CUPE 3778 Employees

Carleton University
Canada’s Capital University

Great-West Life
your Benefits Solutions People
We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

**BENEFIT DETAILS**

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

**Great-West Life Online**

Visit our website at [www.greatwestlife.com](http://www.greatwestlife.com) for:

- information and details on Great-West Life’s corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission
GroupNet for Plan Members

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

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

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

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

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

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

Compatibility of GroupNet Text may vary by mobile device or operating system.
Great-West Life’s Toll-Free Number

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

The information provided in the booklet is intended to summarize the contract provisions of Group Policy Nos. 153180 and 153181 and Plan Document No. 51801 issued by Great-West Life and Policy No. 50813-G issued by Sun Life of Canada. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail to the extent permitted by law.

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

The Plan is administered by

THE

Great-West Life
ASSURANCE COMPANY

and

Sun Life of Canada

This booklet was prepared on April 26, 2019 and reflects the plan design as of February 1, 2019.
Access to Documents

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

Legal Actions

Insured benefits

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.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.
**Appeals**

**Insured benefits**

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.

**Non-insured benefits**

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

**Benefit Limitation for Overpayment**

**Insured benefits**

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 fulfill 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.

**Non-insured benefits**

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer'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

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer’s behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and 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.

**Notice of Liability for Benefits**

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby the Healthcare (except Global Medical Assistance) and Dentalcare benefits outlined in this booklet are uninsured and your employer has liability for them.

This means that the Healthcare (except Global Medical Assistance) and Dentalcare benefits are:

- an unsecured financial obligation and are payable from your employer’s net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Great-West Life.

If British Columbia law applies, the giving of this notice exempts your employer from the requirements under the Financial Institutions Act (British Columbia).
<table>
<thead>
<tr>
<th>Benefit Summary</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commencement and Termination of Coverage</td>
<td>7</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>10</td>
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<td>Beneficiary Designation</td>
<td>10</td>
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<td>Healthcare</td>
<td>23</td>
</tr>
<tr>
<td>Dentalcare</td>
<td>40</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>49</td>
</tr>
</tbody>
</table>
Benefit Summary

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

Employee Basic Life Insurance Benefit
(Underwritten by Sun Life of Canada) See description

Optional Life Insurance

<table>
<thead>
<tr>
<th>Role</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Available in $10,000 units to a maximum of $500,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>Available in $10,000 units to a maximum of $350,000</td>
</tr>
<tr>
<td></td>
<td>If you do not retire on your normal retirement date, all amounts of insurance reduce by 50%, to a maximum of $100,000</td>
</tr>
<tr>
<td></td>
<td>If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum</td>
</tr>
<tr>
<td></td>
<td>See the Optional Life Insurance section of this booklet for evidence requirements</td>
</tr>
</tbody>
</table>

1
Long Term Disability Income Benefits

Waiting Period 6 months

Amount 65% of your monthly earnings to a maximum benefit of $20,000

Healthcare

Covered expenses will not exceed customary charges

Deductibles

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$25 each calendar year</td>
</tr>
<tr>
<td>Family</td>
<td>$50 each calendar year</td>
</tr>
</tbody>
</table>

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

Reimbursement Levels

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Canada Hospital, Global Medical Assistance and Out-of-Country Emergency Care Expenses</td>
<td>100%</td>
</tr>
<tr>
<td>In-Canada Prescription Drug Expenses</td>
<td></td>
</tr>
<tr>
<td>- covered dispense fee portion of the drug charge</td>
<td>100%</td>
</tr>
<tr>
<td>- remaining portion of the drug charge</td>
<td>80%</td>
</tr>
<tr>
<td>All Other Expenses</td>
<td>80%</td>
</tr>
</tbody>
</table>
Out-of-Pocket Maximum for Quebec Residents

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

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

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

Basic Expense Maximums

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Semi-private room</td>
</tr>
<tr>
<td>Home Nursing Care</td>
<td>Included</td>
</tr>
<tr>
<td>In-Canada Prescription Drugs</td>
<td>Included</td>
</tr>
<tr>
<td>Zyban Smoking Cessation Products</td>
<td>3-month supply each calendar year or as otherwise required by law</td>
</tr>
<tr>
<td>Custom-fitted Orthopedic Shoes Or</td>
<td>1 pair each calendar year or the actual cost of modifications and</td>
</tr>
<tr>
<td>Boots</td>
<td>adjustments to stock item footwear</td>
</tr>
<tr>
<td>Custom-made Foot Orthotics</td>
<td>2 pairs every 12 months to a maximum of $450</td>
</tr>
<tr>
<td>Myoelectric Arms</td>
<td>Limited to the cost of an artificial arm</td>
</tr>
<tr>
<td>Item</td>
<td>Frequency or Cost</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>External Breast Prosthesis</td>
<td>1 every 5 calendar years</td>
</tr>
<tr>
<td>Surgical Brassieres</td>
<td>2 pairs each calendar year</td>
</tr>
<tr>
<td>Blood-glucose Monitoring Machines Including Sensors</td>
<td>1 every 4 years</td>
</tr>
<tr>
<td>Continuous Glucose Monitoring Machines Including Sensors and Transmitters</td>
<td>$4,000 each calendar year</td>
</tr>
<tr>
<td>Transcutaneous Nerve Stimulators</td>
<td>Up to 6 months of rental</td>
</tr>
<tr>
<td>Custom-made Compression Hose</td>
<td>2 pairs each calendar year</td>
</tr>
<tr>
<td>Elastic Stockings</td>
<td>6 pairs each calendar year</td>
</tr>
<tr>
<td>Wigs for Cancer Patients</td>
<td>$200 lifetime</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses Following Cataract Surgery</td>
<td>$50 per eye per lifetime</td>
</tr>
<tr>
<td>Automatically-adjusting Positive Airway Pressure Machines (APAP), Positive Airway Pressure Machines (BiPAP and VPAP) and Continuous Positive Airway Pressure Machines (CPAP)</td>
<td>Combined one device every 5 years</td>
</tr>
<tr>
<td>Supplies for CPAP, APAP, BiPAP and VPAP Machines</td>
<td>- Mask 1 every 12 months</td>
</tr>
<tr>
<td></td>
<td>- Head Gear 1 every 12 months</td>
</tr>
<tr>
<td></td>
<td>- Hose 1 every 12 months</td>
</tr>
<tr>
<td></td>
<td>- Filters (Package of 5) 3 packages every 12 months</td>
</tr>
<tr>
<td>Paramedical Expense Maximums</td>
<td></td>
</tr>
<tr>
<td>Chiropractors</td>
<td>$200 each calendar year</td>
</tr>
<tr>
<td></td>
<td>$25 for x-rays each calendar year</td>
</tr>
<tr>
<td>Christian Science Practitioners</td>
<td>Included</td>
</tr>
<tr>
<td>Massage Therapists</td>
<td>$400 each calendar year</td>
</tr>
<tr>
<td>Naturopaths</td>
<td>Included</td>
</tr>
<tr>
<td>Osteopaths</td>
<td>Included</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>Included</td>
</tr>
<tr>
<td>Podiatrists/Chiropodists</td>
<td>Included</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Included</td>
</tr>
<tr>
<td>Speech Therapists</td>
<td>$200 each calendar year</td>
</tr>
</tbody>
</table>
Visioncare Expense Maximums

Eye Examinations                     Once every 24 months
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery  $500 every 24 months
Visual Motor Therapy                  $10 every half hour

Out-of-Country Emergency Care
Expense Maximum                        $1,000,000 lifetime

Lifetime Healthcare Maximum           Unlimited
Dentalcare

Covered expenses will not exceed customary charges

Payment Basis

- for treatment rendered inside Canada
  - The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered

- for treatment rendered outside Canada
  - The dental fee guide in effect in your province of residence on the date treatment is rendered

Specialist fee guides are applicable only when a specialist performs periodontal, surgical and endodontic examinations.

Deductible

Nil

Reimbursement Level

Basic Coverage 100%

Plan Maximums

Basic Treatment Unlimited
COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible for Long Term Disability Income benefits:

− immediately if you are a full-time employee,
− immediately if you are a part-time employee who holds an appointment of 12 months or more with a workload equal to 50% or more of full-time workload, or
− on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 12 months which is extended beyond 12 months.

You are eligible for Dentalcare benefits:

− immediately if you are a full-time employee,
− immediately if you are a part-time employee who holds an appointment of 4 months or more with a workload equal to 50% or more of full-time workload, or
− on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 4 months which is extended beyond 4 months

You are eligible for all other benefits:

− immediately if you are a full-time employee,
− immediately if you are a part-time employee who holds an appointment of 4 months or more with a workload equal to 50% or more of full-time workload, or
− on the date your original appointment is extended if you are a part-time employee who holds an appointment of less than 4 months which is extended beyond 4 months.
In addition, to qualify for coverage for all benefits you and your dependents must reside in Canada, and to qualify for coverage for Healthcare and Dentalcare benefits you and your dependents must be covered under the government health plan in your province of residence.

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

You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Great-West Life, you and your dependents may be required to provide evidence of good health acceptable to Great-West Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

- 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 and seasonal employees may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the plan terminates, whichever is earliest.

- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. Your employer will provide you with details.

- 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 as follows:

- for non-retired employees who are past the normal retirement age, and active employees who would be eligible to retire, until the end of the month in which they cease to be qualified dependents, or the due date of the first payment to which they have not made a required contribution for survivor coverage, whichever happens first.

- for all other non-retired employees, for 3 months or until they no longer qualify, whichever happens first.

Normal Retirement Date

Your normal retirement date is:

- The first day of September coinciding with or next following the date you reach age 65 if you joined the plan before July 1, 1957

- The first day of July closest to the date you reach age 65 if you joined the plan on or after July 1, 1957
DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

- Your unmarried natural, adopted, foster or step-child, including any natural child of an unmarried minor dependent and any other unmarried child for whom you have been appointed legal guardian for all purposes by a court of competent jurisdiction, under age 21, or under age 25 if they are full-time students.

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

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

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

BENEFICIARY DESIGNATION

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

Basic Earnings

The employee's salary or wage including stipends from the employer, excluding any overtime pay, bonuses or commissions.

An employee is insurable if he holds an appointment of 4 months or more with a workload equal to 50% or more of a full-time workload, or an employee holds an appointment of less than 4 months which is then extended.

Deemed Date of Retirement

Unless the employee actually retired earlier, a totally disabled employee's date of retirement is deemed to be the first of July coinciding with or next following the date he/she reached age 65.

Employee

A person classified by the employer as a permanent full-time employee who is scheduled to work at least 24 hours a week, excluding temporary employees, replacement non-faculty employees and visiting scholars.

Employer

Carleton University

Employment

Employment as an employee
Financial Reporting Year

August 1, 2005 to December 31, 2005 and then January 1st to December 31st

Mandatory Benefits

Basic Employee Life Insurance

Spouse

The Employee's spouse by marriage or under any other formal union recognized by law, or

- the Employee's partner of the opposite sex or of the same sex who is publicly represented as the Employee's spouse
- At any one time, only one person may be insured as an Employee's Spouse

Termination of Employment

Occurs on the day a person ceases to qualify under the definition of employee, for any reason other than retirement on pension, or the date he ceases to be actively at work, whichever is earlier.

However, the employer, acting in accordance with rules which apply equally to all employees within the same classification, may deem that employment continues, providing the employee continues to pay premiums at the full workload rate (including the employer's portion of the premium where applicable):

a) during any period which the employee is absent from work due to illness,

b) for the period of the employee's scheduled paid vacation, but not exceeding 3 months,

c) for any period the employee is on maternity/parental leave, but not exceeding the period required under the relevant legislation,
d) for any period of notice as required on termination of employment under the relevant legislation,

e) for a period ending not later than the last day of the calendar month following the month in which the Employee is temporarily laid off or is granted a leave of absence for any reason other than illness, paid vacation or maternity/parental leave.

**Total Disability**

The condition of being totally disabled.

**Totally Disabled**

An employee is totally disabled if he is wholly prevented by illness from performing the regular duties of his own job at the onset of disability.

**Commencement of insurance**

Employee insurance commences on the date of his employment. In any event, if the Employee is not Actively At Work on the date his insurance would otherwise commence, his insurance commences only when he is Actively At Work.
EMPLOYEE BASIC LIFE INSURANCE BENEFIT

Classification Basic                      Amount of Insurance
Class A – All employees                 200% of annual earnings, the
under age 70, excluding retirees        result adjusted to the next
                                          higher $1,000 (if not already
                                          a multiple of $1,000) subject
to a maximum benefit of
                                          $1,000,000

Reduction Of Amount Of Insurance

The Amount of Insurance shown above is reduced to the lesser of 100%
of annual earnings or $25,000 on the date an active employee attains
his/her normal retirement date.

For employees on voluntary reduction program, the amount of insurance
reduces to 100% of annual earnings until normal retirement date.

Termination of insurance

For employees who joined the employer’s retirement plan on or after
July 1, 1957

The Basic Employee Life Insurance for employees ends on the date
they reach age 70

Changes of insurance

Unless otherwise provided in a benefit provision, any increase or any
decrease in the amount of an employee’s insurance will take effect on
the date of the increase.

If an insured employee is not actively at work on the date an increase
would otherwise take effect, or the date the policy is amended to provide
increased benefits, the employee will be insured for the increased
benefits only when he is again actively at work.
**Individual terminations**

An employee will cease to be insured on the earliest of the following dates:

a) the date of termination of employment,

b) the end of the period for which the last premium is paid to Sun Life for the employee’s insurance,

c) the date of termination of the policy.

**Disability benefit**

Upon receipt of Proof Of Claim that an Employee, while insured and before their normal retirement date or earlier retirement, became Totally Disabled, and the Total Disability continues for an uninterrupted period of 6 months, insurance continues from the date of onset of Total Disability without further payment of the Employee's premiums for this benefit.

The Amount Of Insurance is subject to the terms and conditions of this policy in effect on the date of onset of Total Disability, including reductions or terminations.

On the death of the Employee, the Amount Of Insurance is reduced by the amount of any benefit paid under the 31 Day Free Cover of the Conditions Of Conversion, or by the amount of any individual policy issued to the Employee under the Conversion unless such policy is exchanged for a full refund of premiums.
This Disability Benefit ends on the earlier of:

a) the date on which the Employee ceases to be Totally Disabled, and

b) the date on which the Employee fails to furnish proof to Sun Life that he continues to be Totally Disabled.

Conversion

If an employee's life insurance terminates for any reason other than solely as a result of the employee's request, the employee may apply, without evidence of insurability, for an individual life insurance policy on his/her own life, subject to Conditions of Conversion.
OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your spouse. Check the Benefit Summary for the amount of optional life insurance available.

When you apply for optional life insurance, you must provide proof of your insurability for any amount in excess of 100% of your annual earnings to a maximum of $150,000, and for all amounts applied for more than 31 days from the date you first become eligible and your application must be approved by Great-West Life.

When your spouse applies for optional life insurance, proof of insurability must be provided and the application must be approved by Great-West Life.

If you or your spouse dies, Great-West Life has the right to verify any medical information provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

On your death, Great-West Life will pay your life insurance 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. If your spouse dies you will be paid the amount for which your spouse was insured.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your optional life insurance, and your spouse’s, 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 a claim form.
• Your and your spouse’s optional life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your and your spouse’s optional life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

• If your or your spouse’s optional life insurance terminates before your normal retirement date, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your employer for details.

• Your optional life insurance will not continue past the end of the day before the date you reach age 71. Your spouse’s coverage will not continue past the end of the day before the date your coverage ends or your spouse reaches age 65, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received.
LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled as defined by the policy or:

- if you joined the employer’s retirement plan before July 1, 1957, the first day of September coinciding with or next following the date you reach age 65 or;

- if you joined the employer’s retirement plan on or after July 1, 1957, the first day of July closest to the date you reach age 65, whichever comes first. Check the Benefit Summary for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as they are accumulated within a period of 12 consecutive months and the disabilities arise from the same disease or injury. If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the short term disability or sick leave benefit period, but not later than one year after your disability started.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular job.

- After 24 months, LTD benefits will continue only if your disability prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications.
- After the waiting period, separate periods of disability are considered to be one period of disability if they arise from:
  - the same disease or injury and start within 6 months after the previous disability ends, or within 24 months after the end of an approved comprehensive rehabilitation program. Rehabilitation plans are not considered under this 24-month provision.
  - an unrelated disease or injury and start within 1 month after the previous disability ends.

- Because your employer contributes to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance will not continue past the end of the day before the date you reach age 65.

**Other Income**

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Other income includes:

- benefits under any Workers' Compensation Act or similar law
- 50% of income from an approved rehabilitation program

The balance of earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.
**Vocational Rehabilitation Benefits**

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

**Medical Coordination Benefits**

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

**Limitations**

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.
Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.

Any period after you fail to participate or cooperate in a recommended medical coordination program.

Any period during which you are residing outside Canada for more than 90 days unless:

- you are receiving regular and continuous treatment from a physician;

- you provide evidence within 30 days of departure that you are receiving such regular and continuous treatment; and

- you are available to be examined by a doctor provided and paid for by Great-West Life, if required.

Any period of confinement in a prison or similar institution.

Disability arising from war, insurrection, or voluntary participation in a riot.

How to Make a Claim

To submit claims online, go to www.greatwestlife.com.

To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide’s instructions.

You can get this form from your employer, or online from the Great-West Life corporate website. To access the form online, go to www.greatwestlife.com.

Please ensure that your claim is submitted to Great-West Life as soon as possible, but no later than 6 months after proof of your claim has been requested.
HEALTHCARE

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

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

Covered Expenses

- Ambulance, including air ambulance when provided by a licensed ambulance company. Transportation to the nearest centre where adequate treatment is available, from one treatment centre to another on the recommendation of the attending physician, or from a treatment centre to the patient’s residence on the recommendation of the attending physician.

  If the services of a registered nurse are required during an air ambulance flight, nursing services and return air fare for the registered nurse are also covered.

- 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 or convalescent.

  - 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.
The plan covers preferred accommodation in a hospital, excluding chronic care, long term care and palliative care, when provided in Canada.

For hospital accommodation, for a visiting scholar, the plan covers the hospital’s semi-private rate in Ontario. For all other employees, the plan covers the difference between the hospital’s semi-private and standard ward rates.

For out-of-province accommodation, for a visiting scholar, the plan covers the hospital’s semi-private rate in Ontario. For any other employee, the plan covers any difference between the hospital's semi-private rate and the government authorized allowance in your home province.

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 physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses 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 oral contraceptives

- Injectable drugs including vitamins, insulins and allergy extracts. Radium and drugs used for radioactive isotope treatment are covered. Syringes for self-administered injections are also covered.

- Disposable needles for use with non-disposable insulin injection devices, lancets, test strips, alcohol swabs and sensors for flash glucose monitoring machines

- Extemporaneous preparations or compounds if one of the ingredients is a covered drug

- Fertility drugs

- 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.

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 the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician including but not limited to:

- continuous positive airway pressure machines (CPAP), automatically-adjusting positive airway pressure machines (APAP), bilevel positive airway pressure machines (BiPAP) and variable positive airway pressure machines (VPAP) combined to one device every 5 years. A patient must first go through a study done by a sleeping clinic. The following supplies are also covered:
  (a) mask, one every 12 months
  (b) head gear, one every 12 months
  (c) hose, one every 12 months
  (d) filters, a maximum of 3 packages every 12 months. Each package contains 5 filters

- visual services or supplies due to cataract surgery
  (a) eyeglasses or contact lenses following cataract surgery, limited to the amount listed in the Benefit Summary
  (b) replacement of unbroken visual aids in lieu of cataract surgery
  (c) replacement for glasses and contact lenses as a result of natural growth of a dependent child under age 18

- visual services or supplies due to an accidental injury
  (a) eyeglasses including prescribed safety glasses
  (b) contact lenses where vision in the better eye cannot be corrected to the 20/70 level by glasses
  (c) repairs due to breakage from the accidental injury
  (d) replacement for glasses and contact lenses as a result of natural growth of a dependent child under age 18

• Custom-made foot orthotics when prescribed by a physician, podiatrist or chiropodist

• Custom-fitted orthopedic boots or shoes, when prescribed by a physician
• Hearing aids, including initial batteries, tubing and ear molds provided at the time of purchase, when prescribed by an audiologist, otolaryngologist, otologist or a physician. Repair charges are also covered. Ear examinations and tests are excluded

• Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

• Blood-glucose monitoring machines prescribed by a physician

• Flash glucose monitoring machines prescribed by a physician

• Continuous glucose monitoring machines prescribed by a physician, including sensors and transmitters

• Radium therapy, radioactive isotopes and diagnostic laboratory and imaging procedures performed in the person’s province of residence are covered when that type of procedure is not listed as an insured procedure under his or her provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under his or her provincial government plan

• Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor

• Out-of-hospital services of a Christian Science Practitioner who is listed in the current Christian Science Journal

• Out-of-hospital services of a qualified massage therapist when referred by a physician. A new referral is required if the ongoing treatment has been interrupted by a period of 12 months or longer

• Out-of-hospital services of a licensed naturopath

• Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
• Out-of-hospital treatment of movement disorders by a licensed physiotherapist when recommended by a physician. Referrals are required every 12 months for ongoing treatment. A new referral is required if the ongoing treatment has been interrupted by a period of 6 months or longer. The physiotherapist must not be a participant in the Ontario Health Insurance Plan (OHIP), except that the initial assessment performed by a physiotherapist who is an OHIP participated will be covered.

• Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist or chiropodist.

• Out-of-hospital treatment by a registered psychologist when recommended by a physician. Referrals are required every 12 months for ongoing treatment. A new referral is required if the ongoing treatment has been interrupted by a period of 6 months or longer.

• Out-of-hospital treatment of speech impairments by a qualified speech therapist when recommended by a physician. A new referral is required if the ongoing treatment has been interrupted by a period of 12 months or longer.
• Treatment of injury to sound natural teeth. Treatment must start within 90 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.

No benefits are paid for:

- accidental damage to dentures
- dental treatment completed more than 36 months after the accident
- orthodontic diagnostic services or treatment

If an alternate dental procedure or material will restore the tooth (teeth) or dental arch(es) satisfactorily, then payment for the lesser procedure or material will be made toward a more elaborate or precision appliance/procedure that the patient and his or her dentist may choose.

Visioncare

• Eye examinations, including refractions, once every 24 months, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

• Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

• Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

• Visual motor therapy performed by a licensed ophthalmologist or optometrist.
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 and it is required during the first 180 days starting with the person’s departure from Canada. 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 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
- dental accident treatment if it would have been covered in Canada

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.

No benefits will be paid for:

- expenses for the regular treatment of an injury or disease that existed before the departure; and

- expenses incurred on a non-emergency or referral basis.

You or your dependent must return to his or her province of residence for at least 30 consecutive days before becoming eligible for another 180 days of coverage.
Limitations

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

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (“government plan”), without regard to whether coverage would have otherwise been available under this plan
  
  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - contraception, other than oral contraceptives
- 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 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 benefits would have been paid under this plan 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

• Expenses for which benefits are payable under a Workers’ Compensation Act, Workplace Safety and Insurance Act or a similar statute

• Expenses incurred due to intentionally self-inflicted injuries, while sane or insane

• Expenses for services and products rendered or prescribed by a person who is ordinarily a resident in the patient’s home or who is related to the patient by blood or marriage

• Out-of-province expenses for elective (non-emergency) medical treatment or surgery

• Brain or body scanners, or in connection with cosmetic or plastic surgery, unless for restorative purposes to repair tissue damaged by disease or bodily injury

• Eyeglasses or hearing aids, except otherwise provided in this plan, rest cures, travel for health reasons, periodic health check-ups or examinations, or examinations for insurance purposes

• Services provided in a health spa, chronic care or psychiatric hospital or chronic care unit of a general hospital, except as otherwise provided in this plan, or for services or supplies provided while confined in a nursing home or home for the aged
- Any care, services or supplies which are not medically necessary

- Bodily injury sustained while committing or attempting to commit a criminal offense

- Replacement of any supply, appliance or prosthetic device covered under this plan, except where the replacement is normal because the item is no longer serviceable due to general usage, or as a result of the natural growth of a child

- Chronic care

- Visioncare services and supplies required by an employer as a condition of employment

- Non-prescription sunglasses and safety glasses

- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
In addition under the prescription drug coverage, no benefits are paid for:

- 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

- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada

- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- 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

- Anti-obesity drugs

- Protein supplements
• Experimental drugs
• Smoking cessation products, other than Zyban
• Drugs used to treat erectile dysfunction
• Drugs or drug supplies not listed in the Liste de médicaments published by the Régie de l’assurance-maladie du Québec in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

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

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

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

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

“Basic prescription drug coverage” means the portion of drug expenses that is reimbursed by the Régie de l’assurance-maladie du Québec.
How to Make a Claim

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

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

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

Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life’s Out-of-Country Claims Department at 1-800-957-9777.
• **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

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

Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 18 months after you incur the expense.

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

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

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

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

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

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

Treatment Plan

- Before incurring any large dental expenses, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, 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
  - periodontal, surgical and endodontic examinations
  - limited oral examinations once every 5 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations once every 5 months
  - specific oral and emergency oral examinations once every 12 months
  - complete series of intra-oral x-rays once every 24 months
  - intra-oral x-rays:
    - periapical x-rays
    - bite-wing x-rays once every 5 months
  - panoramic x-ray every 24 months
  - histological and pulp vitality tests
  - consultation with patient
• Preventive services:
  - polishing once every 5 months
  - scaling, limited to a maximum combined with periodontal root planing of 16 time units every 12 months
    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - topical application of fluoride once every 5 months
  - oral hygiene instruction once every 5 months
  - pit and fissure sealants on bicuspid and permanent molars every 60 months for dependent children only
  - interproximal disking for dependent children under age 12
  - recontouring of teeth for functional reasons

• Minor restorative services:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns
  - natural tooth preparation
  - acrylic or composite resin (white fillings) restoration on permanent molars without the limitation of amalgam equivalent
• Endodontic services:
  - treatment of the pulp chamber
  - root canal therapy
  - apexification
  - periapical services. Apicoectomies are covered for permanent teeth only
  - isolation of teeth
  - bleaching
  - emergency procedures

• Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 16 time units every 12 months
  - periodontal surgery
  - occlusal adjustment and equilibration, limited to a combined maximum of 8 time units every 12 months
    
    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - periodontal appliances, once every 5 years including adjustments, relines and repairs
  - temporomandibular joint appliances including adjustments, relines and repairs
  - post surgical treatment
- desensitization
- periodontal re-evaluations
- temporomandibular joint x-rays
- surgical excision of benign cysts and granulomas
- denture-related surgical services for remodelling and recontouring oral tissues
- dislocation management of temporomandibular joint

- Denture maintenance, including:
  - denture relines for dentures
  - denture rebases for dentures
  - denture repairs and additions and resetting of denture teeth
  - tissue conditioning

- Oral surgery

- Adjunctive services
Limitations

If you do not apply for dental care coverage within one month after you become eligible, benefits are limited to $250 during the first 12 months of your coverage, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect.

No benefits are paid for:

- Duplicate x-rays, occlusal x-rays, custom fluoride appliances, group or audio-visual oral hygiene instruction and nutritional counselling

- Removal of an amalgam restoration and its replacement with a composite restoration, unless there is evidence of recurrent decay or significant breakdown

- The following endodontic services - endosseous intra coronal implants, intential removal of tooth apical filling and replantation, removal of root filling materials or foreign bodies and mummification

- The following periodontal services - topical application of antimicrobial agents, subgingival periodontal irrigation and dental floss ligation

- Resilient liner in relined or rebased dentures

- The following oral surgery services:
  - implantology
  - surgical movement of teeth other than surgical repositioning
  - remodeling of bone
  - extraoral surgical incision and drainage, and surgical incision for removal of foreign bodies
  - surgical excision of malignant tumors
  - cheiloplasty
  - augmentations of the jaw
  - sequestrectomy
  - mandibulectomy
  - maxillectomy
  - treatment of fractures
- treatment of maxillofacial deformities other than frenectomy or frenoplasty
- treatment of muscular disorders
- treatment of salivary glands
- treatment of neurological disturbances
- antral surgery for oro-antral fistula closure – gold plate
- surgical grafts
- emergency office procedures

• The following adjunctive services:
  - hypnosis or acupuncture
  - emergency services not specified in Guide
  - local anaesthesia
  - provision of general anaesthetic facilities, equipment and supplies by a separate anaesthetist
  - laboratory procedures

• Orthodontic treatment

• Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare

• Crowns (other than prefabricated crowns), bridgework, dentures or repairs to bridgework or dentures

• Expenses private benefit 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 coverage

• Services or supplies that do not represent reasonable treatment

• Treatment performed for cosmetic purposes only other than bleaching

• Congenital defects or developmental malformations in people 19 years of age or over
• Temporomandibular joint disorders. This limitation does not apply to temporomandibular joint radiographs and appliances, management of a temporomandibular joint dislocation and occlusal equilibration.

• Vertical dimension correction except occlusal equilibration

• Myofacial pain

• Services or supplies rendered for the correction of any congenital or developmental malformation which is not a Class I, Class II or Class III malocclusion

• Expenses arising from war, insurrection, or voluntary participation in a riot

• Lost, stolen or mislaid appliances

• Failure to keep a scheduled appointment with the dentist

• A duplicate device or appliance

• Expenses for which benefits are payable under a Workers’ Compensation Act, Workplace Safety and Insurance Act or a similar statute

• Expenses incurred due to intentionally self-inflicted injuries

• Expenses for services performed by a person who is ordinarily a resident in the patient’s home or who is closely related to the patient by blood or marriage

• Treatments or services by any person other than a denture therapist or dentist, except that scaling and cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision and guidance of the dentist
• Services rendered through a medical department, clinic or similar facility provided or maintained by your or your dependent’s employer

• Services or supplies which do not meet accepted standards of dental practice, including charges for services which are experimental in nature

**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 18 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.