical expenses (prescription drugs) under the HSA?

Yes. Employees may use the HSA to pay for their spouse's medical expenses. However, such expenses must first be submitted for reimbursement to their spouse's group plan. The portion that was not reimbursed may then be assumed by the HSA (the HSA is the last payor).

21. How do I get reimbursed for HSA claims that I submit?

The reimbursement is deposited directly into your bank account, as it is done currently for your Health and Dental Care benefits.

22. a) What happens to my HSA balance if I change my module selection?

You retain your HSA balance, regardless of the module that you select. The standard rules continue to apply to any amount that constitutes your HSA balance. It will be changed to the amount of your new module combination on January 1 of the year following your change.

b) What happens to my HSA if I change my family coverage to single coverage or vice versa?

You retain your HSA balance, regardless of the coverage, whether it is familial or individual. The standard rules continue to apply to any amount that constitutes your HSA balance. It will be changed to the amount of your new coverage on January 1 of the year following your change.

c) What happens to my HSA if I opt out of Health and Dental Care coverage during the calendar year?

You retain your HSA balance. The standard rules continue to apply to any amount that constitutes your HSA balance. It will be changed to the amount provided for exemption on January 1 of the year following your change.

23. What happens to any HSA amounts that are forfeited at the end of the year?

These amounts are not refundable. The Canada Revenue Agency's regulations governing Health Spending Accounts do not allow employers to pay unused amounts to employees.

24. What happens to my HSA if I terminate my employment?

Your participation in the plan ceases on termination of employment. You have three months following the date of termination to submit claims for eligible expenses incurred prior to the date of your termination.

WELLNESS ACCOUNT (WA)

1. **Am I covered under the Company's WA?**

   You will be covered under the WA if you are eligible to group insurance for permanent employees.

2. **What are the advantages of a WA?**

   The WA allows you to be reimbursed for expenses for physical activities to encourage you to be active and healthy.

3. **Whose claims are eligible to be reimbursed under the WA?**

   You can only submit expenses which have been incurred by yourself. The costs incurred for your dependents are not eligible.

4. **What wellness expenses are eligible for reimbursement under the WA?**
   a) Fitness membership fees (e.g. YMCA, Curves);
   b) Sports leagues and facility fees where the main focus is physical activity (e.g. hockey, tennis);
   c) Registration fees for instructed group exercise classes (e.g. yoga, pilates, Karate, aerobics);
   d) Instruction fees for a physical activity led by a certified instructor (e.g. personal trainers, tennis, skiing, golf lessons);
   e) Season passes or annual membership fees for a physical activity (e.g. ski passes, golf membership fees);
   f) Registration fees for participation in a sporting event that requires training (e.g. foot races, ski races).

   In order to be eligible expenses, the activities must be in line with the program objective which is to encourage continuous and regular physical activity.

5. **Is my WA considered a taxable benefit by the Canada Revenue Agency?**

   Yes, the reimbursed amounts, as well as administration expenses of 4% and related taxes, are taxable. The taxable benefit, if any, will be reflected on the last pay of the year.

6. **Could you give me examples of non eligible expenses:**
   a) Incidental expenses related to the use of an exercise room and a gym (e.g. rental of lockers, towels or meals);
   b) Cost of programs related to weight control, to advice on diet and to stress management;
   c) Daily tickets or entries (e.g., lift tickets for skiing, golf tee, renting a tennis court);
   d) Purchase of physical or sports conditioning equipment;
   e) Clothing;
   f) Video Games & Consoles (e.g. Wii Fit).

7. **How do I submit a claim under my WA?**

   For reimbursement of a claim under the WA, you must submit the Wellness Account claim form duly completed and signed, along with proof of payment of the expense. The claim for reimbursement must be submitted by March 31 of the year following the calendar year in which the expenses were incurred. You must be employed by iA Financial Group on the date on which the expenses were incurred.

8. **What happens to unused credits?**

   Credits must be used from January 1st to December 31st during the year in which they were granted. Unused credits cannot be carried over in into the next year and will be lost.

9. **How do I get reimbursed for WA claims that I submit?**

   The reimbursement is deposited directly into your bank account, as it is done currently for your Health and Dental Care benefits.

10. **To what amount of WA will I be eligible in the year of my enrolment?**

    The amount deposited in your WA is pro-rated based on the number of full months of coverage under the plan in the year of your plan enrolment.

11. **What happens to my WA if I terminate my employment?**

    Your participation in the plan ceases on termination of employment. You have three months following the date of termination to submit claims for eligible expenses incurred prior to the date of your termination.

Can't find an answer to your question here?

Contact to the Group Insurance Department,
indicating that you are insured under group 1000,
at groupinsurance@ia.ca
or call them toll-free at 1-844-268-6400 **option 1**