

My Group Benefits Plan



**ARKAY CONTRACTING
LTD.**

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
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at www.greatwestlife.com. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

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

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Healthcare and Dentalcare sections of this booklet
- extensive health and wellness content

Using our GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

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

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain 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.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 158683** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail.

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

Michael Ramage
Ramage Benefits
(604) 375-6541
mike@ramagebenefits.com

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 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.

Employee Life Insurance	\$25,000, reducing by 50% at age 65
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Employee Accidental Death, Dismemberment and Specific Loss (Principal Sum)	An amount equal to your Life Insurance
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Employee Critical Illness Insurance	\$10,000
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Dependent Critical Illness Insurance

Spouse	\$10,000
Child	\$5,000

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
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Reimbursement Levels

In-Canada Prescription Drug Expenses	80%
All Other Expenses	100%

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	\$10,000 for a maximum of 12 months per condition
In-Canada Prescription Drugs	Included
Hearing Aids	\$500 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	\$300 every 12 months
Myoelectric Arms	\$10,000 per prosthesis
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 every 12 months
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines	1 every 4 years
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	\$250 each calendar year
Wigs for Cancer Patients	\$500 lifetime

Paramedical Expense Maximums

Chiropractors	\$500 each calendar year
Physiotherapists	\$500 each calendar year
Podiatrists	\$500 each calendar year
Chiropodists	\$500 each calendar year
Naturopaths	\$500 each calendar year
Osteopaths	\$500 each calendar year
Psychologists/Social Workers	\$500 each calendar year
Speech Therapists	\$500 each calendar year
Massage Therapists	\$500 each calendar year
Acupuncturists	\$500 each calendar year
Audiologists	\$500 each calendar year

Visioncare Expense Maximums

Eye Examinations	
- Dependent children under age 21	1 every 12 months
- All others	1 every 24 months

Lifetime Healthcare Maximum Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis The dental fee guide in effect
in your province of residence
on the date treatment is
rendered

Deductible Nil

Reimbursement Levels

Basic Coverage	80%
Major Coverage	50%
Orthodontic Coverage	50%
Accidental Dental Injury Coverage	100%

Plan Maximums

Accidental Dental Injury Treatment	Unlimited
Orthodontic Treatment	\$1,500 lifetime
All Other Treatment	\$1,500 each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 3 months of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide evidence of insurability for you and your dependents before you can participate.
- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

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

- Temporary, part-time and seasonal employees may not join the plan.

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

- 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 be continued for a period of 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

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

Children under 15 days are not covered for critical illness insurance.

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. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

EMPLOYEE LIFE INSURANCE

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

- Your life insurance terminates when you reach age 70.
- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.
- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

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

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

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

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

Loss	Amount Payable
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use

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

Your AD&D insurance terminates when you reach age 70.

Surgical Reattachment

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

Repatriation

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

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Great-West Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death, or he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrolls as a full-time student at a post-secondary institution within 365 days after the accident.

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

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

Family Transportation Benefit

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

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

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

Occupational Training Benefit for Spouses

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

Great-West Life will pay up to 10% of the Principal Sum, or \$10,000, whichever is less.

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

Educational Benefit

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

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

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Great-West Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

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

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

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

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

Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment, except surgical reattachment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

- To claim benefits for yourself, ask your employer for a claim form. Complete it and return it to your employer.
- If you die accidentally, your employer will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

CRITICAL ILLNESS INSURANCE

If you or your dependent is diagnosed with one of the illnesses defined below while insured, Great-West Life will pay you the critical illness insurance benefit. Check the **Benefit Summary** for the amount. The benefit is payable after a waiting period of 30 days following the date of diagnosis or at the end of the waiting period, if any, specified for the condition below, whichever is longer. In addition to this benefit, provided it is \$10,000 or more, Great-West Life will make a \$500 donation in your name to a registered charitable organization of your choice.

Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person.

Your critical illness insurance terminates when you reach age 65.

Covered Illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a physician practicing medicine in Canada or the United States who is recognized by the physician's medical licensing body as a specialist in the field of medicine relating to the applicable critical illness. The diagnosis must be supported by objective medical evidence.

- **"heart attack"** – means 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.

No benefits will be paid under this condition for:

- elevated biochemical cardiac markers after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

- **"stroke"** – means an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extracranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

No benefits will be paid under this condition for:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

- **"coronary artery bypass surgery"** – means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"cancer (life-threatening)"** – means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

No benefits will be paid under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of the policy, the term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer exclusion period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

- **"kidney failure"** – means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.
- **"blindness"** – means 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
 - the field of vision being less than 20 degrees in both eyes.
- **"major organ transplant"** – means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

- **"dementia, including Alzheimer's disease"** – means dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:
 - aphasia (a disorder of speech);
 - apraxia (difficulty performing familiar tasks);
 - agnosia (difficulty recognizing objects); or
 - disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive deterioration in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

- **"Parkinson's Disease and Specified Atypical Parkinsonian Disorders"** – Parkinson's Disease means primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:
 - muscular rigidity; or
 - rest tremor.

The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

No benefits will be paid under this condition for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

- **"paralysis"** – means 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.

- **"multiple sclerosis"** – means at least one of the following:
 - two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
 - well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
 - 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.

- **"deafness"** – means 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 3000 hertz.

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

No benefits will be paid under this condition for all psychiatric related causes.

- **"coma"** – means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

No benefits will be paid under this condition for a medically induced coma.

- **"severe burns"** – means third degree burns over at least 20% of the body surface.

- **"aortic surgery"** – means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"benign brain tumour"** – means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

Benign brain tumour exclusion period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Great-West Life within six months of the date of the diagnosis. If this information is not provided within this period, Great-West Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

- **"heart valve replacement or repair"** – means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

- **"loss of independent existence"** – means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
 - dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
 - toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
 - 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;
 - transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
 - feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.
- **"loss of limbs"** – means the 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.

- **"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.
- **"occupational HIV infection"** – means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person's effective date of insurance or, for an increase, the effective date of the increase.

Payment under this condition requires satisfaction of all the following:

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

No benefits will be paid under this condition if:

- the person has 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.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

- **"bacterial meningitis"** – means 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 benefits will be paid under this condition for viral meningitis.

- **"aplastic anaemia"** – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:
 - marrow stimulating agents;
 - immunosuppressive agents; or
 - bone marrow transplantation.

Limitations

No benefits are paid for:

- a critical illness that is directly or indirectly related to a condition for which you or your dependent received medical care within 24 months before your insurance started. This limitation does not apply:
 - if the illness is diagnosed after you or your dependent has been continuously insured for 24 months, or
 - to any amounts of insurance for which evidence of insurability is required.
- a critical illness resulting directly or indirectly from or associated with any of the following:
 - intentionally self-inflicted injury, or attempt at suicide, while sane or insane
 - war, insurrection or voluntary participation in a riot
 - participation in a criminal offence or provoking an assault

- use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
- operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

How to Make a Claim

- To claim benefits, obtain a claim form at the Great-West Life website **www.greatwestlife.com**. Complete it and return it to the address shown on the form.
- Claims should be submitted as soon as possible, but no later than 3 months after the end of the benefit payment waiting period or 3 months after the plan terminates, whichever is earlier.

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.

Except to the extent otherwise required by law, your healthcare coverage terminates when you reach age 70.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Semi-private room and board in a hospital or the 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.

Semi-private 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. 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

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

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision.
 - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug
 - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered
 - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips

- Extemporaneous preparations or compounds if one of the ingredients is a covered drug
- Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

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

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

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician
- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician
- 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
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

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

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

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

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

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to \$1,500 and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of \$1,500

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

Out-Of-Country Emergency Care

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

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

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

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

Other Services and Supplies

Great-West Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Limitations

Great-West Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Great-West Life.

Great-West Life can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

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

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

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

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
 - treatment performed only for cosmetic purposes
 - recreation or sports rather than with other daily living activities
 - the diagnosis or treatment of infertility
 - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by Great-West Life to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and 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
- Chronic care
- Eye examinations 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 or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Fertility drugs
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction

Prior Authorization

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

These services and supplies, including a listing of the prior authorization drugs, can be found on the Great-West Life website as follows:

http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

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

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

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Great-West Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

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

Health Case Management Expense Benefit

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

Designated Provider Limitation

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

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

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

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

How to Make a Claim

- **Out-of-country claims (other than 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 15 months after you incur the expense.

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

Before your prescription is filled, 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.

PREFERRED VISION SERVICES (PVS)

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network provider.

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program
- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed
- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

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.

Your dentalcare coverage terminates when you reach age 70.

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 twice every 12 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 twice every 12 months
 - complete series of x-rays every 36 months
 - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
 - polishing and topical application of fluoride each twice every 12 months
 - scaling, limited to a maximum combined with periodontal root planing of 10 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 bicuspid and permanent molars every 60 months
 - space maintainers including appliances for the control of harmful habits
 - finishing restorations

- interproximal disking
- recontouring of teeth
- Minor restorative services including:
 - caries, trauma, and pain control
 - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
 - retentive pins and prefabricated posts for fillings
 - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
 - root planing, limited to a maximum combined with preventive scaling of 10 time units every 12 months
 - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

- Denture maintenance, including:
 - denture relines for dentures at least 6 months old, once every 36 months
 - denture rebases for dentures at least 2 years old, once every 36 months
 - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
- Oral surgery
- Adjunctive services

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 required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only 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 while the person is covered and 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
- Denture and bridgework maintenance following the 3-month post-insertion period including:
 - denture remakes, once every 36 months
 - denture adjustments, once every 12 months
 - denture repairs and additions, tissue conditioning and resetting of denture teeth
 - repairs to covered bridgework
 - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over 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 dental care coverage within one month 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, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. 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, 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, except orthodontics
- 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 15 months after the dental treatment.

COORDINATION OF BENEFITS

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

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

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

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

You, your dependents and your and your dependent's physician can access this service if the physician has made a diagnosis of a serious physical illness or condition for which there is objective evidence, or if the covered person or his or her physician suspects that the person has this illness or condition. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the covered person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.
- If the covered person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet his or her specific medical needs. Expenses incurred for travel and treatment are not covered by this service.
- If the covered person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.
- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.