THE
Great-West Life
ASSURANCE COMPANY

My Group Benefits Plan

ENERGIZE
625
INTERNATIONAL BROTHERHOOD ELECTRICAL WORKERS

BENEFIT DETAILS

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

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms

This booklet describes the principal features of the group benefit plan sponsored by your union, but **Group Policy Nos. 165052 and 162053** issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

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

This coverage set out in this booklet is either underwritten or administered by

Plan Administrator

Benefit Plan Administrators (Atlantic) Limited
38 Solutions Drive, Suite 100, Ravine Centre Two
Halifax, NS B3S 0H1
Phone: (902) 455-7277
Toll Free: 1-888-426-4433
Fax: (902) 454-5936

This booklet was prepared on: May 25, 2018

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 fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life’s right to use other legal means to recover the overpayment.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by plan administrator. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit plan administrator’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 plan sponsor has an agreement with Great-West Life in which your plan sponsor has financial responsibility for some or all of the benefits in the plan and we process claims on your plan sponsor’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 Board of Trustees has entered into an agreement with The Great-West Life Assurance Company whereby the Trust Fund will have full liability for the Healthcare and Dentalcare benefits outlined in this booklet. This means the Trust Fund has agreed to fund these benefits and they are, therefore, uninsured.

The Life, Accidental Death, Dismemberment and Specific Loss, Weekly Indemnity and Long Term Disability benefits outlined in this booklet are insured by Great-West Life.

Benefit Administration

Healthcare claims (excluding claims for Drug expenses, expenses for services and supplies subject to Prior Authorization or Health Case Management, Global Medical Assistance, and Out-of-Country Emergency expenses), Weekly Indemnity and Dentalcare are administered by Benefit Plan Administrators (Atlantic) Limited.

Claims for Drug expenses, expenses for services and supplies subject to Prior Authorization or Health Case Management, Global Medical Assistance, Out-of-Country Emergency and Drug expenses, Life, Accidental Death, Dismemberment and Specific Loss and Long Term Disability are administered by The Great-West Life Assurance Company.

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Benefit Summary

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

Life Insurance	$30,000
Dependent Life Insurance	
Spouse	$10,000
Child	$5,000
Member Accidental Death, Dismemberment and Specific Loss (Principal Sum)	$20,000

Member Weekly Indemnity (WI) Insurance	See benefit description
Waiting Period	
Injury	No waiting period
Disease	7 days If you are hospitalized or have day surgery before the last day of the waiting period for disease, benefits will begin on the day you are hospitalized or the surgery is performed
Maximum Benefit Period	26 weeks less the number of full or partial weeks' payment under the Employment Insurance Act of Canada
Amount	An amount equal to the maximum weekly payment under the Employment Insurance Act, integrated with EI sick benefits
Long Term Disability Income Benefits (applicable to Active Members and Self-Pay Members 1-6 months only)	
Waiting Period	181 days
Amount	$1,500

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
Reimbursement Level	
Insulin Infusion Pumps and Convalescent Care	50%
All Other Expenses	100%
Basic Expense Maximums	
Hospital	Semi-private room
Convalescent Care	Semi Private room to a maximum of 60 days per condition
Home Nursing Care	$10,000 each calendar year
In-Canada Prescription Drugs	Included
Smoking Cessation Products	100% of the cost of the first treatment to a maximum of $400 and 50% of the cost of the second treatment to a maximum of $200
Hearing Aids	$1,000 every 60 months
Speech Aids	$1,000 lifetime
Insulin Infusion Pumps	
- Pumps	$3,000 per pump once every 5 years
- Supplies	Unlimited
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	$400 every 24 months
Prosthetic Equipment	$25,000 lifetime
Myoelectric Arms	$10,000 per prosthesis (included in the prosthetic equipment maximum)
External Breast Prosthesis	2 every 24 months
Surgical Brassieres	2 every 12 months

Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	$2,000 lifetime
Blood-glucose Monitoring Machines	$1,000 lifetime
Transcutaneous Nerve Stimulators	$1,000 lifetime
Aerosol Equipment	$1,000 lifetime
Mist tents and Nebulizers	$1,000 lifetime
Enuresis Alarms	$1,000 lifetime
Apnea Monitors	$1,000 lifetime
Peak Flow Meters	$1,000 lifetime
Aerochambers	$1,000 lifetime
Chest Precussors, Drainage Boards and Sputum stands	$1,000 lifetime
Tracheostoma Tubes	$1,000 lifetime
Suction Pumps	$1,000 lifetime
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	$250 each calendar year
Support Hose (when prescribed by physician)	$500 each calendar year
Wigs for Cancer Patients	$200 lifetime
Dental Accident Treatment	$5,000 per accident
Intermittent Positive Pressure Breathing Machines (IPPB)	Once every 5 years to a maximum of $2,000
Continuous Positive Airway Pressure Machines	Once every 5 years to a maximum of $2,000
Automatically Adjusting Positive Airway Pressure Machines	Once every 5 years to a maximum of $2,000
Positive Airway Pressure Machines	Once every 5 years to a maximum of $2,000

Paramedical Expense Maximums

Chiropractors	$1,000 each calendar year
Massage Therapists	$1,000 each calendar year $90 per visit
Naturopaths	$1,000 each calendar year
Osteopaths	$1,000 each calendar year
Physiotherapists	$1,000 each calendar year
Podiatrists	$1,000 each calendar year
Psychologists/Social Workers/ Counselling Therapists	$1,000 each calendar year
Speech Therapists	$1,000 each calendar year

Visioncare Expense Maximums

Eye Examinations	
- dependent children under age 18	$100 once every 12 months
- all others	$100 once every 24 months
Glasses or Contact Lenses or Prescription Sunglasses or Safety Glasses (members only) or Post Cataract Surgery Lenses and Laser Eye Surgery	
- dependent children under age 18	$400 every 12 months to a maximum of 1 pair of glasses or lenses every 12 months
- all others	$400 every 24 months to a maximum of 1 pair of glasses or lenses every 24 months
Contact Lenses for Special Conditions	$200 every 24 months

Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The Nova Scotia dental fee guide in effect on the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	100%
Plan Maximum	
Basic and Major Treatment	$1,500 each calendar year

Before incurring any large basic dental and all major expenses, ask your dental service provider to complete a treatment plan and submit it to the plan administrator. 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.

COMMENCEMENT AND TERMINATION OF COVERAGE

Persons Who May Be Covered

The class of persons who may be covered shall consist of members in good standing of IBEW Local 625 and their dependents, provided you meet the eligibility requirements and provided that initial contributions have been made on your behalf by a contributing employer.

Date of Eligibility

You will become eligible for coverage on the later of the following dates:

- the policy effect date, or
- the date you become a member of the class of persons who may be covered.

Dependents will become eligible for coverage on the later of the following dates:

- the date you become eligible, or
- the date the person becomes a dependent.

Date Coverage Becomes Effective

An account is kept by the plan administrator for each Member, called an "Hour Bank" account. Each month the plan administrator credits a Member's "Hour Bank" Account with the hourly contribution reported by his employer.

A Member and his/her eligible dependents may become insured on the first day of the second month following the date when he/she has accumulated 360 hours in his/her "Hour Bank" Account, provided he/she is actively at work or available for work on that date. Each month 120 hours are deducted from the Members account to pay his/her insurance premiums. The maximum number of hours which a Member can accumulate in his/her "Hour Bank" is 1,440.

Termination of Your Coverage

The insurance of any Member under this Policy shall automatically terminate on the earliest of the following:

- the day this Master Policy terminates or if the Master Policy is amended so that he/she ceases to be eligible;
- the last day of the month in which the Member has less than 120 hours in his/her "Hour Bank" Account, unless otherwise indicated in the paragraph below; or
- on the Member's termination age as indicated in the benefit details

In addition, a Member's eligibility for Weekly Indemnity and Long Term Disability Income Benefits will terminate on the date he/she has depleted his/her "Hour Bank" Account, the commencement of retirement pension or on his/her 60th birthday, whichever is earlier. The termination age for Members that are actively at work on or after their 60th birthday shall be on their 65th birthday.

A Member's coverage will only terminate once there are insufficient hours in their "Hour Bank" Account and they choose not to self-pay.

Termination of a Dependent's Coverage

A Member's dependent coverage terminates at the earlier of:

- when the Master Policy terminates
- their dependent no longer qualifies, or
- upon termination of the Member's coverage, except due to death and as qualified below:

If a Member reaches age 65 and his/her spouse is younger, the Member will have the option of continuing his/her spouse's coverage until the spouse reaches his/her 65th birthday, provided premiums are paid and the Master Policy remains in force.

- 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 plan administrator will provide you with details.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your plan administrator will provide you with details.

Reinstatement of a Member's Coverage

A member whose coverage ceased due to a drop in his/her "Hour Bank" balance to less than 120 hours may be reinstated on the first day of the second month following the month his/her "Hour Bank" balance has reached at least 240 hours.

Self Pay Provision

Any Member who has no hours contributed and is not paying self-pay premiums after a three year period will be required to work 360 hours before they become reinstated into the plan.

Survivor Benefits

If you die while your coverage is still in force, the health and Contact benefits for your dependents will be continued for a period of 12 months or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law or former spouse.

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

  A former spouse means a divorced or ex-common-law spouse of the employee for whom insurance protection for some of the benefits available under the employer's benefit program is mandated by court order

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

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

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

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a new application card that you can obtain by either your administrator or Union office.

LIFE INSURANCE

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

- Your life insurance will not continue past the end of the day of the last day of the month in which you reach age 70 unless you are a Member not actively at work or available for work, in which case your life insurance will not continue past the end of the day of the last day of the month in which you reach age 65.

- If you are a retired pensioner (not working) with 5 years of consecutive Union membership prior to retirement, you are eligible for a $10,000 Life benefit compliments of the Union.

- If you become disabled while insured, Great-West Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

- Your 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 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 any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details.

DEPENDENT LIFE INSURANCE

If one of your dependents dies, Great-West Life will pay you the dependent life insurance benefit. Your plan administrator will explain the claim requirements.

- Your spouse's dependent life insurance will not continue past the end of the day on the last day of the month in which they reach age 65. Your spouse's dependent life insurance may be extended past age 65 if you are actively working and under age 70. Your dependent children's life insurance terminates when you are no longer eligible or when they are no longer considered eligible dependents, whichever comes first.

- If you are disabled and the premiums for your life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.

- Your dependent 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 and your life insurance is continued, your dependent life insurance will be continued on the same basis.

- If your spouse's insurance terminates on or before his or her 65th birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your plan administrator for details.

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

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

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

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

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

Loss of Use

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

Your AD&D insurance will not continue past the end of the day of the last day of the month in which you reach age 70 unless you are a Member not actively at work or available for work, in which case your AD&D insurance will not continue past the end of the day of the last day of the month in which you reach age 65.

Surgical Reattachment

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

Repatriation

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

Educational Benefit for Dependent Children

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

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

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

Family Transportation Benefit

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

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

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $0.44 per kilometre travelled.

Occupational Training Benefit for Spouses

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

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

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

Educational Benefit

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

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

Wheelchair Benefit

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

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

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

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

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

Limitations

No benefits are paid for injury or death resulting from:

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

How to Make a Claim

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

WEEKLY INDEMNITY (WI)

The plan provides you with regular income to replace income lost because of a disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled or until the end of the benefit period, whichever comes first. Check the **Benefit Summary** for the benefit amount, waiting period and benefit period.

- WI benefits are payable after the waiting period if disease or injury prevents you from doing your own job.

- If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.

- Separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 2 weeks of continuous full-time work.

- Your WI benefits are taxable.

- Your Weekly Indemnity coverage will not continue past the end of the last day of the month in which you reach age 60, the date you have depleted your “Hour Bank” Account or the commencement of retirement pension, whichever is earlier. For Members that are actively at work on or after their 60th birthday their Weekly Indemnity coverage will not continue past the end of the the last day of the month in which you reach age 65

Other Income

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

- disability benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts
- benefits under any Workers' Compensation Act or similar law
- to the extent permitted by law, loss of income benefits payable under a provincial or territorial automobile insurance plan that does not take income benefits payable under the Employment Insurance Act (Canada) into account when determining its benefits

Earnings received from an approved rehabilitation plan or program are not used to reduce your WI benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your weekly 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:

- Any period:

  - preceding the date you are first treated by a legally licensed doctor of medicine; or
  - in which you do not participate or cooperate in a reasonable and customary treatment program.

  A reasonable and customary treatment program is systematic treatment:

  - that is performed or prescribed by a legally licensed doctor of medicine or other health care provider or health care facility;
  - that is of the nature and frequency usually required for the condition involved; and
  - where attendance, participation and progress can be verified through medical records.

  Notwithstanding the above, based on the nature or severity of the condition, for a treatment program to be considered reasonable and customary, Great-West Life may:

  - require you to be under the care of a legally licensed doctor of medicine instead of or in addition to another health care provider or health care facility; and
  - require the treatment program to be prescribed, performed or supervised by a legally licensed doctor of medicine certified as a specialist for the condition involved.

  If the use of drugs or alcohol contributes to your disability, the treatment program must be overseen by a legally licensed doctor of medicine and the treatment program's primary goal must be abstinence, unless otherwise approved by Great-West Life.

- Any period you are eligible for Employment Insurance benefits.

- 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 of employment, except in an approved rehabilitation plan or program.

- 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.

- The normal recovery period for treatment performed for cosmetic purposes only. This limitation does not apply where such treatment was undertaken as a result of a disease or injury.

- 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

Notify your plan administrator of your disability as soon as possible and contact your plan administrator to obtain a WI application form.

Please ensure that your claim is submitted within 10 days after the onset of your disability.

The policy number is 165052.

Subrogation Clause

If you become totally disabled due to an injury or disease for which a third party is or may be legally liable, benefits will be paid when you sign and submit a reimbursement agreement to Great-West Life. You will be required to reimburse Great-West Life for benefits received in accordance with the terms and conditions stated in the reimbursement agreement. You must obtain written consent from Great-West Life before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this plan.

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 the earlier of the following:

- you are no longer disabled **as defined by the policy**,
- the commencement of retirement income,
- the date you reach age 60 if you are not actively at work,
- the date you reach age 65 if you are actively at work; or
- the last day of the month coinciding with or next following the 6 months from the date your minimum “Hour Bank” credits deplete

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 no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

- 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 occupation, **and**, except for any employment under an approved rehabilitation plan, you are **not** employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the **Benefit Summary**.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

- Loss of any license required for work will not be considered in assessing disability.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

- 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 60, the date you have depleted your “Hour Bank” Account or the commencement of retirement pension, whichever is earlier. For Members that are actively at work on or after their 60th birthday their 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 if the total of it and the other income you are entitled to receive while you are disabled exceeds 85% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount. Other income includes:

- disability or retirement benefits you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan

- benefits under any Workers' Compensation Act or similar law

- loss of income benefits under an automobile insurance plan, to the extent permitted by law

- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability

- the wage loss portion of any criminal injury award

- disability benefits under a plan of insurance available through an association

- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

Earnings received from an approved rehabilitation plan are not used to further 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.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Vocational Rehabilitation

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Great-West Life. In considering whether to recommend or approve a rehabilitation plan, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination

Medical coordination is a program, recommended or approved by Great-West Life, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

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 after you fail to 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.

- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan.

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

- Any period after you fail to participate or cooperate in a required medical or vocational assessment.

- The scheduled duration of a 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 in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life pre-authorized the absence prior to your departure.

- Any period of incarceration, confinement, or imprisonment by authority of law.

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

How to Make a Claim

Before the end of the weekly indemnity benefit period, Great-West Life will ask your plan administrator to provide information to begin processing your LTD claim. All information must be submitted within 3 months of the request.

The policy number is 165052.

Subrogation Clause

If you become totally disabled due to an injury or disease for which a third party is or may be legally liable, benefits will be paid when you sign and submit a reimbursement agreement to Great-West Life. The member will be required to reimburse Great-West Life for benefits received in accordance with the terms and conditions stated in the reimbursement agreement. You must obtain written consent from Great-West Life before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this plan.

HEALTHCARE

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.

Your healthcare coverage will not continue past the end of the day on the last day of the month in which you reach age 70 or upon depletion of your hour bank. If you are not actively at work or available for work your healthcare coverage terminates when you reach age 65 or upon depletion of your hour bank, unless otherwise required by law.

Covered Expenses

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

- Semi-private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care.

    - Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

- Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care. Convalescent care is limited as shown in Benefit Summary.

- Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

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

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

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

- Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse

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

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision.

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

  - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips

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

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

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

- You will be provided 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.

- **The Maintenance Program:** This program encourages patients to get a larger drug supply for medications intended for treatment of a chronic condition. The intent is to increase patients' awareness while reducing the number of dispensing fees associated with medications used for maintenance conditions.

  When a claim is submitted for any of the selected maintenance drugs listed in the program, the pharmacist will be informed that the patient is eligible for a 3 month supply of medication. The pharmacist may ask the patient if he/she would like to participate in the program. If the patient refuses, the pharmacist will use an override code and the claim will be adjudicated in the same manner as other eligible prescription drugs that are covered under the plan. If the patient agrees to participate, the pharmacist may need to contact the patient's doctor to increase the days supply. Upon approval from the physician, the pharmacist would then adjust the drug quantity and days' supply by resubmitting the claim for three months.

How to Make a Drug Claim

- If you did not use your drug card for your prescription and are submitting a paper claim, obtain a claim form from the Great-West Life website at www.greatwestlife.com. Complete this form making sure it shows all required information. Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

The policy number is 165053.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase and repairs, when prescribed by a physician

- Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a physician when no alternative method of communication is possible

- 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

- External insulin infusion pumps prescribed by a physician

- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan

- Treatment of injury to sound natural teeth. Treatment must start within 100 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 12 months after the accident
  - orthodontic diagnostic services or treatment

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- 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

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

- Out-of-hospital treatment by a registered psychologist, qualified social worker or registered counselling therapist

- Out-of-hospital treatment of speech impairments by a qualified speech therapist

Visioncare

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

- Glasses or prescription sunglasses or safety glasses (for members only) or contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

- Contact lenses when the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses

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

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 dependents are outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

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

- The following services and supplies are covered when related to the initial medical treatment:

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

How to Make an Out-Of-Country Emergency Care Claim

- Obtain an Out-of-Country claim form from the Great-West Life website at www.greatwestlife.com. 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.

The policy number is 165053.

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

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

- Expenses private 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
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and 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
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Fertility drugs
- Anti-obesity drugs
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Preventative immunization vaccines and toxoids. This limitation does not apply to vaccines used for the prevention of shingles
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Drugs used to treat erectile dysfunction

Prior Authorization

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

For services and supplies, including a listing of the prior authorization drugs, go to www.greatwestlife.com.

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

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

Health Case Management

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

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

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

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as Great-West Life determines, where:

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

Designated Provider Limitation

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

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

Patient Assistance Program

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

If you or your dependents are eligible for a patient assistance program, you or your dependent may be required to apply to and participate in such a program. Where financial assistance is available from a patient assistance program the plan administrator requires participation in, the covered expense for a service or supply may be reduced by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- For all other Healthcare claims, obtain a claim form from your plan administrator. Complete this form making sure it shows all required information. Attach your receipts to the claim form and return it to your plan administrator as soon as possible, but no later than 15 months after you incur the expense.

For drug claim enquires please call Great-West Life
Customer Contact Services - Toll Free: 1-800-957-9777

The policy number is 165053.

CONTACT – EMPLOYEE ASSISTANCE PROGRAM

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact employee assistance program are available by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English:	1-800-387-4765
For service in French:	1-800-361-5676

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: **www.shepell.com**.

DENTALCARE

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 practicing 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 practice independently, or performed by a denturist.

Your dentalcare coverage will not continue past the end of the day on the last day of the month in which you reach age 70 or upon depletion of your hour bank. If you are not actively at work or available for work your dentalcare coverage terminates when you reach age 65 or upon depletion of your hour bank.

Treatment Plan

- Before incurring any large basic dental and all major expenses, ask your dental service provider to complete a treatment plan and submit it to the plan administrator. 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 24 months
  - limited oral examinations once every 6 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 6 months
  - complete series of x-rays every 24 months
  - intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing and topical application of fluoride each once every 6 months. Fluoride treatments are covered for dependent children under age 21 only
  - scaling, limited to a maximum combined with periodontal root planing of 8 time units each calendar year

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - pit and fissure sealants once per tooth every 24 months to a maximum of $100

- space maintainers including appliances for the control of harmful habits
- finishing restorations
- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 1 year old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months

- Periodontal services including:

  - root planing, limited to a maximum combined with preventive scaling of 8 time units each calendar year

  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

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

  - periodontal surgery to a maximum of 4 sites each calendar year, one procedure per site

  - periodontal appliances when approved by a dental consultant

- Denture maintenance, including:

  - denture relines for dentures at least 6 months old, once every 36 months

  - denture rebases for dentures at least 2 years old, once every 36 months

  - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months

- Oral surgery

- Adjunctive services

Major Coverage

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns. The cost of a temporary stainless steel crown will be deducted from the cost of a permanent crown.

- Onlays and inlays. Coverage for tooth-coloured onlays or inlays on molars is limited to the cost of metal

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

- Removal and recementation of crowns, onlays and inlays

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- When implants are provided, benefits are subject to the Alternate Benefit Clause and will be limited standard dentures or bridgework. In order to confirm coverage the plan administrator requires an estimate from the dentist who is performing the surgery as well as the dentist who will be doing the restoration.

- Denture-related surgical services for remodelling and recontouring oral tissues

- Denture and bridgework maintenance following the 3-month post-insertion period including:

    - denture remakes, once every 36 months

    - denture adjustments, once every 12 months

    - denture repairs and additions, tissue conditioning and resetting of denture teeth

    - repairs to covered bridgework

    - removal and recementation of bridgework

Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling

- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants

- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations

- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns and staining porcelain

- Crowns, onlays and inlays if the tooth could have been restored using other procedures. If crowns, onlays and inlays are provided, benefits will be based on coverage for fillings

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

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

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

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

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

- 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

- 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

- Congenital defects or developmental malformations in people 19 years of age or over

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

How to Make a Claim

- Obtain a claim form from your plan administrator. Have your dental service provider complete the form and return it to your plan administrator as soon as possible, but no later than 15 months after you incur the expense.

The policy number is 165053.

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 a member 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.