

My Group Benefits Plan



Retirees

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

BENEFIT DETAILS

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

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

GroupNet for Plan Members

As a Great-West Life plan member, you can register for GroupNet™ for Plan Members at www.greatwestlife.com/register. Follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

GroupNet™ makes it easier to access benefits information from any device, including:

- your benefit details and claims history
- your personal benefit cards
- online claim submission for most of your claims
- extensive health and wellness content

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

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

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

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-800-957-9777.

The information provided in the booklet is intended to summarize the contract provisions of Group Policy No. 163647. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail to the extent permitted by law.

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

The Plan is underwritten by



and arranged by

Jamie Meldrum, Partner
Meldrum Horne & Associates
www.meldrumhorne.com

This booklet was prepared on: April 22, 2019

Access to Documents

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

Legal Actions

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

Appeals

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

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

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

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

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

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

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

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

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

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Benefit Summary

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

Healthcare

Covered expenses will not exceed customary charges

Deductibles

Individual	\$60 each calendar year
Family	\$100 each calendar year

The individual and family deductibles do not apply to In-Canada Hospital, Chronic Care, Global Medical Assistance and Out-of-Country Emergency Care expenses

Reimbursement Levels

In-Canada Hospital, Chronic Care, Global Medical Assistance and Out-of-Country Emergency Care Expenses	100%
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In-Canada Prescription Drug Expenses	80% until \$3,000 in out-of-pocket expenses have been accumulated in a calendar year. After the out-of-pocket maximum has been reached, additional drug expenses in the same calendar year will be payable at 100%
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Physiotherapy Expenses	80% of the first \$500 of covered expenses incurred each calendar year, no coverage for the next \$500 of covered expenses, and 80% of covered expenses in excess of \$1,000 incurred each calendar year
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All Other Expenses	80%
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Out-of-Pocket Maximum for Quebec Residents

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

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

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

Basic Expense Maximums

Hospital	
- Level 1	\$60 per day
- Level 2	\$140 per day
- Level 3	\$220 per day
Home Nursing Care	\$15,000 each calendar year

Chronic Care	\$25 per day
In-Canada Prescription Drugs	Included
Drugs Used To Treat	
Erectile Dysfunction	\$500 each calendar year
Smoking Cessation Products	\$1,000 lifetime
Hearing Aids	\$1,000 every 5 years. This maximum does not apply if hearing aids are required as a direct result of surgery or an accident and are purchased within 6 months of the surgery or accident
Insulin Infusion Pumps	1 every 5 years
Insulin Jet Injectors	\$760 every 36 months
Incontinence Supplies	
- Enuresis Monitors	1 lifetime
- All Other Supplies	Included
Continuous Positive Airway Pressure (CPAP) Machines & Related Dental Sleep Apnea Appliances	1 every 5 years
Chest Percussors	1 every 5 years
Sputum Stands (Maximists)	1 every 5 years
Custom-fitted Orthopedic Shoes	\$150 each calendar year
Custom-made Foot Orthotics	1 pair each calendar year
Permanent Artificial Limbs	
- Dependents under age 22	1 every 12 months
- All Others	1 every 5 years
Myoelectric Arms	\$10,000 per prosthesis
External Breast Prosthesis	1 every 24 months
Surgical Brassieres	\$200 each calendar year
Walkers	1 every 5 years
Mechanical or Hydraulic Patient Lifters	1 lifetime
Wheelchairs	1 every 5 years
Accessories and repairs for covered wheelchairs	1 every 5 years
Roho Cushions	1 every 12 months
Hospital Beds	1 lifetime

Therapeutic Mattresses	1 every 5 years
Traction Kits	1 lifetime
Blood-glucose Monitoring Machines	1 every 5 years
Continuous Glucose Monitoring Machines Including Sensors and Transmitters	\$4,000 each calendar year
Transcutaneous Nerve Stimulators	1 every 10 years
Extremity Pumps for Lymphedema	1 lifetime
Custom-made Compression Hose/ Elastic Stockings	Included
Wigs for total hair loss due to an illness	\$1,000 every 5 years

Paramedical Expense Maximums

Acupuncture Treatments	Included
Chiropractors	\$500 each calendar year
Electrologists	\$20 per visit
Massage Therapists*	\$300 each calendar year
Naturopaths/Naturopathists	\$300 combined each calendar year
Osteopaths	\$300 each calendar year
Physiotherapists*	Included
Podiatrists	\$300 each calendar year
Psychologists/Social Workers*	\$1,000 each calendar year
Speech Therapists*	\$500 each calendar year

For Massage Therapists, Psychologists, Social Workers, Speech Therapists and Physiotherapists, a physician's prescription is required and is valid for 1 year

Visioncare Expense Maximums

Eye Examinations	1 every 2 calendar years
Glasses and Contact Lenses	\$275 every 2 calendar years

Out-Of-Country Care Maximums

Emergency Care Expenses
- Employees required to travel
on "official travel status" for
government business

Are covered for emergency
medical care and emergency
travel assistance services
during the entire period of
"official travel status" to a
maximum of \$500,000 per trip
40 days per trip to a
maximum of \$500,000 per trip

- All Others

Non-Emergency (Referral) Care
Expenses

\$25,000 per illness or injury

Lifetime Healthcare Maximum

Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered.
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Deductibles

Individual	\$15 each calendar year
Family	\$30 each calendar year

The individual and family deductibles do not apply to Accidental Dental Injury expenses

Reimbursement Levels

Basic Coverage	100%
Major Coverage	60%
Orthodontic Coverage	50%
Accidental Dental Injury Coverage	100%

Plan Maximums

Accidental Dental Injury Treatment	Unlimited
Orthodontic Treatment	\$3,000 lifetime
All Other Treatment	\$1,200 each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your retirement begins.

A retired employee is defined as a pensioner and is insurable if:

1. he is in receipt of a pension, pursuant to the Acts applicable to the Public Service and the Public Service Superannuation Act; and
2. he was insured under the employer's benefit program the day before he retired.

Coverage is continuous for retired employees who were members of the Government of Nunavut Health Care Plan immediately before retirement and who are entitled to an immediate annuity or an annual allowance on retirement date. Employees who defer their pension to age 60 have access to the benefits once they are in receipt of a monthly pension benefit.

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

You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 60 days of loss of such coverage, or you were previously declined for coverage by Great-West Life, you and your dependents may be required to provide evidence of insurability acceptable to Great-West Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

Your coverage terminates when you are no longer eligible or the policy terminates, whichever is earlier.

- Your dependents' coverage terminates when your insurance terminates or your dependent no longer qualifies, whichever is earlier.
- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your employer will provide you with details.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will continue until they no longer qualify. Coverage is provided as long as the request is received within 60 days of the member's death.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

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

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

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

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

BENEFICIARY DESIGNATION

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

HEALTHCARE

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

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

Covered Expenses

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

- Room and board in a hospital or government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care.
 - Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.
 - Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.
 - Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

Room and board in an out-of-province hospital is covered when the treatment received is acute, convalescent or palliative care. For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is also covered.

The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in your home province.

Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada and prescribed by a physician. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse. The physician's prescription must be renewed every 12 months.

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

- Chronic care, provided in a hospital, nursing home or for home nursing care in Canada, for a condition where improvement or deterioration is unlikely within the next 12 months
- Drugs and drug supplies described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care provision.
 - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives and contraceptive patches.
 - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered. Specialised formulas for infants with a confirmed intolerance to bovine and soy protein are also covered.
 - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips, and sensors for flash glucose monitoring machines
 - Extemporaneous preparations or compounds if one of the ingredients is a covered drug
 - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

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

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

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician
- Custom-made foot orthotics when prescribed by a physician or podiatrist. A new prescription is required every 3 years
- Custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician or podiatrist. A new prescription is required every 12 months
- Hearing aids, including tubing and ear molds provided at the time of purchase, when prescribed by a physician
- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs
- Blood-glucose monitoring machines prescribed by a physician
- Flash glucose monitoring machines prescribed by a physician
- Continuous glucose monitoring machines prescribed by a physician, including sensors and transmitters
- External insulin infusion pumps prescribed by a physician
- Needleless insulin jet injectors prescribed by a physician
- Intrauterine devices (IUDs)

- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under his or her provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under his or her provincial government plan
- Out-of-hospital acupuncture services performed by a physician
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a certified electrologist (or physician providing similar treatment) for the removal of excessive hair from exposed areas of the face and neck if you suffer from severe emotional trauma because of this condition. When services are provided by an electrologist, a prescription by a psychologist or psychiatrist is required every 3 years
- Out-of-hospital services of a qualified massage therapist when prescribed by a physician. A new prescription is required every 12 months
- Out-of-hospital services of a licensed naturopath or naturotherapist
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist when prescribed by a physician. A new prescription is required every 12 months
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist

- Out-of-hospital treatment by a registered psychologist when prescribed by a physician. A new prescription is required every 12 months. If you live in an isolated post and no psychologist practices in that isolated post, services of a social worker will be covered in place of a psychologist
- Out-of-hospital treatment of speech impairments by a qualified speech therapist when prescribed by a physician. A new prescription is required every 12 months

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

Global Medical Assistance Program

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

- On-site hospital payment when required for admission, to a maximum of \$1,000
- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

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

- Benefits described below, to a combined maximum of \$2,500 for any one travel emergency:
- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings and meals up to \$ 150 per day and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings and meals for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of \$ 150 per day

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation
- In case of death, preparation and transportation of the deceased home, to a maximum of \$3,000
- Return transportation home for minor children under age 16 travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of \$1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

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

Out-Of-Country Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

- the amount payable under this plan for continued treatment outside Canada, and
- the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

No benefits are paid for:

- any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency
- any subsequent and related episodes during the same absence from Canada
- expenses related to pregnancy and delivery, including infant care:

- after the 34th week of pregnancy, or
 - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.
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- expenses incurred more than 40 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 40-day period, benefits will be extended to the end of the confinement. This limitation does not apply to employees who are on official travel status.
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- **Non-emergency care** outside Canada is covered for you and your dependents if:
 - it is required as a result of a referral from your usual Canadian physician
 - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties
 - you are covered by the government health plan in your home province for a portion of the cost, and
 - a pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

No benefits will be paid for:

- investigational or experimental treatment
- transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

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

Limitations

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

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance coverage

- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

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

- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
 - treatment performed only for cosmetic purposes
 - recreation or sports rather than with other daily living activities
 - the diagnosis or treatment of infertility, other than drugs
 - contraception, other than oral contraceptives, intrauterine devices (IUDs) and contraceptive patches
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province

This limitation does not apply to Global Medical Assistance

- Expenses arising from war, insurrection, or voluntary participation in a riot
- Visioncare services and supplies required by an employer as a condition of employment

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas (unless the child is lactose and soy protein intolerant) or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

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

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

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

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

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

How to Make a Claim

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

Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

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

Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-800-957-9777.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after you incur the expense.

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

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your employer. Complete this form making sure it shows all required information.

Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 12 months after you incur the expense.

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

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

When your coverage ends, return your direct pay drug identification card to your employer.

DENTALCARE

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

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

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

Treatment Plan

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

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
 - one complete oral examination every 36 months
 - limited oral examinations once every 9 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
 - limited periodontal examinations once every 9 months
 - complete series of x-rays every 36 months
 - intra-oral x-rays, except bitewing x-rays, to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
 - intra-oral bitewing x-rays once every 12 months
- Preventive services including:
 - polishing, limited to 1 time unit every 9 months
 - topical application of fluoride once every 9 months
 - scaling, limited to a maximum combined with periodontal root planing of 8 time units every 12 months

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

 - oral hygiene instruction once in a person's lifetime
 - pit and fissure sealants on permanent molars for children under age 15, once every 60 months

- space maintainers including appliances for the control of harmful habits
- finishing restorations
- interproximal diskings
- recontouring of teeth
- Minor restorative services including:
 - caries, trauma, and pain control
 - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 3 years old or the existing filling was not covered under this plan
 - retentive pins and prefabricated posts for fillings
 - prefabricated crowns for primary teeth
 - inlays. If inlays are provided, benefits will be based on coverage for fillings
- Endodontics, including:
 - root canal therapy for permanent teeth, limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months.
 - chemical bleaching of an endodontically-treated tooth

- Periodontal services including:
 - root planing, limited to a maximum combined with preventive scaling of 8 time units every 12 months. No benefits are paid for root planing done at the same time as gingival curettage
 - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

 - temporomandibular joint appliances
- Denture maintenance, including:
 - denture remakes, once every 36 months
 - denture relines for dentures at least 6 months old, once every 36 months
 - denture rebases for dentures at least 2 years old, once every 36 months
 - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
 - denture repairs and additions, tissue conditioning and resetting of denture teeth after the 3-month post-insertion care period has elapsed
 - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
 - denture cleaning and polishing, once every 9 months
- Oral surgery
- Adjunctive services

Major Coverage

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays

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

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
 - the existing appliance is a covered temporary appliance
 - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.
- If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth
- Denture-related surgical services for remodelling and recontouring oral tissues

- Appliance maintenance following the 3-month post-insertion period including:
 - repairs to covered bridgework
 - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for children age 6 to 18 when treatment starts

Accidental Dental Injury Coverage

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

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

Limitations

If you do not apply for dentalcare coverage within 60 days after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic Coverage expenses are limited to \$100 during the first 12 months of your coverage
- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage
- No benefits will be paid for Orthodontic Coverage expenses during the first 24 months of your coverage

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, services performed to remodel or recontour oral tissues (other than minor alveoplasty, gingivoplasty and stomatoplasty) and alveoplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

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

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

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

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

- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident (or, in the case of a dependent child under age 17, before reaching age 18), denture repair or replacement, or any orthodontic services
- Expenses private plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

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

Online claims must be submitted to Great-West Life as soon as possible, but no later than 6 months after the dental treatment.

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

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 12 months after the dental treatment.

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.
- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:
 1. the plan of the parent with custody of the child;
 2. the plan of the spouse of the parent with custody of the child;
 3. the plan of the parent without custody of the child;
 4. the plan of the spouse of the parent without custody of the child

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