

GROUP BENEFIT PLAN

FOR

**HAMILTON-WENTWORTH
DISTRICT SCHOOL BOARD**

SECONDARY TEACHERS

BENEFIT DETAILS

This booklet describes the principal features of the group benefit plan sponsored by Hamilton-Wentworth District School Board and insured by Great-West Life under Group Policy No. 136993. Although every attempt has been made to ensure the accuracy of the information provided in this booklet, if there are variations between the information in this booklet and the provisions of the Policy, the Policy will prevail.

PROTECTING YOUR PERSONAL INFORMATION

Great-West Life recognizes and respects every individual's right to privacy. When you apply for coverage or benefits, we establish a confidential file of personal information.

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- 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 limit access to 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. Great-West Life, your health care provider, other insurance and reinsurance companies, and your plan administrator may also exchange information when the information is needed to administer the Group Benefit Plan.

For more information about our privacy guidelines, please ask for Great-West Life's ***Privacy Guidelines*** brochure.

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BENEFIT SUMMARY

The following briefly highlights the Group Benefits covered and should be read in conjunction with the Group Benefit Plan details provided in this booklet. Your **BENEFIT YEAR** runs from September 1st to August 31st of each year.

BASIC EMPLOYEE LIFE INSURANCE: \$50,000

OPTIONAL EMPLOYEE LIFE INSURANCE: Units of \$25,000 to a maximum of \$150,000.

OPTIONAL DEPENDENT LIFE INSURANCE:

Spouse	\$25,000
Each Child	\$10,000

SEMI-PRIVATE HOSPITAL ROOM: 100% reimbursement on an unlimited basis.

EXTENDED HEALTH CARE:

Deductible:

Employee	Applicable only to the Drug Benefit
Dependents	\$10 per Benefit Year.

\$10 per Benefit Year for a total family deductible of \$20 per Benefit Year.

Reimbursement:

100% reimbursement of eligible expenses on a reasonable and customary basis up to the stated maximums. Where no maximum is stated, coverage is on an unlimited basis.

Overall Benefit Maximum:

In Canada	Unlimited.
Out-of-Canada Expenses:	Limited to \$500,000 lifetime per covered person.

Covered Expenses:

Include prescription drugs, diabetic supplies, vision care, hearing aids, named paramedical practitioners, ambulance, private duty nursing, orthotics, orthopaedic shoes, private room hospital accommodation, breathing equipment, mobility aids and certain other medical supplies and services. Please refer to the details in the Extended Health Care Section of this booklet.

Extended Health Care Maximums

The following maximums are ***per covered person***:

Convalescent Care	\$3 each day for 120 days
Nursing	\$10,000 every 36 months
In-Canada Prescription Drugs	The covered expense for the dispensing fee portion of a prescription drug charge is limited to \$7 (this dispensing fee maximum does not apply to diabetic supplies)
Smoking Cessation Products	\$200 lifetime
Drugs to Treat Erectile Dysfunction	\$1,000 each Benefit Year
Fertility Drugs	one 12-month period (\$5000 Life time)
Hearing Aids	\$500 every 5 years
Custom-made Foot Orthotics/ Custom-fitted Orthopaedic Shoes	\$750 max every 24 months eff. July 1, 2005
Myoelectric Arms	Limited to cost of standard type
External Breast Prosthesis	1 each Benefit Year
Surgical Brassieres	2 every Benefit Year
Custom-made Compression Hose	4 pairs each Benefit Year
Out-Of-Country Expenses	\$500,000 lifetime
Paramedical Expense Maximum	
Chiropractors	20 visits each Benefit Year
Osteopaths	20 visits each Benefit Year
Naturopaths	20 visits each Benefit Year
Physiotherapists	Unlimited
Podiatrists	20 visits each Benefit Year
Psychologists	\$200 each Benefit Year
Speech Therapists	\$200 each Benefit Year
Massage Therapists	\$20 per visit to a maximum of \$225 each Benefit Year –effective July 1, 2005
Visioncare Expense Maximum	
Glasses and Contact Lenses	\$250 every 2 Benefit Years Effective Sept 1, 2005 \$300 including laser eye surgery

DENTAL CARE:

Deductible: Nil

Reimbursement: Based on the Dental Fee Guide in effect in your Province of residence one (1) year prior to the date treatment is rendered – effective Sept 1, 2007 current year fee guide.

Basic Treatment:	100%
Endodontic and Periodontal Treatment:	75%
Major Treatment:	75%
Orthodontic Treatment:	50%
Accidental Dental Injury:	100%

Maximums:

Basic Treatment:	Unlimited
Endodontic and Periodontal Treatment:	Unlimited
Major Treatment:	\$2,000 per person each calendar year
Orthodontic Treatment:	\$2,000 per person lifetime
Accidental Dental Injury:	Unlimited

GENERAL INFORMATION

COMMENCEMENT AND TERMINATION OF COVERAGE

If you are under age 65, you are eligible to participate in the Benefit Plan on your date of employment for all benefits except Dental Care. You are eligible to participate in the Dental Care Benefit on the first of the month coinciding with or immediately following your date of employment. In order for your coverage to be effective, you must:

- apply for coverage by completing an application form no later than 31 days after your date of employment.
- be actively at work when coverage takes effect.

Commencement of Your Coverage

Your coverage will be effective on the first day you are eligible provided you have applied for coverage within 31 days of your date of employment and are actively at work on that day.

If you apply for coverage more than 31 days after you are first eligible, you must provide satisfactory evidence of your insurability by completing a Statement of Health and submitting it to the insurance company. Your coverage will not be effective until it is approved by the insurance company.

If you are not actively at work when your benefit coverage should commence, your coverage will not become effective until you return to active work. Actively working includes being on a paid leave of absence such as vacation or on a teaching exchange but excludes any disability leave of absence.

Termination of Your Coverage

Your coverage terminates on the earliest of the following dates:

- the date your employment ends
- the day you are no longer eligible for coverage
- the date you stop paying the required premiums
- the end of the school year in which you turn age 65
- for Optional Employee Life Insurance and Optional Dependent Life Insurance, the date you retire¹

¹ If you retire at the end of June in any year, benefit coverage as an active employee continues for July and August of that year. You are eligible for Retiree Benefits on September 1st of that year.

- for Basic Life Insurance, Semi-private Hospital, Extended Health Care and Dental Care, the date you retire¹ unless you elect to continue the coverage at your own expense
- the date the policy terminates

Commencement of Your Eligible Dependents' Coverage

Dependent coverage begins on the later of the date your coverage begins or the date you first have an eligible dependent. You must apply for dependent coverage no later than 31 days after the date they first become eligible. If you do not apply for dependent coverage within this 31 days, you must provide satisfactory medical evidence of insurability for your dependents before they can participate. Their coverage will become effect on the date approved by the insurance company.

If your dependent (other than a new-born child) is hospitalized on the date their coverage, or a change in their coverage, would normally be effective, their coverage will not become effective until they are discharged.

Termination of Your Dependents' Coverage

Your dependent coverage terminates on the earliest of the following dates:

- the date your coverage ends unless your coverage ceases as a result of your death – please refer to survivor benefits in this section
- the day your dependent no longer qualifies as an eligible dependent or reaches the limiting age
- the date you stop paying the required premiums for their coverage

Changes in Coverage

Changes in your coverage take effect on the date they occur but will not become effective unless you are actively at work. If you are not actively working on the date they would normally become effective, the change will not take place until you return to active work.

ELIGIBLE DEPENDENTS

Your eligible dependents are your spouse or common-law spouse (partner) and dependent children from birth up to and including age 21 or, while a full-time student, under the age of 25. Dependent children of any age are covered if physically or mentally disabled.

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Your **Spouse** is your legal spouse, common-law spouse, or former spouse. A Common-law spouse (partner) means a person of the opposite or same sex who is living with you in a common-law relationship for at least 12 months and is represented as your spouse. A former spouse means a divorced or ex-common-law spouse for whom insurance protection under the employer's benefit program is court mandated. Only one spouse may be covered at any time. Coverage for a court-mandated former spouse takes priority over a current legal or common-law spouse.

Your **Dependent Children** are your or your insured spouse/partner's unmarried natural, adopted or stepchildren and other unmarried children for whom you or your insured spouse have been appointed as guardian. A child under age 22 must not be working more than 30 hours per week unless they are a full-time student. A child of the insured spouse is covered if they are also your child or the spouse is living with you and has custody of the child. For Dependent Life Insurance, a child is covered from living birth.

KEEPING YOUR COVERAGE UP TO DATE

To ensure that coverage is kept up to date, it is important that you report any of the following changes to your Benefits Department:

- change of name
- change in marital status
- addition of a child
- change in beneficiary

COVERAGE UNDER MORE THAN ONE HEALTH OR DENTAL PLAN (COORDINATION OF BENEFITS)

In the event that you or your dependents are covered under more than one Group Extended Health Care or Dental plan, the Coordination of Benefits provision ensures that, although claims may be made for the same expense under more than one plan, total reimbursement received does not exceed 100% of the actual expense incurred. Please note that, if both you and your spouse are employed by the Board, you can both elect family coverage and use the coordination of benefits provisions under this plan.

Benefits for you or a dependent will be directly reduced by any amount payable under a government plan.

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.

SURVIVOR BENEFITS

If you die while your dependents are insured under the plan, and if you are survived by your spouse, or in the event of no spouse, you are survived by eligible dependent children, your dependents will be given the option to continue Semi-Private Hospital, Extended Health Care (excluding private hospital room accommodation) and Dental Benefits for up to a maximum of two years. Survivor Benefits will cease on the earliest of the following dates:

- the date your spouse reaches age 65
- the date your dependent child reaches the limiting age
- the date two years following the date of your death
- the date premiums are no longer paid to extend the coverage

The decision to continue coverage must be made within 31 days of your date of death and the annual premium paid in advance to the Board. In the event of your death during the summer period, the 31-day provision will be calculated from September 1st.

Survivor Benefits are paid to the Spouse; however, where there is no spouse, Survivor Benefits are paid to the guardian of the eligible dependent children or to the individual responsible/appointed by the courts for the care and maintenance of the eligible dependent child(ren).

TIME LIMIT FOR SUBMITTING HEALTH AND DENTAL CLAIMS

All Extended Health Care and Dental claims must be submitted within 15 months of the date the expense was incurred. If claims are not submitted within this time limit, they will be not be considered an eligible expense under this plan and reimbursement will be declined.

LIFE INSURANCE BENEFITS

EMPLOYEE BASIC LIFE INSURANCE

In the event of your death from any cause, your named beneficiary will receive your Employee Basic Life Insurance in the amount of \$50,000 (reference "Continuation of Life Insurance when disabled").

You may name a beneficiary for your life insurance and change that beneficiary at any time by completing a form available from your Employer. On your death, the Benefits Department will explain the claim requirements to your beneficiary. Great-West Life will pay your life insurance benefits to your beneficiary.

OPTIONAL EMPLOYEE LIFE INSURANCE

You may purchase additional Group Term Life Insurance in units of \$25,000 up to a maximum of \$150,000. Your Optional Life Insurance is paid to the same beneficiary as you have named under your Basic Life Insurance. Your Optional Life Insurance is payable in the event of your death, due to any cause, after coverage or any increase in coverage has been in effect for two years. During the first two years of coverage, Optional Employee Life Insurance will not be payable if your death is a result of suicide.

Medical Evidence Requirements

If you elect Optional Life Insurance within 31 days of your eligibility date (date of employment), no medical evidence is required and the full amount you elect is effective immediately.

If you want coverage or an increase in your coverage and apply more than 31 days after you are first eligible, you will be required to provide satisfactory evidence of your good health by completing a statement of health and submitting it to the insurance company. Your coverage or increased coverage will not be effective until it is approved by the insurance company.

OPTIONAL DEPENDENT LIFE INSURANCE

You may purchase Optional Dependent Life Insurance which covers your spouse for \$25,000 and each child for \$10,000. If one of your dependents dies, Great-West Life will pay you the dependent life insurance benefit. Your employer will explain the claim requirements.

Medical Evidence Requirements

If you elect Optional Dependent Life Insurance within 31 days of your eligibility date (date of employment or the date you first acquire a dependent), no medical evidence is required and the coverage is effective immediately.

If you want coverage and apply more than 31 days after you are first eligible, you will be required to provide satisfactory evidence of your dependents' good health by completing statements of health for each eligible dependent and submitting it to the insurance company. Your Optional Dependent Life Insurance coverage will not be effective until it is approved by the insurance company.

CONTINUATION OF LIFE INSURANCE COVERAGES WHILE DISABLED (Waiver of Premium Provisions)

If you become disabled for 6 months or more, you may be entitled to have your Basic Life Insurance, Optional Employee Life Insurance and Optional Dependent 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 continuation of your Life Insurance within 12 months of becoming disabled.

Employees Who Are Covered for Long Term Disability

If you are covered for Long Term Disability benefits at the time you become disabled, you are eligible to apply for continuation of Basic, Optional Employee and Optional Dependent Life Insurance under the waiver of premium provision if you become totally and continuously disabled for a period of 6 months prior to attainment of age 65 or prior to your retirement date, if earlier.

Employees Who Are NOT Covered for Long Term Disability

If you are NOT covered for Long Term Disability benefits at the time you become disabled:

1. You are eligible to apply for continuation of Basic, Optional and Dependent Life Insurance under the waiver of premium provision when you become totally and continuously disabled for a period of 6 months prior to attainment of age 65 or prior to your retirement date, if earlier;

OR

2. You are eligible to apply to receive a Total Disability Income from the first \$40,000 of Basic Life Insurance and continuation under the waiver of premium provision on the balance of the Life Insurance Benefits. Life Insurance benefits include Basic Life Insurance plus any Optional Life Insurance and/or Dependent Life Insurance benefits in force immediately prior to commencement of disability.

If you elect this Option 2, you will receive \$40,000 of your Basic Life Insurance in monthly installments payable from the first day of the 7th month following the start of your disability. Installments are payable for a maximum of 60 months but will not be payable beyond your attainment of age 65, your recovery or death, whichever is earliest. If you die before all installments are paid, your beneficiary will receive your Life Insurance Benefits minus the total of the installments paid.

CONVERSION OF LIFE INSURANCE TO AN INDIVIDUAL POLICY

If any or all of your insurance terminates, you are eligible to apply for an individual conversion policy without providing proof of your insurability. You may convert all or part of your Basic and Optional Insurance up to a combined maximum of \$200,000. You must apply and pay the first premium no later than 31 days after your group insurance terminates. Please contact your Benefits Department for details.

If your spouse's insurance terminates, he or she may be eligible to apply for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. Please contact your Benefits Department for details.

HEALTH CARE BENEFITS

The deductible noted in the Benefit Summary is applicable only to the Drug Expenses. 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 the following services and supplies if they are not covered under your provincial government plan and provincial law permits the plan to cover them. 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

- Local emergency ambulance transportation to and from the nearest centre where adequate treatment is available
- Emergency transportation by air ambulance or any vehicle normally used for public transportation to and from the nearest hospital where the necessary treatment can be provided including ground ambulance to and from the points of departure and arrival limited to the cost of one return trip per year

Hospital Accommodation

- Semi-private room and board in a hospital except for convalescent care.
- The difference between the hospital's charge for Private room and board and its charge for Semi-private accommodation in a hospital in your home province except for convalescent 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 covered.
- Great-West Life also covers the hospital facility fee related to dental surgery.
- Convalescent care for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.
- The plan covers the government-authorized co-payment for accommodation in a nursing home up to the limit specified in the Benefit Summary. Residences established primarily for senior citizens or which provide personal rather than medical care, are not covered.
- Out-patient services in a hospital in your home province.

Private Duty Nursing

- Services of a registered nurse, registered practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse up to the maximum stated in the Benefit Summary.

Drugs

- Drugs and drug supplies described below when provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country care provision. Please note, your direct-pay drug card will not work outside Canada.
 - Drugs which require the written prescription of a physician or dentist, including oral contraceptives
 - 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 when prescribed by your physician or dentist. If you have any questions, contact your plan administrator before incurring the expense.
 - Vaccines used to prevent disease and anti-histamines including the generic equivalents
 - Smoking cessation products up to \$200 lifetime
 - 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.

Services, Equipment and Supplies

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a doctor
- Oxygen and its administration
- Custom-made foot orthotics and custom fitted orthopaedic shoes, including modifications to orthopaedic footwear
- Hearing aids including repairs, batteries, tubing and ear moulds provided at the time of purchase
- Diabetic supplies: 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
- Mechanical or hydraulic patient lifters (excluding electric stair-lifts)
- Outdoor wheelchair ramps
- Transcutaneous nerve stimulators
- Extremity pumps for lymphedema
- Corrective prosthetic lenses and frames provided only once following cataract surgery or when the person lacks an organic lens

Paramedical Services

Paramedical Services are covered up to the maximums stated in the Benefit Summary. Coverage for chiropractors, osteopaths and podiatrists include one x-ray per person per Benefit Year. Services include:

- Out-of-hospital treatment of muscle and bone disorders by a licensed chiropractor
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment of foot disorders by a licensed podiatrist
- Out-of-hospital treatment by a registered psychologist
- 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 naturopath
- Out-of-hospital services of a licensed osteopath

Visioncare

Visioncare expenses are covered up to the maximum stated in the Benefit Summary for the following services:

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Prescription safety glasses for science, technical, art or physical education teachers only

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.
- 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 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
- for emergency care only, ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available

General Limitations

Limitations applicable to all Health Care Expenses

No benefits are paid for:

- Expenses private insurers are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage
- The portion of the expenses 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

- 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
- 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
- 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
- Expenses arising from war, insurrection or voluntary participation in a riot
- Intentionally self-inflicted injuries
- Expenses for which compensation is provided under government legislation
- Chronic care
- Visioncare services or supplies required by an employer as a condition of employment

Limitations Applicable to the Direct-Pay Drug Card Benefit

Under the Drug Card Benefit, 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 formulae 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
- Proprietary or patent medicines registered under the Food and Drugs Act, Canada
- Any single purchase of drugs that would not reasonably be used within 100 days.
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs dispensed during treatment as an in-patient or an out-patient in a hospital
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens

How to Make a Claim

Out-of-Country Claims

Out-of-country claims 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 Benefit Payment Office immediately as your Provincial Medical Plan has very strict time limitations.

Obtain form M5432 (Out-of-Country Statement of Claim) from your employer and, if applicable, the Government Assignment form (all provinces except Manitoba) and the Special Government Claim Form (British Columbia, Quebec and Newfoundland). Complete these forms, making sure all required information is included. Attach all original receipts and forward the claim to the Great-West Life Benefit Payment Office. Be sure to keep a copy for your own records.

Great-West Life will pay all eligible claims including your Provincial Medical Plan portion. Your Provincial Medical Plan will then reimburse Great-West Life for the government's share of the expenses.

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

Drug Claims

For drug claims, your employer will provide you with a prescription drug identification card. Present your card when purchasing drugs at any of the **participating pharmacies**.

Before your prescription is filled, a Health Assure check will be done. Health Assure 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 purchasing drugs at a **non-participating pharmacy**, you will be required to pay the full price of the prescription and the Health Assure check will not be available. For reimbursement, ask your employer for a prescription drug claim form. Attach your drug receipts to the completed claim form and mail it to the address on the claim form.

Please note, your drug card can be used at most pharmacies across Canada. Your drug card will not work outside Canada. You will have to pay the full cost of any prescriptions you obtain outside Canada and submit them to Great-West Life for reimbursement.

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

All Other Healthcare Claims

For all other Healthcare claims, 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 Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

Preferred Vision Services (PVS)

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

Preferred Vision Services (PVS) entitles you to a discount on a wide selection of quality eyewear and vision care services when you purchase these items from a PVS network optician or optometrist. 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 to purchase services and eyewear for yourself and your dependents at a reduced cost.

Shopping for eyewear through 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 or eye examination, 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 of purchase

- Select your eyewear and pay the reduced PVS price. If you have vision care coverage, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

DENTAL CARE BENEFITS

All expenses will be reimbursed at the level shown in the **Benefit Summary** and as noted below. Reimbursement will be based on the dental fee guide in effect in your province of residence one year prior to the date treatment is rendered as shown in the **Benefit Summary**. The plan covers reasonable and customary charges to the extent they do not exceed this dental fee guide level.

Benefits may be subject to plan maximums and frequency limits. Please refer to the details below for this information.

Treatment Plan

Before incurring any large dental expenses in excess of \$300, or beginning any orthodontic treatment, ask your dentist 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.

Covered Expenses

The following describes the services covered:

Basic Coverage (Reimbursed 100%, Unlimited)

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 calendar year that a complete oral examination is also performed
- limited periodontal examinations once every 9 months
- complete series of x-rays every 36 months
- intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Bite-wing x-rays are limited to once every 9 months. Services provided in the same 12 months as a complete series are not covered.

Preventive services including:

- polishing and a single unit of scaling once every 9 months.

- topical application of fluoride once every 9 months
- oral hygiene instruction once every 9 months
- pit and fissure sealants on bicuspid and permanent molars for children under age 18
- finishing restorations
- interproximal disking
- recontouring of teeth
- recall packages once every 9 months

Minor restorative services including:

- caries, trauma, and pain control
- amalgam fillings. Tooth-coloured fillings of anterior and bicuspid teeth. Replacement fillings are covered only if the existing filling was not covered under this plan
- retentive pins and prefabricated posts for fillings
- prefabricated crowns for primary teeth

Extractions

Adjunctive services including:

- local anaesthesia
- professional visits

Oral surgery

Additional adjunctive services for complex oral surgery including:

- general anaesthesia
- conscious sedation
- therapeutic injection of intra muscular drug

Denture Maintenance Services after 3-month post-insertion care period 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, once every 36 months

Endodontic Services (Reimbursed 75%, unlimited)

- Root canal therapy for permanent teeth is 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 (Reimbursed 75%, unlimited)

Where services are based on units of time, a TIME UNIT is considered to be a 15-minute interval or any portion of a 15-minute interval. Services include:

- scaling and root planing, limited to a combined maximum of 12 time units every 12 months. Please note if 1 unit of scaling is done in conjunction with a recall exam, the single unit is reimbursed at 100% and is not counted towards the 12 time units. If two (2) or more units of scaling are done in conjunction with a recall exam, they are reimbursed at 75% and do count towards the maximum time units every 12 months.
- occlusal adjustment and equilibration, limited to a combined maximum of 8 time units every 12 months

Major Services (Reimbursed 75%, \$2,000 Calendar Year Maximum per Person)

Major Services include coverage for:

Crowns and Onlays

- Crowns and onlays are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures. The following crowns and related items are covered:
 - metal, plastic, porcelain, and ceramic 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.
 - posts, cores, and pins related to covered crowns.
 - copings related to covered crowns.
 - repairs to covered tooth-coloured materials.
 - removal and recementation of crowns and onlays.
- Replacement crowns and onlays are covered when the existing restoration is at least 3 years old and cannot be made serviceable.
- No benefits will be paid for:
 - veneers
 - recontouring existing crowns

- staining porcelain
- inlays, except as provided under alternative benefits
- If a crown or onlay is provided when a tooth could have been adequately restored using other procedures, alternative benefits will be provided based on coverage for fillings.
- If inlays are provided, alternative benefits will be provided based on coverage for fillings.

Dentures and Bridgework

- Dentures and bridgework, including overdentures and implant-retained appliances. Replacement appliances are covered only when:
 - the existing appliance is temporary and replaces one or more teeth extracted while covered
 - the existing appliance is at least 3 years old and cannot be made serviceable. If the existing appliance is less than 3 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.

- 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 3 years old and cannot be made serviceable. If the existing appliance is less than 3 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
- 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 (Reimbursed 50%, \$2,000 Lifetime Maximum per Person)

- Orthodontics are covered for persons age 6 or over when treatment starts

Accidental Dental Injury Coverage (Reimbursed 100%, Unlimited)

Treatment of injury to sound natural teeth. Treatment must be complete within 12 months 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 for Late Application

If you do not apply for dental 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 12 months of your coverage

General Limitations

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 - 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). Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Alveoplasty or gingivoplasty performed in conjunction with extractions
- 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 the person is entitled to without charge by law or for which a charge is made only because the person has 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
- Expenses for which compensation is provided through government legislation
- Expenses as a result of commission or attempted commission of a criminal offense by the covered person
- Intentionally self-inflicted injuries
- Treatment commenced prior to the commencement of coverage

How to Make a Claim

Obtain form M445D from your employer. Have your dentist complete the form and return it to the benefit payments office as soon as possible, but no later than 15 months after the dental treatment.

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

The Plan is underwritten by

THE
Great-West Life
ASSURANCE  COMPANY
A member of the Power Financial Corporation group of companies.