THE Great-West Life ASSURANCE COMPANY

THE CATHOLIC INDEPENDENT SCHOOLS OF VANCOUVER ARCHDIOCESE

All Employees on an Approved Leave of Absence

BENEFIT DETAILS

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

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

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

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

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

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

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

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

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

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

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

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

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 335645** and **Plan Document No. 56565** 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.

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

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

10-16

Access to Documents

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

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life’s right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

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 policy 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 Dental 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.

TABLE OF CONTENTS

Welcome to Great-West Life!

Welcome to Great-West Life! Your employer and Great-West Life have worked together to develop a package of benefits to meet your needs. These benefits are an important part of the total compensation package from your employer.

Our goal is to make it easy for you and your family to have your questions answered. If you have any questions about your benefits, you can ask your employer or contact a customer service representative.

Why is this booklet important

This booklet outlines the benefits that are available under your employer's policy with Great-West Life. The section called "General Terms" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides and what you are not covered for.

Definitions

Here are definitions for some of the terms in your employee booklet. You will find more definitions included in each section.

Child

A child is your unmarried son or daughter. This includes a step-child and a common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance.

A child must be under age 22 and depend on you for support and maintenance. We will continue coverage while the child is under age 25 and attending an accredited college or university on a full-time basis. We must receive confirmation that the child is a full-time student and remains dependent on you for support and maintenance.

We will continue coverage beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as:

- the child became handicapped before reaching the applicable maximum age stated above, and
- we receive proof satisfactory to us that the child is not capable of self-support due to the handicap.

Covered person

Covered person means you or your dependent who is covered under the plan.

Dependent

A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Emergency

An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Employee

Employee means you while working for your employer on a permanent and non-seasonal basis for at least 20 hours a week.

Family

You and all your dependents who are covered under the policy.

Illness

Illness means a sickness or disease of the mind or body, including conditions related to pregnancy.

Insured person

Insured person means you or your dependent who is covered under the policy.

Reasonable Treatment

Reasonable treatment means treatment that is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is a form, intensity, frequency and duration essential to diagnosis or management of an illness, injury or pregnancy.

Spouse

A spouse is a person to whom you are legally married.

Only one spouse can be covered at a time.

Waiting period for coverage

The waiting period for coverage is the time you must wait before coverage may begin.

We, our and us

We, our and us mean The Great-West Life Assurance Company.

General Terms

Waiting period for coverage

There is no waiting period for coverage.

When your coverage begins

You must enrol to receive coverage. Your employer can provide you with the form to complete. This form must be signed and dated.

When you enrol

If you are not actively at work

If you are not actively at work on the date coverage would begin according to the following, your coverage will begin when you are actively at work.

If you enrol before the end of the waiting period for coverage

Coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

If you enrol after the end of the waiting period for coverage

If you enrol within 31 days of the end of the waiting period for coverage, coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

Proof of insurability is required if you enrol more than 31 days after the end of the waiting period for coverage. Coverage will begin on the date the proof of insurability is approved by us, if you are actively at work on that day.

When you enrol and apply for family coverage

If you enrol and apply for family coverage before the end of the waiting period for coverage

Coverage for a dependent who is not hospitalized will begin on the date your coverage begins.

If you enrol and apply for family coverage after the end of the waiting period for coverage

If you enrol within 31 days of the end of the waiting period for coverage, coverage for a dependent who is not hospitalized will begin on the date your coverage begins.

Evidence of good health is required if you enrol more than 31 days after the end of the waiting period for coverage. Coverage for a dependent who is not hospitalized will begin on the date the dependent's evidence of good health is approved by us or the date your coverage begins, whichever is later.

If your dependent is hospitalized

If your dependent other than a newborn child is hospitalized on the date coverage would otherwise begin, coverage for that dependent will begin on the first day after the dependent is discharged from the hospital.

Health and Dental coverage for a newborn child will begin at birth or the date dependent coverage would otherwise begin, whichever is later.

What changes to report to your employer

You must report the following changes immediately to your employer:

- changes in dependent coverage;
- adding or removing a dependent;
- change of spouse;
- change to your coverage;
- change of name;
- change of banking information (if we are depositing your claim expenses directly into your bank account).

You report these changes by filling out the appropriate form that is available from your employer. You must sign and date all forms.

Any resulting change in your coverage will take effect on the date the above changes occur. You must be actively working for any increase in coverage to take effect.

When your coverage ends

This section applies to all benefits. Any additional terms that apply to a particular benefit have been included in that benefit section.

Your coverage ends

Your coverage will end on the earliest of the following dates:

- the date you no longer satisfy the definition of employee;
- the date you become a full-time member of the armed forces.

If you are absent from work due to a temporary lay-off, coverage may be continued until the last day of the month that follows the month the lay-off began unless the temporary lay-off is due to the end of the school year in which case coverage will continue until the beginning of the following school year.

Health coverage for an employee who is absent from work due to an approved leave of absence may be continued until the earlier of:

- the termination date stated in the written notice from the employer, and
- the 12th month following the date the leave began.

Your dependent coverage ends

A dependent's coverage will end on the earliest of the following dates:

- the date your coverage ends;
- the date your dependent no longer satisfies the definition of dependent.

Beneficiary designation

You may make, alter or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

Medical examinations and autopsies

When you apply for coverage, we may ask for a medical examination by a physician of our choice, depending on the medical condition or the amount of coverage applied for. We will pay for this examination.

You will have to pay for this examination if the application is completed more than 31 days after the end of the waiting period for coverage.

When you submit a claim for payment, we may ask the covered person to have medical examinations by physicians of our choice. We will pay for these examinations. We will not make any claim payments if the covered person refuses to have these examinations.

If a death occurs, we can ask for an autopsy to be performed. We will pay for the autopsy.

Recovering damages from a third party

If another person or organization is responsible for causing a disability or a medical or dental condition, we will suspend payments and recover our payments from the amount you recover for loss of income or the medical or dental condition through legal action or an out-of-court settlement as we are entitled in law to do. We also reserve the right to recover our payments directly from the person or organization that caused the disability or condition. You shall co-operate with us in our attempt to recover our payments, including participation in a lawsuit. You must notify us of any planned legal action and when payments are received.

Incontestability

If a loss or disability occurs within the first two years of coverage or increased coverage, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

If a loss or disability occurs two or more years after coverage begins or increases, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person fraudulently either made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

We can end coverage at any time if the covered person made any false statement about age.

Your Health Care coverage

What is Your Health Care coverage

We will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy.

We will only cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made.
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care.
- Services and supplies that we are legally allowed by the government to cover. We will not cover any portion of services or supplies which the insured person is entitled to receive, or for which the insured person is 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.
- Charges for services and supplies that are incurred while the person is insured.

The coverage includes the following. Details of coverage can be found under "What you are covered for":

- Drugs
- Hospital accommodation
- Laser eye surgery, eye examinations, eyeglasses or contact lenses
- Medical services and equipment
- Paramedical services
- Referrals for medical treatment outside the insured person's home province
- Emergency out-of-province/country treatment

How much we will pay

We will pay a percentage of the covered medical costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

The deductible is $25, each calendar year, unless otherwise shown below.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

For covered drugs purchased in Quebec, 80% of the covered costs after the deductible is paid.

For covered drugs purchased outside Quebec:

- covered drugs purchased from Costco Wholesale Canada Ltd. or one of its affiliates using the drug card, 90% of the covered costs after the deductible is paid.
- covered drugs subject to Prior Authorization or Health Case Management and purchased from a provider designated by us (whether or not the insured person used the drug card), 90% of the covered costs after the deductible is paid.
- covered drugs purchased from another source or covered drugs purchased without the drug card, 80% of the covered costs after the deductible is paid.

For hospital expenses, 80% of the difference between the cost of a ward and a semi-private room in a hospital after the deductible is paid.

For laser eye surgery, eyeglasses and contact lenses, 80% of the covered costs up to $250 and $65 for eye examinations in any two consecutive calendar year period for an insured person age 21 and over and every calendar year for an insured person under age 21 after the deductible is paid.

For emergency out-of-province/country, 100% of the covered costs above the insured person's provincial health plan coverage with no deductible.

For all other expenses, 80% of the covered costs after the deductible is paid.

When your Health Care coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply to when your coverage ends.

Coverage for surviving dependents

If you die, Health Care coverage for your dependents may continue until your spouse remarries or until the second anniversary of your death, whichever is earlier.

If the insured person is totally disabled when your employment ends

Coverage will be continued for you or your dependent who is totally disabled on the date it would otherwise end because you are no longer employed. We will continue to pay covered costs that result from the total disability for 90 days, while the policy is in force.

For Health Care coverage, you are totally disabled while unable to perform the essential duties of any occupation for which you are reasonably suited by education, training or experience, for any employer.

For Health Care coverage, a dependent is totally disabled while:

- unable to perform the normal activities of a person of the same age and sex, and
- receiving treatment from a physician because of illness or injury.

What you are covered for

Drugs

We cover the cost of drugs that can only be obtained with a prescription and are prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them. We will only pay for eligible drugs that are approved by the Canadian government for sale to the general public and that have a Drug Identification Number (DIN). This does not include experimental drugs. We also cover some life-supporting, non-prescription drugs approved by us as well as disposable needles, syringes, lancets and testing materials for monitoring diabetes.

We cover up to a 100 day supply for all drugs.

An insured person can use the drug card to purchase eligible drugs. Use of the drug card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the insured person. We, or our authorized agent, are not legally liable for this information.

Use of the drug card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the insured person. We, or our authorized agent, are not legally liable for this information.

You are responsible for the payment of all charges at the time of purchase. We will reimburse you on the earlier of the date (i) 30 days from the date of purchase and (ii) the date the covered drug costs are $75 or more.

A physician, dentist, clinic, hospital, or some pharmacies may not be able to process a claim using the insured person's card, but you can make a claim for the cost of eligible medicines by using a claim form and including the receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN).

If an insured person's drug card is lost or stolen, it must be reported immediately to the employer.

We will not pay for the following:

- alcohol
- bandages
- contraception, other than contraceptive drugs and products containing a contraceptive drug which are *not* used for contraception
- drugs used as abortifacients
- cosmetic items
- hair growth stimulants
- sunscreens
- cotton
- vitamins (except injectible), minerals, dietary supplements
- food substitutes, infant food or formula
- disinfectants
- fertility drugs
- homeopathic medicines
- immunizations and vaccines
- non-disposable insulin injectors
- products used to quit smoking
- spring loaded devices used to hold lancets
- products used to lose weight

Hospital accommodation

We will cover the difference between the cost of a ward and a semi-private room in a hospital. Room charges for outpatients will not be covered. The hospital stay must be because of illness, injury or pregnancy.

A hospital is a facility that is licensed to provide active, convalescent or chronic care treatment for sick or injured patients. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care.

Laser eye surgery, eye examinations, eyeglasses or contact lenses

We will cover the cost of laser eye surgery, contact lenses or eyeglasses, including sunglasses or safety glasses, prescribed by an ophthalmologist or optometrist, if they are prescribed to correct vision. We will pay up to the maximum amount shown in the "How much we will pay" section.

We will cover the cost of one eye examination (including eye refractions)

- every calendar year for an insured person under age 21, or
- every two calendar years for an insured person age 21 or over.

We will pay 50% of the cost of:

- visual training
- remedial exercises.

When you make a claim, make sure that the receipt includes the name of the person who was prescribed the eyeglasses or contact lenses, as well as the date on which they were received. Receipts for deposits are not acceptable. If you have a receipt for a deposit, send it along with the receipt for the balance when you make a claim.

Preferred Vision Services (PVS) Discount

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.

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 aid, if needed

- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery

- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Medical services and equipment

We will cover the cost of the following services and supplies if they are prescribed by a physician:

- services provided by a professional nurse. We must approve the services before we will cover the cost. These services must be provided in the insured person's home by a professional nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

  We will pay up to $10,000 per calendar year until the insured person reaches age 65. After age 65, we will pay up to $10,000 per calendar year with a lifetime maximum of $25,000. This change to a lifetime maximum takes place on the January 1st following the 65th birthday. If the birthday is January 1st, this $25,000 lifetime maximum begins on the 65th birthday.

  We will not cover the cost of a professional nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a professional nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

  A professional nurse is a Registered Nurse or a Licensed Practical Nurse. If the insured person lives in Ontario, a professional nurse is a Registered Nurse or a Registered Practical Nurse.

- out-patient services and supplies from a hospital in the insured person's home province or from a surgical supply company.

- walkers, braces, artificial limbs and eyes, and other prosthetic devices that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a device. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover.

- crutches and canes.

- initial pair of frames and one corrective lens, contact lens or prosthetic lens prescribed after cataract surgery and only for the eye that had the surgery. We will cover once per eye in the insured person's lifetime.

- breast prosthesis after a mastectomy, including replacement(s) every two calendar years, and two surgical bras in a calendar year.

- oxygen.

- custom-made orthopaedic shoes, prescribed by a physician, podiatrist or chiropodist, when no other method such as orthotics and/or off-the-shelf orthopaedic shoes can correct the problem. We will cover one pair each calendar year. We will not cover modifications to shoes.

- foot orthotics prescribed by a physician, podiatrist, or chiropodist, 2 pairs per two calendar years for an insured who is a dependent child under 19 years of age and 1 pair per two calendar years for all other insured. They must be determined as being necessary by a biomechanical examination and be custom-made. They must be required to carry out regular daily living activities, and not just for sports or recreation. We will pay up to $300 in any two calendar years.

- two pairs of surgical stockings each calendar year.

- wigs, up to $100 in the insured person's lifetime following chemotherapy or radiation treatment, and up to $250 in the insured person's lifetime for total hair loss from alopecia totalis, a medical condition where all of the hair is lost.

- certain diagnostic tests, radium treatments and x-rays performed in the insured person's province of residence when coverage is not available under the provincial government.

- services directly provided by a speech therapist. The speech therapist must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to $1,000 per insured person in a calendar year.

- services directly provided by a clinical psychologist. The psychologist must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to $1,000 per insured person in a calendar year.

- hearing aids and repairs, not including batteries. We will pay up to $500 in any period of four consecutive calendar years.

- rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that we approve. We may cover the cost of purchasing this equipment if we determine that it is more economical than renting. We must approve the purchase before it is made. We will pay for the least expensive device that is medically adequate.

The following is a list of examples of items that we will cover if prescribed by a physician and approved by us:

- aerochambers
- apnea monitor
- casts
- ostomy supplies
- compressors
- blood glucose monitor
- grab bars
- Mozes detector
- nebulizers to administer asthma medication
- oxygen equipment and
- T.E.N.S. machine (for chronic pain)

The following is a list of examples of items that we will not cover even if prescribed by a physician:

- air conditioners or purifiers
- blood pressure kits
- breast pumps
- Craftmatic, Ultramatic or other lifestyle beds
- exercise equipment, machines or programs
- home or car modifications (for example, ramps or lifts)
- humidifiers
- mattresses (except for standard mattresses with approved hospital beds)
- Obus Formes or orthopaedic pillows

Ambulance services

We will cover the cost of a licensed ambulance or other emergency service that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the insured person, if it is medically necessary.

Dental accident

If healthy, natural teeth are damaged or lost due to a sudden impact, we will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while the insured person is covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount we will pay is based on the least expensive treatment that is adequate to correct the damage. We will not cover more than the fee stated in the current Dental Association General Practitioner's Fee Guide. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, we must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing crossbites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

Paramedical services

We will pay up to $500 in a calendar year for the services of each of the following:

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists
- naturopaths
- osteopaths
- physiotherapists

Costs for speech therapists and clinical psychologists are included in Health Care coverage. For details, please look under “Medical services and equipment.”

We will cover up to the usual charge for each service, up to the maximum charge set in the Schedule of Fees for the type of paramedical practitioner providing the service. If there is no Schedule of Fees, we will set a fee for the service.

We will cover the cost of laboratory tests and x-rays recommended by a licensed chiropractor, osteopath or podiatrist.

Where provincial registration exists, the paramedical practitioner must be registered in the province where the service is given, and the paramedical practitioner cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family.

Other Services and Supplies

We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Referrals for treatment outside your home province

If a physician in the insured person's home province gives a written referral for treatment that is not performed in that home province, we will cover the cost of the treatment as specified below, if it is provided in Canada or the United States.

The physician must give us full details of the treatment and we must approve it in advance. The insured person must apply and provide us with a statement from the provincial health plan that describes what it will cover.

We will pay up to $10,000 in the insured person's lifetime for the following:

- hospital room and board at the ward rate
- hospital services and supplies, and
- diagnosis and treatment by physicians

Emergency out-of-province/country coverage

The insured person must be eligible for benefits under a government health plan in Canada to qualify for emergency out-of-province/country coverage.

We will only cover the first 30 days of a trip.

We will cover the cost of emergency treatment, described below, that is required while temporarily outside the home province, (including outside Canada) on business or vacation. We will not cover emergency treatment while travelling for health reasons. An emergency means any sudden, unexpected illness or injury which requires immediate treatment. We will pay up to $10,000 for each insured person for all the covered costs related to any one emergency under this emergency out-of-province/country coverage. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

When used under this emergency out-of-province/country section, hospital means a facility licensed to provide emergency treatment for sick or injured patients. It must have facilities for diagnosis and treatment. Physicians and registered nurses must be in attendance 24 hours a day. It does not include nursing homes, homes for the aged, rest homes, convalescent care facilities or any facility that provides similar care.

We will cover the charges for emergency treatment that are over the amount covered by the provincial health plan of the insured person's home province. This coverage includes the cost of:

- hospital room and board at the ward rate
- hospital services and supplies, and
- treatment by licensed physicians

In emergency out-of-province/country situations, other charges included under the Health Care coverage section of this policy are covered to the same extent that they would be in Canada. This includes coverage such as wheelchair rental, crutches and prescription drugs.

In the event of a medical emergency, you or someone acting on your behalf must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible for you to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, you must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you or your dependents be moved to a different facility at the destination, and you choose not to go, eligible costs for emergency coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you or your dependent return to your home province, and you choose not to go, emergency coverage will end.

What is not covered for Emergency out-of-province/country treatment

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while you or your dependent was operating a vehicle, vessel or aircraft, if you or your dependent :
    i) were impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Please see "What you are not covered for under any Health Care coverage" section for additional terms that apply to emergency out-of-province/country and the Health Care coverage.

How to make an out-of-province/country claim

There are special rules for claiming the costs of emergency treatment outside of your home province or Canada.

For all medical expenses, complete the applicable forms, making sure all required information is included. Attach all initial receipts and forward to Great-West Life after the expense is incurred. This will enable Great-West Life to co-ordinate payment directly with the hospital and/or medical provider involved, providing the insured person gives approval to Great-West Life to co-ordinate payment with the Provincial Health Care plan. It is very important that you send your claims to the Great-West Life Out-of-Country Claims Department immediately as your Provincial Health Care Plan has very strict time limitations.

If a medical provider or hospital bills you directly, send the bill along with your claim form to Great-West Life Out-of-Country Claims Department.

What you are not covered for under any Health Care coverage

We can decline a claim for services or supplies that were purchased from a provider that is not approved by us.

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

We will not pay for the cost of:

- services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply determined by us to be a covered service or supply
- health care services or supplies that the insured person is eligible to claim under Workers' Compensation legislation in the insured person's province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the insured person is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, the insured person's employer, a school or anyone other than the insured person's physician (For example, the insured person's employer requiring a doctor's note or a court requiring that the insured person receive psychological services.)
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

Prior Authorization

In order to determine whether coverage is provided for certain services and supplies, we will maintain a limited list of services or supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the Great-West Life website as follows:
http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

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

If the use of a lower cost alternative service or supply represents reasonable treatment, an insured person may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

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

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

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

Health Case Management Limitation

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

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

Health Case Management Expense Benefit

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

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that a new service or supply be purchased from or administered by a provider designated by us, and:

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

Patient Assistance Program

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

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

Co-ordination of benefits with your spouse's plan

Co-ordination with your spouse's plan is one of the advantages of the group policy. It may allow you to receive up to 100% of Health Care costs. First, you must have family coverage that includes Health Care coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage where they work.

Here are the procedures to follow:

Claiming your expenses

If you are claiming your expenses, the claim must be sent to us first. We will pay for the portion of the claim that is covered by us and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to their group plan.

Claiming your spouse's expenses

If you are claiming your spouse's expenses, a claim must be sent to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

Claiming your child's expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinated based on the standard industry guidelines.

Submitting a claim

Claims for prescription drugs, paramedical services and visioncare may be submitted online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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 claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer. Complete this form making sure it shows all the required information.

Make sure that your receipts include:

- the name of the person who received the service or supply
- the date the service or supply was received
- the type of service or supply and
- the cost

Your Dental coverage

What is Your Dental coverage

We pay for the covered dental care charges that are incurred while the person is covered and care was provided by a licensed dentist, denturist, dental hygienist entitled by law to practice independently, anaesthetist or specialist. When we use the term “dentist” in this provision, we intend it to include all of the above.

How much we will pay

The amount we will pay is based on the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide.

We base coverage on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, we will only cover the cost of the least expensive treatment.

We will pay a percentage of the covered dental costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

There is no deductible for covered dental costs.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

Preventive coverage

100% of Preventive covered costs with no deductible.

Maintenance coverage

100% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is unlimited.

Major restorative coverage

50% of Major restorative covered costs with no deductible. The maximum we will pay is $1,000 per covered person in a calendar year.

Orthodontic coverage

50% of Orthodontic covered costs with no deductible. The maximum we will pay is $3,000 per covered person in a lifetime.

Limitation

If you enrol more than 31 days after the end of the waiting period for coverage, the maximum amount payable to you for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

If you enrol for family coverage more than 31 days after the end of the waiting period for coverage or more than 31 days after first acquiring a dependent, the maximum amount payable for each dependent for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

Please refer to the “General Terms” section for details on the waiting period for coverage and enrolment procedures.

When your Dental coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply when your coverage ends.

Coverage for your surviving dependents

If you die, dental coverage for your dependents may continue until your spouse remarries or until the second anniversary of your death, whichever is earlier.

When your Dental treatment will cost more than $500

If the cost of any dental treatment will be more than $500, we recommend that you send us a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. We will determine how much of the treatment is covered and give a written estimate of how much the covered person will be responsible to pay before the treatment begins.

We may also need the following information:

- a fully completed written estimate; and
- pre-operative x-rays, study models, and laboratory reports.

If we ask for the above information, we cannot process the pre-determination or pay any claim until we receive it.

What you are covered for

Dental coverage is made up of various types of coverage. We have included detailed descriptions of each type below.

Preventive coverage

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays, fluoride treatment and fillings.

1. Examinations

A. Initial or Complete Examinations

A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment.

One complete examination is covered per lifetime, once per general practitioner.

B. Recall Examinations

A recall examination includes a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient.

One recall examination is covered every six months.

C. Specific Examinations

A specific examination may include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion.

One specific examination is covered once every six months.

D. Emergency Examinations

An emergency examination includes checking for pain or infection and pulp vitality tests.

E. Consultation

This is a visit to the covered person's dentist to discuss a serious dental problem and to agree on a treatment plan and is covered for up to $50 per consultation.

2. X-rays

A. Full Mouth Series X-rays

Full mouth x-rays are a series of at least 16 films including bitewings. One series is covered every 36 months.

B. Panorex X-rays

A panorex is one view of the entire mouth and is covered once every calendar year.

C. Periapical X-rays

Periapical x-rays are x-rays of single teeth. These are limited to the maximum amount payable for 13 films per covered person per calendar year.

D. Bitewing X-rays

A bitewing x-ray is used to detect decay in molar teeth. One set of bitewing x-rays are covered every 6 months.

E. Bite X-rays

Bite x-rays are x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact. There is no limit to the number of bite x-rays the covered person is covered for.

3. Tests

A. Biopsy of Oral Tissue

A biopsy occurs when a small piece of tissue is removed and sent to a laboratory to be tested for disease. There are no limits.

B. Pulp Vitality Test

The pulp is the soft tissue inside a tooth. This test is performed to see if the pulp is healthy. One pulp vitality test per tooth is covered if the test is done more than 30 days prior to a root canal therapy.

4. Unmounted Study Models

These are diagnostic casts or models of the upper and lower teeth, each separate from the other. These are used for diagnostic ability or for construction of impression trays and temporary bridges and partial denture. These are limited to one set per calendar year.

5. Cavity Prevention

A. Polishing or Cleaning Teeth

One unit (15 minutes) is covered each visit and up to one treatment every six months.

B. Recall Scaling

One unit (15 minutes) is covered each visit and up to one visit every six months as part of the Recall Package. (For periodontal scaling, please see the "Treatment of gums" section.)

C. Fluoride

Fluoride is a substance which is applied to the teeth to strengthen the enamel and prevent decay in primary and permanent teeth. The covered person is covered for one treatment every six months.

D. Recall Package

Recall Package includes polishing, recall scaling and recall examinations. It may also include fluoride and is covered once every six months.

E. Pit and Fissure Sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. There is no limit to the number of treatments the covered person is covered for.

6. Space Maintainers

A. Space Maintainers

A space maintainer is an appliance that a dentist uses to maintain a space where a tooth has been removed.

B. Maintenance of space maintainers

Maintenance of a space maintainer means adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed.

7. Fillings

Please note: These procedures may include local anaesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

All restoration done to the same tooth will be covered as a single visit to the dentist.

A. Amalgam Fillings

These are silver fillings that are used to restore teeth. If a bonded silver filling is installed, we will only cover the cost of a non-bonded silver filling.

B. Composite Fillings

These are white filling that are used to restore teeth.

C. Veneer Applications

Veneers are white facings put on a tooth's surface. Veneer applications that are done for cosmetic purposes are not covered.

D. Retentive Pins

These are pins used to make sure that a restoration or filling stays in place.

E. Pre-fabricated Posts

These are pre-made posts used for additional support to the tooth after root canal treatment.

F. Sedative Fillings for Caries, Trauma and Pain Control

Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anaesthesia to reduce pain before a permanent filling is installed.

Sedative fillings that are applied to reduce pain are covered. This procedure includes local anaesthesia, removal of decay and/or removal of existing restoration, bite adjustment (treatment to make sure that the fit between the top and bottom teeth is correct), pulp cap (a sedative placed on an exposed nerve to reduce pain and prevent infection) and placement of a sedative filling (a sedative placed under a filling to reduce pain).

G. Stainless Steel, Plastic and Polycarbonate Caps

This is a cap that is installed to cover the whole tooth or teeth. These are limited to once in 5 years.

8. Bite Adjustment/Equilibration

This is a procedure to correct the bite problem between the upper and lower teeth when they are in contact. Bite adjustments are covered for up to eight units every calendar year.

9. Minor Oral Surgery

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

A. Extractions

Extraction means removing a tooth, including an impacted tooth. There is no limit to the number of extractions per visit.

B. Residual Root Removal

Residual root removal means removing tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

Maintenance coverage

Some of the procedures that are covered for are root canal therapy and major oral surgery.

1. Major Oral Surgery

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

Treatment for these procedures are unlimited as long as they are not for cosmetic purposes and are not part of any implant (supports for artificial teeth surgically placed in the jaw bone) or part of any orthognathic surgery, remodelling or repositioning of the lower jaw.

A. Surgical Exposure

This is surgical incision to expose teeth that will not erupt or come on time.

B. Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty

Alveoloplasty means remodelling, removing or reducing bone. Gingivoplasty means remodelling gums. Stomatoplasty means remodelling the floor of the mouth. Vestibuloplasty involves ridge reconstruction.

C. Surgical Excision

This includes the removal of cysts or a foreign body.

D. Surgical Incision

This is an incision made to an infected area usually to allow drainage.

E. Fractures

The treatment of fractures of the upper or lower alveolar bone which holds the teeth in the sockets.

F. Frenectomy

Frenectomy involves surgery on the frenum (a thin tissue that connects the lips to the gums and the tongue to the floor of the mouth).

F. Sialolithotomy

This is the partial removal of the salivary duct.

G. Antral Surgery

This is the surgical removal of a tooth that has been forced up into a sinus cavity.

H. Hemorrhage Control

This is treatment to stop bleeding resulting from an extraction or trauma.

I. Post Surgical Care

This is treatment given by the dentist after surgery until healing is complete.

2. Treatment of roots

A. Pulpotomy

Pulpotomy is the removal of dental pulp from the crown portion of the tooth. This procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

B. Pulpectomy

Is the removal of the tissue from the pulp chamber and this procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

C. Root Canal Therapy

This procedure includes:

- treatment plan
- pulp vitality test
- pulpectomy (removing the diseased nerve from inside the tooth to reduce pain)
- opening and drainage
- tooth isolation and
- clinical procedure with appropriate x-rays

One root canal therapy is covered per tooth in a lifetime. Retreatment procedures are not covered.

If dental coverage ends during root canal therapy, we will extend coverage for 30 days to complete the root canal service. If the dental coverage is replaced by another plan before the procedure is completed, the replacing plan will be responsible for the cost of the entire procedure.

D. Apexification

Apexification means closing the root of a tooth with hard tissue. This procedure may include a treatment plan, anaesthesia, tooth isolation, the treatment with appropriate x-rays, placement of dentogenic media (material which causes a root tip to form in young teeth so that root canal therapy can be done), and follow-up care. Apexification is covered once per tooth in a lifetime.

E. Retrofilling

This is a filling done through the root end and is covered once per tooth in a lifetime.

F. Apicoectomy

This is the surgical removal of a root end after root canal therapy and is covered once per tooth in a lifetime.

G. Root Amputation

Root(s) from a tooth may have to be removed because of infection. However, the crown and at least one root remains so that the tooth does not have to be removed and is covered once per tooth in a lifetime.

H. Hemisection

Hemisection means removing a portion of the root(s) and the crown of a tooth but leaving the other root(s) in place and is covered once per tooth in a lifetime.

I. Bleaching Endodontically Treated Tooth/Teeth

This is the whitening of a tooth internally through the root canal opening of a tooth.

J. Intentional Removal, Apical Filling and Reimplantation

This is the intentional removal of a healthy tooth and implanting it. For example, a third molar is removed and used to replace a missing first molar. The covered person is covered for one procedure per tooth in a lifetime.

3. Treatment of gums

Please note: These procedures may include local anaesthesia, surgical dressing, sutures and follow-up care for one month. Post-treatment evaluation is not covered.

A. Displacement Dressing

A displacement dressing means placing a medicated pack on inflamed gums to move gums away from the calculus (deposits on teeth that irritate gums).

B. Desensitization

Desensitization means applying fluoride to reduce sensitivity.

C. Gingival Curettage

Gingival curettage means scraping out damaged tissue inside the gums.

D. Gingivectomy

Gingivectomy means removing damaged gum tissue.

E. Flap Surgery

Flap surgery is the opening made for bone removal.

F. Tissue Graft

Tissue graft is the transfer of healthy gums to an area where the gums have receded.

G. Periodontal Scaling and/or Root Planing (Tartar Removal)

Scaling means removing calcium deposits on teeth. Root planing means the smoothing of rough tooth surfaces and removing any calcium deposits and is covered for up to 12 units of scaling and/or root planing every calendar year.

4. Appliances and Appliance Adjustment

A. Periodontal Appliances

A periodontal appliance is a plastic appliance which covers the chewing surfaces of either the upper or the lower (or both) teeth to protect the teeth from damage caused by grinding.

B. Adjustment of Periodontal Appliances

This is done to confirm or adjust the bite of the upper and lower teeth with the periodontal appliance in the mouth.

4. Denture Maintenance

A. Denture Adjustments

Adjustments are covered and unlimited as long as the adjustments are made more than three months after the new dentures were first inserted.

B. Denture Repairs

Repairing dentures means fixing broken or damaged dentures and is unlimited.

C. Denture Rebasing and Relining

Rebasing dentures means fitting dentures with a new base. Relining dentures means adding material so that the dentures fit properly.

D. Tissue Conditioning

Tissue conditioning means applying a conditioner to the alveolar ridge that ensures a proper denture fit.

Major Restorative Coverage

These are procedures used to treat major dental problems. Some of the procedures are dentures, denture maintenance, post and core, crowns, bridgework, inlays, onlays and veneers.

1. Caps and Tooth Coverings

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary services, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

If the covered person's coverage ends after a tooth has been prepared for a crown, inlay, onlay or veneer but before the procedure has been finished, we will extend coverage for 90 days to complete the procedure even if the dental coverage is replaced by another plan.

Charges for replacing an existing crown, veneer, inlay, or onlay will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below:

- it has been more than 60 months since the last crown, veneer, inlay or onlay was inserted; or
- it has been less than 60 months since the last crown, veneer, inlay or onlay was inserted and the existing crown, veneer, inlay or onlay is no longer wearable. We must approve this.

A. Inlay/Onlay Restorations

Inlays and onlays are metal or porcelain casts placed on the surface of the tooth.

B. Crowns

A crown is a cap that covers the whole tooth.

C. Laboratory Processed Veneer Applications

Veneers are white facings put on a tooth’s surface. Veneer applications that are done for cosmetic purposes are not covered.

D. Retentive Pins in Inlays, Onlays and Crowns

These pins are used to make sure that the inlays, onlays or crowns stay in place.

E. Build-up/Fillings

This means restoring a tooth prior to capping for better adaptation of the cap.

2. Dentures

Please note: These procedures may include treatment plan, initial and final impressions, jaw relations records, try-in insertion, bite equilibration (work done to make sure that the fit between the top and bottom teeth is correct), and three month follow-up care.

If coverage ends after preparations have been made for a denture(s) but before the procedure has been finished, we will extend coverage for 90 days to complete the denture(s), even if the dental coverage is replaced by another plan.

If the covered person is covered by this plan on the date that the denture is installed, we will continue to cover the cost even if this plan is replaced by another plan.

A. Complete Dentures

Complete dentures means dentures that replace either all of the top teeth or all of the bottom teeth.

Charges for replacing an existing denture will only be paid if such replacement is for an equivalent denture and meets one of the conditions shown below:

- it has been more than 60 months since the last complete dentures was inserted; or
- it has been less than 60 months since the last complete dentures was inserted and the existing denture is no longer wearable. We must approve this.

B. Transitional Dentures

Transitional dentures are temporary dentures used for healing purposes due to the extraction of one or more teeth. Permanent dentures must be inserted within 12 months of the date the temporary dentures were inserted.

C. Acrylic Denture

Acrylic dentures are dentures with an acrylic denture base. Acrylic dentures are covered only if it has been more than 60 months since the last acrylic dentures were inserted.

D. Partial Dentures

Partial dentures replace one or more top or bottom teeth. They may be acrylic (plastic), metal or chrome base that can have acrylic, wire or chrome clasps (which hold on to the teeth). Partial dentures are covered only if it has been more than 60 months since the last partial dentures were inserted or additional teeth have been extracted.

3. Bridges

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary coverage, splinting, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

If the covered person's coverage ends after a tooth has been prepared for a bridgework but before the procedure has been finished, we will extend coverage for 90 days to complete the bridgework even if the dental coverage is replaced by another plan.

Charges for replacing an existing bridge will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below:

- it has been more than 60 months since the last bridge was inserted; or
- it has been less than 60 months since the last bridge was inserted and the existing bridge is no longer wearable. We must approve this.

A. Pontics

A pontic is an artificial tooth that replaces a missing tooth. Pontic replacement is covered only if it has been more than 60 months since the last pontic was installed in that space. A porcelain pontic installed on a molar is not covered.

B. Retainers/Abutments

A retainer/abutment is the tooth beside the missing tooth that will be used to support the bridge. The preparation of the tooth is covered only if it has been more than 60 months since the last preparations were made to that tooth.

C. Bridgework Repairs

Repairing bridgework means fixing or repairing damaged bridgework.

D. Posts in Retainers/Abutments

These are posts and cores used for additional support to the retainer/abutment. Posts and cores are covered only if it has been more than 60 months since the last installation to that tooth.

Orthodontic Coverage

These are procedures used to correct crooked or misaligned teeth. This includes all necessary dental treatment needed to correct this problem such as examinations, x-rays, models, photographs, reports and surgical exposure of teeth, appliances and adjustments.

We require that a treatment plan prepared by the dentist be sent to us. We will then pay up to 30% of the cost at the beginning of treatment, minus the diagnostic fee. We will calculate the remaining payments by dividing the rest of the cost by the number of months in the treatment plan. We will pay monthly or quarterly, depending on when the dentist bills us or when we receive the receipts. We will not make any advance payments.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment will be included and covered as if it were an orthodontic service.

What you are not covered for

We will not pay for:

- dental services or supplies that the covered person is eligible to claim under the Workers' Compensation legislation
- any dental charges not included in the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide
- cosmetic procedures
- charges for appointments that are not kept
- charges for completing claim forms
- treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called the temporomandibular joint.)
- any endodontic treatment which was started before the effective date of coverage
- the replacement of dental appliances that are lost, misplaced or stolen
- any treatment related to orthognathic surgery (remodelling or reconstruction of your jaw)
- procedures or supplies used in vertical dimension corrections (changing the height of the teeth) or to correct attrition problems (worn down teeth);
- implanting fabricated teeth or any major surgery resulting from implanting fabricated teeth
- any crowns, bridges or dentures for which tooth preparations were started before the effective date of coverage
- any orthodontic services received before the effective date of coverage
- experimental treatment or testing

Co-ordination of benefits with your spouse's plan

Co-ordination with your spouse's plan is one of the advantages of your group policy. It may allow you to receive up to 100% of your Dental costs. First, you must have family coverage that includes Dental coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage where they work.

Here are the procedures to follow:

Claiming your expenses

If you are claiming your expenses, send the claim to us first. We will pay for the portion of the claim that is covered by us and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to your spouse's group plan.

Claiming your spouse's expenses

If you are claiming your spouse's expenses, send a claim to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

Claiming your child's expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinated based on the standard industry guidelines.

Submitting a claim

For claims submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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 claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form.

Your employer may have made arrangements to allow your dental service provider to send claims to us electronically. If so, you will not have to fill out a claim form and we will make the payment to the person designated. Once payment has been made, we will send an explanation of our payment.

We will pay benefits to you when we receive satisfactory proof of claim.

We must receive all claims by the earlier of the following dates:

- June 30th of the year following the treatment, or
- 90 days after the date the policy terminates

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.

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.shepellfgi.com**.

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