

Group Benefit Plan



Great-West Life
your Benefits Solutions People



Lambton Kent
District School Board
Student Achievement ✓ Community Success

Elementary Occasional Teachers - Division 1
November 2011

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

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website www.greatwestlife.com.

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at www.greatwestlife.com.

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

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for medical and dental
- extensive health and wellness content

Great-West Life's Toll-Free Number

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

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 153336** (Life

Insurance for Employees and Global Medical Assistance) and **Plan Document No. 51804** (Optional Semi-private Hospital, Prescription Drugs, Healthcare (excluding Global Medical Assistance), Dentalcare and Visioncare) issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policy or plan document, the policy or plan document will prevail.

More detailed information may be obtained by contacting your employer. A copy of the policy or plan document may be obtained upon written request to your employer, who may make a reasonable charge for this service.

This booklet is up to date as of October 31, 2011.

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

The Plan is underwritten by



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

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

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

LIABILITY FOR BENEFITS

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby your employer will have full liability for Optional Semi-private Hospital, Prescription Drugs, Healthcare (excluding Global Medical Assistance), Dentalcare and Visioncare benefits outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

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SCHEDULE OF BENEFITS

FOR

EMPLOYEES

Life Insurance	\$20,000
	Your amount of Life Insurance will reduce by 50% at age 65

EMPLOYEES AND DEPENDENTS

Hospital Daily Room and Board Amount	Semi-private
Prescription Drugs	
Deductible	Nil
Co-insurance Percentage	100%
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to \$9
Fertility Drugs Lifetime Maximum	\$18,000

Healthcare

Deductible	Nil
Co-insurance Percentages	
Orthopedic Shoes Expenses	50%
All Other Expenses	100%
Hospital Daily Room and Board Amount	
- for confinement inside Canada	Semi-private
- for confinement outside Canada	Private
- maximum days per disability	31 days
Out-of-hospital Nursing Calendar Year	
Maximum	\$50,000
Mastectomy Brassieres Calendar Year	
Maximum	2 bras
Paramedical Covered Expenses	
Physiotherapist Calendar Year Maximum	\$500
Naturopaths Calendar Year Maximum	\$500
Osteopaths	
- calendar year maximum	\$500
- x-rays calendar year maximum	\$15
Podiatrists	
- calendar year maximum	\$500
- surgical removal of toenails and excision of plantar warts each calendar year	\$100
Chiropractors	
- calendar year maximum	\$500
- per visit maximum	\$40
- x-rays calendar year maximum	\$15

Extracare Covered Expenses

Out-of-hospital Psychologist Calendar Year Maximum	\$500
Out-of-hospital Speech Therapist Calendar Year Maximum	\$500
Out-of-hospital Massage Therapist	
- calendar year maximum	\$500
- per visit maximum	\$30
Nursing Home Care Daily Maximum	\$20
Orthopedic Shoes Calendar Year Maximum	2 pairs
Hearing Aid Maximum (in any 5-year period)	\$2,000
Blood Glucose Monitors	Reasonable & Customary
Elastic Support Hose Calendar Year Maximum	\$75
Lifetime Maximum	Unlimited

Dentalcare

Dental Fee Guide	The Ontario Dental Association Fee Guide in effect on the date treatment is rendered
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Deductible	Nil
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Co-insurance Percentages

Routine Treatment	100%
Major Treatment	60%
Orthodontic Treatment	50%

Plan Maximums

Routine Maximum	Unlimited
Major Calendar Year Maximum	\$5,000
Major Adjusted Calendar Year Maximum	\$2,500
Orthodontic Lifetime Maximum	\$4,000

Visioncare

Deductible	Nil
Co-insurance Percentage	100%
Eyeglass or Contact Lens Maximum (every 2 calendar years)	\$400
Laser Eye Surgery Lifetime Maximum	\$2,000
Contact Lenses for Special Conditions Lifetime Maximum	\$200
Eye Examination Maximum (every 2 calendar years)	\$75

CHANGES IN LIFE INSURANCE BENEFITS

If your Life Insurance benefits change because of an amendment to the plan, or because of a change in your age, class, earnings, etc., the new benefits become effective on the date the change affecting your benefits occurred.

Except where federal or provincial legislation requires otherwise, when a change results in increased benefits you must be actively at work to be eligible for the new benefits. If you are not at work on the date the new benefits would otherwise become effective, the change will not become effective until you return to work.

ELIGIBILITY

If you are a new employee, you will become eligible to join the group plan on the date your service commences. Temporary employees may not join the plan.

- Coverages which require a premium contribution on your part will require proof of insurability if they are not applied for within one month of the date you become eligible.
- If you wish to insure your dependents, you must apply for their coverage. Dependent coverages which require a premium contribution on your part will require proof of insurability if they are not applied for within one month of the date you become eligible to insure your dependents.
- If you do not apply for Optional Semi-private Hospital within one month after you become eligible, you will be required to submit proof of good health unless you are applying for coverage because of involuntary loss of similar coverage through your spouse's plan within one month of loss of coverage under your spouse's plan.
- If you are away from work on the date when your Life Insurance would normally start, it will not become effective until you return to work.
- If you do not apply for coverage within one month after you become eligible, your dentalcare benefits will be subject to certain initial coverage restrictions. Except where the expenses are incurred solely as a result of an accident occurring after the insurance took effect,
 - Routine Treatment expenses are limited to a maximum of \$100 during the first 12 months.
 - no benefits will be paid for Major Treatment expenses during the first 12 months.
 - no benefits will be paid for Orthodontic Treatment expenses during the first 24 months.

DEFINITION OF DEPENDENT

Dependent means:

- Your spouse (legal or common-law)

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

- Your insurable children

Children are insurable if they are

- your or your insured spouse's unmarried natural, adopted, or step child, or
- an unmarried child you or your insured spouse have been appointed guardian for all purposes by a court of competent jurisdiction.

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

Children age 21 or over must either be:

- (1) full-time students under age 25, or
- (2) incapacitated for a continuous period beginning before age 21 **or** while a full-time student and before age 25.

Unmarried children of your spouse are considered dependents only if

- they are also your children, or
- your spouse is living with you and has custody of the children.

Children for whom you or your insured spouse have been appointed guardian are not insurable unless:

- (1) Great-West Life has received satisfactory proof of guardianship, and
- (2) if your insured spouse is the guardian, your spouse is living with you.

Children are considered full-time students if they have been in registered attendance at an elementary school, high school, university, or similar educational institution for 15 hours a week or more sometime in the last 6 months. Children are **not** considered full-time students if they are being paid to attend an educational institution.

Children are considered incapacitated if they are incapable of supporting themselves due to a physical or mental disorder.

LIFE INSURANCE FOR EMPLOYEES

- In the event of your death, your beneficiary will be paid the amount of your group life insurance. (See the **Schedule of Benefits** at the front of this booklet for the amount.)
- Should you become totally disabled while insured and before reaching the age of 65, and such disability continues for an uninterrupted period which ends on the later of the date disability commenced or the date of expiration of sick leave credits, your life insurance will remain in force without further premium payment. Your employer will contact you regarding the appropriate claim forms to be submitted to Great-West Life. Your premiums will be waived upon satisfactory proof of your disability but only until you reach age 65. Satisfactory proof of disability must be submitted within 12 months of the commencement of the disability and when requested thereafter.

If you are not approved for waiver of premium your life insurance will be continued on a premium paying basis until the earlier of the following:

- (1) the date your insurance is terminated by your employer, or
- (2) the date your insurance would normally terminate under the Termination of Insurance section.
- (3) the date you start working for pay or profit other than with this Employer.
- (4) the date premium payment ceases.

- If any or all of your insurance terminates **at or before age 71**, you may be able to apply to convert to an individual policy without medical evidence.

Application to convert to an individual policy must be made within 31 days after termination of insurance. During this period your life insurance under this plan will remain in force free of charge.

Ask your employer for an application form.

OPTIONAL SEMI-PRIVATE HOSPITAL

Should you incur hospital expenses for room and board and other necessary services and supplies above those paid by your provincial government hospital plan, this plan will pay the reasonable and customary charges incurred, provided the confinement is medically necessary and is not for custodial care.

- For regular hospital room and board, the plan pays up to the usual daily charge of the hospital concerned for semi-private care.
- The plan will also pay for charges for confinement in an Intensive Care Unit.
- If you or one of your dependents is confined in a convalescent hospital, the plan pays up to the usual daily charge of the hospital concerned for semi-private convalescent care, as long as the confinement
 - (1) is recommended by your doctor, and
 - (2) follows a 3-day confinement in a hospital as a registered bed-patient and is for the same condition.

Please Note: No benefits will be payable for a hospital confinement which started before your coverage became effective.

Continuation of Optional Semi-private Hospital

If you or your dependents are totally disabled when your Optional Semi-private Hospital terminates, and you have expenses for that illness which would have been paid had your coverage continued, your benefit payments will continue until the earliest of the following:

- the date the disability ceases,
- the date the plan terminates,
- the end of the calendar year next following the calendar year in which you or your dependent's coverage terminates.

PRESCRIPTION DRUGS

Prescription Drugs provides protection against the cost of medically necessary prescription drugs for which there is no reimbursement from the provincial health plans. Prescription Drugs covers only those expenses which are considered reasonable and customary for the drug provided in the area where the expenses are incurred.

Co-insurance Percentage

- The plan pays 100% of covered drug expenses.

Plan Maximums

- The covered expense for the dispensing fee portion of a prescription drug charge is limited to \$9.
- Benefits are limited to \$18,000 for all fertility drug covered expenses during the entire time a family member is covered.

Covered Expenses

- Drugs and medicines prescribed by a doctor and dispensed by a licensed pharmacist (including oral contraceptives). Prescription drug covered expenses will also include drugs and supplies of a non-prescription nature required as a result of colostomy, and /or for the treatment of cystic fibrosis, diabetes, parkinsonism and heart disease.

Limitations

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

- Food and food products including diet and infant foods, contraceptive devices
- Any single purchase of drugs or medicines which would not be used within a 90-day period
- Any drug or item which does not have a drug identification number as required by Section 005 of Division 1 of the Food and Drugs Act, Canada
- Drugs that are registered under Division 10 of the Regulations to the Food and Drugs Act, Canada
- Smoking cessation products
- Drugs used to treat erectile dysfunction

Please Note: Prescription drug coverage is limited to the deductible amount and co-insurance you are required to pay under your Provincial Pharmacare Plan.

HEALTHCARE

Healthcare provides protection against the cost of those medically necessary services and supplies for which there is only partial or no reimbursement from the provincial health plans. Healthcare covers only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Co-insurance Percentage

- The plan pays 100% of all covered expenses.

Covered Expenses

The following services and supplies are covered by your Healthcare benefits **where permitted by law and to the extent they are not covered under your Provincial Medicare Plan:**

Hospital Charges

- Regular hospital room and board up to the usual daily charge of the hospital concerned for Semi-private room in a hospital inside Canada
- Charges for confinement in an Intensive Care Unit
- Convalescent hospital care up to the usual daily charge of the hospital concerned for a private room but only if the confinement
 - (1) is recommended by your doctor, and
 - (2) follows a 3-day confinement in a hospital as a registered bed-patient and is for the same condition
- Other medically necessary hospital services and supplies

Medical Charges

- Doctors' services for treatment provided outside your province of residence
- Radio-active materials
- Oxygen
- Blood transfusions
- Ambulance transportation to the nearest centre where adequate treatment is available (including licensed air ambulance)
- Injectable drugs when administered by a doctor for which no non-injectable alternative is available
- Out-of-hospital treatment of accidental injury to natural teeth completed within 6 months after the accident
- Rental or, at the plan's discretion, purchase of the following supplies, appliances and prosthetic devices prescribed by a doctor:
 - standard wheelchairs (excluding electric wheelchairs except for quadriplegics)
 - standard hospital beds (excluding electric hospital beds), bed rails and trapeze bars
 - trusses and crutches
 - Jobst sleeves for lymphoedema following mastectomy, Jobst burn garments and Jobst support hose
 - braces (excluding lumbar supports)
 - iron lung
 - artificial eyes, including repairs

- artificial limbs (including repairs and replacement but excluding myoelectrical limbs)
- mastectomy brassieres, limited to 2 bras in a calendar year
- Out-of-hospital services of a registered nurse, licensed practical nurse or registered nursing assistant. Benefits are limited to \$50,000 for all services in any calendar year. 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 nurse, licensed practical nurse or registered nursing assistant.
- Out-of-hospital professional services of the following licensed, certified or registered practitioners (when operating within their recognized fields), provided the practitioner is not a member of the employee's family:
 - physiotherapists up to a maximum of \$500 for all visits in any calendar year
 - naturopaths up to a maximum of \$500 for all visits in any calendar year
 - osteopaths up to a maximum of \$500 for all visits in any calendar year and \$15 for all x-rays in a calendar year
 - podiatrists up to a maximum of \$500 for all visits in any calendar year and \$100 for the surgical removal of plantar warts and toe nails in any calendar year
 - chiropractors up to a maximum of \$40 for each visit. Benefits are limited to \$500 for all visits in any calendar year and \$15 for all x-rays in any calendar year.
 - psychologists up to a maximum of \$500 for all visits in any calendar year
 - speech therapists up to a maximum of \$500 for all visits in any calendar year

- massage therapists up to a maximum of \$30 for each visit.
Benefits are limited to \$500 for all visits in any calendar year

Under some circumstances, benefits may not be payable until the government plan concerned has paid its annual maximum. Check with your Human Resources Department if you require further details.

- Confinement in a licensed nursing home up to a maximum of \$20 for each day of confinement provided the confinement has been approved and recommended by a doctor.
- Elastic support hose, limited to a maximum of \$75 in any calendar year
- For an insulin dependent diabetic only, blood glucose monitoring machines and blood letting devices. Supplies for a blood glucose monitoring machine and blood letting devices will also be covered.

Hearing Aids

- The plan covers 100% of covered expenses in excess of coverage provided under the Assistive Devices Program (ADP). Coverage is for hearing aids prescribed by an Ear, Nose and Throat Specialist, provided such expenses are considered reasonable and customary in the area where the expenses are incurred.

The maximum benefit payable is \$2,000 for any one person in any 5-year period.

Batteries and repairs are not included.

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
 - 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.

Points to Note

Neither the communications network nor Great-West Life is responsible for the availability, quantity, quality or results of any medical treatment received by you or a dependent or for unsuccessful attempts by you or a dependent to obtain medical services.

When your insurance terminates, you must return your identification cards to your employer.

Services Not Paid by Healthcare

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- Services not listed as covered expenses
- Delivery and transportation charges
- Services and supplies which are required for recreation or sports but which are not medically necessary for regular activities
- Services and supplies received during a period of hospital confinement which began before your coverage became effective

Continuation of Healthcare

If you or your dependents are totally disabled when your Healthcare terminates, and you have expenses for that illness which would have been paid had your coverage continued, your benefit payments will continue until the earliest of the following:

- The date the disability ceases,
- The date which is 90 days after the group plan terminates,
- The date you have received benefits for a period equal in length to the period for which you were covered,
- The end of the calendar year next following the calendar year in which your or your dependent's coverage terminates.

If your coverage terminates due to termination of Healthcare, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while Healthcare was still in force.

OUT-OF-PROVINCE

The Optional Semi-private Hospital, Prescription Drugs and Healthcare parts of this plan provide coverage for expenses incurred outside your home province when:

- (1) you or your dependent is temporarily out-of-province on business or vacation or for educational or training purposes and the expenses arise as a result of an emergency or unexpected sudden illness, or
- (2) the required medical treatment is not readily available in your home province.

For Optional Semi-private Hospital, if the medical treatment is readily available elsewhere in Canada but you seek treatment outside Canada, benefits will be limited to the reasonable and customary charges of the nearest Canadian medical centre equipped to provide the necessary treatment.

For Prescription Drugs and Healthcare, if the medical treatment is readily available elsewhere in Canada but you seek treatment outside Canada, no benefits will be paid.

Before incurring **any** non-emergency expenses outside Canada it is strongly suggested that you submit a treatment plan so you can know the amount payable before you incur the expense.

Please Note: In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, benefits for hospital expenses incurred outside of Canada are limited to 31 days per disability.

Coverage for hospital confinement outside Canada is limited to semi-private.

DENTALCARE

Dentalcare benefits provide protection against the cost of dental services which are often significant and unexpected. To be considered a covered expense, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred and will be limited to the maximum fee level of The Ontario Dental Association Fee Guide in effect on the date treatment is rendered.

Dentalcare covers necessary dental treatment by a dentist or physician or by other qualified personnel under the direct supervision of the dental or medical profession (e.g. dental assistants and dental hygienists) and will also cover services rendered by dental specialists, denturologists, denturists, dental hygienists and denture therapists where they are permitted by law to deal directly with the public. If there is no fee schedule for these practitioners in your province, payment will be based on the appropriate General Practitioners' schedule.

Co-insurance Percentage

- The plan pays 100% of Routine Treatment covered expenses, 60% of Major Treatment covered expenses and 50% of Orthodontic Treatment covered expenses.

Maximum Benefit

- Benefits are unlimited for all Routine Treatment covered expenses for any one family member.
- Benefits are limited to \$5,000 for all Major Treatment covered expenses for any one family member in any calendar year.

This maximum is reduced to \$2,500 during the first year a family member is covered if his coverage starts on or after July 1 of any calendar year.

- Benefits are limited to \$4,000 for Orthodontic Treatment during the entire time a family member is covered.

Treatment Plan

- Before your dental service provider starts a course of treatment, he will, upon request, prepare a "treatment plan" - a written report describing his recommendations as to necessary treatment and cost.
- It is suggested you submit a treatment plan before treatment starts for any Routine or Major Treatment expected to cost more than \$300, and for all Orthodontic Treatment.
- A pre-determination of the benefits payable for the proposed treatment will then be calculated so you know in advance the portion of the cost you will have to pay. Any pre-determination of benefits is only valid for 90 days from its date of issue.

Orthodontic Treatment Only

Because Orthodontic Treatment is normally rendered over a long period, in calculating the benefits such expenses are considered to be spread over the treatment period in the manner specified below, regardless of the way in which the orthodontist's bill is actually paid.

- **Single-charge basis:** If your orthodontist submits a cost estimate showing a single charge for the total treatment, then the single charge is divided by the number of months of the treatment period. This amount is then paid on a quarterly basis subject to the co-payment under this plan.
- **Itemized basis:** If your orthodontist estimates a separate cost for initial appliances (e.g., braces) the first month's covered expense for orthodontia is considered to be:
 - (1) the estimated cost of these appliances, or
 - (2) 25% of the total estimated orthodontic covered expense,whichever is the smaller amount. The remainder of the orthodontic expenses are averaged over the remaining months of the treatment period.

Covered Expenses

The following items are considered covered expenses under Dentalcare:

Routine Treatment

- oral examinations, polishing of teeth, topical application of fluoride solutions and bite-wing x-rays, twice in any calendar year but not more than once in any 5-month period
- scaling of teeth
- full mouth series of x-rays once every 24 months
- oral hygiene instructions once during the entire time the person is covered
- extractions and alveolectomy at the time of tooth extraction
- amalgam, silicate, acrylic and composite fillings
- dental surgery
- general anaesthesia and diagnostic x-ray and laboratory procedures required in relation to dental surgery
- endodontics (root canal therapy)
- periodontal treatment
- necessary treatment for relief of dental pain
- cost of medication and its administration when provided by injection in the dentist's office
- space maintainers for missing primary teeth and habit-breaking appliances
- consultations required by the attending dentist

- relines and rebases to existing dentures
- repairs to existing bridgework or dentures
- adjustments to bridgework or dentures after the 3-month post-insertion care period
- stainless steel crowns
- pit and fissure adhesive sealants

Major Restorative Treatment

- crowns (other than stainless steel crowns)
- installation of an initial appliance (bridgework or dentures) if such appliance is required because at least one additional natural tooth was necessarily extracted after the effective date of coverage for the individual
- replacement of existing dentures or bridgework if
 - (a) they are required because of the extraction of one or more natural teeth after the effective date of coverage for the individual and the existing bridgework or dentures cannot be made serviceable

If the existing bridgework or dentures can be made serviceable, only the expense of the portion of the replacement bridgework or dentures that replaces the extracted teeth is considered a covered expense
 - (b) the existing bridgework or denture is at least 5 years old and cannot be made serviceable
 - (c) the existing bridgework or denture was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance

(d) the replacement bridgework or denture is made necessary as the result of an initial placement of an opposing denture while covered

(e) the replacement denture or bridgework is made necessary as the result of an accidental dental injury while covered

- treatment involving the use of gold when such treatment cannot be rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice

Orthodontic Treatment

- orthodontic treatment (the correction of malposed teeth) for yourself, your spouse or your dependent children who are at least 6 years of age at the time treatment commences

Exclusions

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- cosmetic treatment, experimental treatment, dietary planning, congenital or developmental malformation
- expense of dentures which have been lost, mislaid or stolen
- charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used
- charges made by a dentist for broken appointments or for completion of claim forms required by the plan
- services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction
- covered expenses for treatment of accidental injury to natural teeth completed more than 12 months after the accident

Continuation of Dentalcare

If the plan has started making payments for Orthodontic Treatment and the coverage for the person receiving the treatment terminates, orthodontic benefits will be continued during the 3-month period immediately following termination of coverage.

If your coverage terminates due to termination of Dentalcare, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while Dentalcare was still in force.

VISIONCARE

Visioncare benefits provide protection against the cost of vision services and supplies rendered or prescribed by an ophthalmologist or an optometrist. Visioncare benefits cover only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Covered Expenses

The plan pays 100% of the following covered expenses:

- Visual training or remedial therapy to correct faulty visual skills but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part.
- Eye examinations (including refractions) but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part. Benefits for these expenses are limited to one exam to a maximum of \$75 every 2 calendar years and is included in the overall visioncare maximum of \$400 every 2 calendar years.
- Eyeglass frames and lenses (or contact lenses selected in place of lenses and frames) when required to correct vision. Benefits for these expenses are limited to \$400 every 2 calendar years.
- Laser eye surgery when required to correct vision. Benefits for these expenses are limited to \$2,000 in a person's lifetime.
- Contact lenses which are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least the 20/40 level in the better eye with ordinary eyeglasses. Benefits for these expenses are limited to a lifetime maximum of \$200.

Services Not Paid for by Visioncare

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- eye tests or examinations required by an employer, school or government for screening purposes
- artificial eyes, non-prescription sunglasses or safety glasses

PREFERRED VISION SERVICES (PVS)

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

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

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

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

Using PVS:

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

CO-ORDINATION OF BENEFITS

If you or one of your dependents is entitled to benefits for the same expenses

- (1) from this plan and some other group plan, or
- (2) as both husband and wife under this plan, or
- (2) from this plan and any government insurance plan, or
- (3) from this plan and any automobile insurance plan, or
- (4) as a spouse under this plan, or
- (5) 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 the expenses actually incurred.

The rules of establishing the benefit determination are that benefits will be determined first under the plan which covers the person for whom expenses have been incurred:

- (a) other than as a dependent; or
- (b) as a dependent of the person whose date of birth, excluding year of birth, is earlier in the calendar year.

GENERAL LIMITATIONS

Your health coverage does not cover Optional Semi-private Hospital, Prescription Drugs, Healthcare, Dentalcare and Visioncare services and supplies in the following situations:

- illness or injury for which you or your dependents are covered under Workers' Compensation or similar program
- services received for confinement which is primarily for chronic or custodial care
- services received in a government hospital unless you are required to pay for such services
- services to which there would be no charge if there were no coverage
- 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 portion thereof provided under any government sponsored hospital or medical care program
- aesthetic surgery (cosmetic surgery for beautification purposes)
- services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits
- services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group

- service, including part-time or temporary service, in the armed forces of any country
- services required due to war (declared or undeclared), insurrection, or participation in a riot
- services required due to any intentional self-inflicted injury or disease, while sane or insane

TERMINATION OF COVERAGE

Your coverage will terminate when:

- your employment ends, or
- the group plan terminates, or
- you stop making required contributions, or
- for Optional Life Insurance, you reach age 65, or
- you are no longer in an eligible class.

Your dependents' coverage will terminate when:

- your coverage terminates, or
- your dependent is no longer an eligible dependent, or
- you stop making contributions for dependent coverage, or
- for optional life insurance, your spouse reaches age 70, or
- you are no longer in a class eligible for dependent coverage.

With regard to injury, sickness, approved leave of absence or temporary lay-off, you may be entitled to continued coverage under this plan. Your employer will provide you with the details on the types of coverage, if any, that may be continued and the length of the extensions available.

CONTINUATION OF BENEFITS FOR DEPENDENTS

In the event of your death, your dependents' benefits (Optional Semi-private Hospital, Prescription Drugs, Healthcare, Dentalcare and Visioncare) which were in force prior to your death, will be continued for a period of 90 days.

- If your surviving children cease to qualify as eligible dependents (as defined earlier in this booklet), the health benefits being continued for your children under this provision will terminate automatically on the date they no longer qualify.
- If a dependent is disabled on the date coverage under this continuation provision would otherwise terminate, payments for that dependent will be continued until the earlier of the following:
 - the date the disability ends,
 - 90 days from the date the coverage terminated.

Please Note: If your dependent is in the hospital on the last day of this 90-day period, payments for that dependent will be continued until the hospital confinement ends.

HOW TO MAKE YOUR CLAIMS

Life Insurance

- If you die, your employer will contact your beneficiary to explain what is required before payment of the insurance money can be made.
- For disability waiver of premium benefits, contact your employer for claim forms and procedures.

Hospital, Prescription Drugs, Healthcare and Visioncare

- Claims for prescription drugs, 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.

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 Healthcare claims not submitted online, 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.

Dentalcare

- For dental claims 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 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.

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 dental claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete this form and send it to the Great-West Life Benefit Payment Office.

Benefit Payments Office

The Great-West Life Assurance Company
Group Health and Dental Claims
255 Dufferin Avenue
London, Ontario
N6A 4K1

Out-of-Country Claims

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

Obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. Unless you are a resident of the Territories 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.

If you are a resident of the Territories, you must submit your out-of-country claims to your territorial government for processing before submitting the claim to Great-West Life. When you receive your Explanation of Benefits back from the territory, please send the following to the Great-West Life Out-of-Country Claims Department (be sure to keep copies for your own records):

- a copy of the payment from your territory
- a completed Statement of Claim Out-of-Country Expenses form (form M5432)
- all required information
- copies of all original receipts

Residents of the provinces 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 Medical Plan portion. Your Provincial 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. 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.