THE Great-West Life ASSURANCE COMPANY

My Group Benefits Plan

Local 1460 Alberta Millwrights

Active Members

To All Eligible Members:

The Millwrights' Health and Welfare Trust Fund for Alberta ("the Fund") was established in 1968 to fund a benefit plan ("the Plan") for union members of Millwrights Union Local 1460 ("the Union") who are employed by contributing employers ("Employers").

This booklet has been published to give you an up-to-date description of the benefits provided by the Plan, as of January 1, 2017. It provides a description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits, and the procedures that should be followed when making a claim.

We have tried to explain the benefits in this booklet using straightforward language, while still making every effort to be accurate. However, if there is any conflict between this booklet and the insurance policies, plan text or trust agreement, the wording of the insurance policies, plan text or trust agreement shall prevail.

We urge you to read this booklet carefully and thoroughly familiarize yourself with the benefits which are available to you and your dependants. While it is our hope that you and your family will enjoy good health, it is comforting to know that these benefits are available when needed.

Because of the ever changing economic environment, the benefits described in this booklet cannot be guaranteed for the future. In order to protect the Fund, the Board of Trustees ("the Trustees") has the right, at any time, to amend, delete, add or change the Plan benefits and eligibility rules as they apply to all current and future members and retirees, including the right to add or delete benefits, monetary or otherwise, as circumstances warrant.

If at any time you have any questions about the benefits, or would like assistance in filing a claim, please do not hesitate to contact the Administrator where a member of the staff will be pleased to assist you.

Sincerely,
BOARD OF TRUSTEES
January 1, 2017

INTRODUCTION

The Millwrights Health and Welfare Trust Fund For Alberta was established in 1968. It was established in order to fund a benefit plan for union members of Millwrights Union Local 1460.

The Fund is controlled by Trustees who have the sole authority for all operations of the Fund and the Plan. Their actions are scrutinized and regulated by federal and provincial agencies dedicated to safeguarding your interests as a Plan member. This includes the handling of the personal information you provide for the creation of your Plan records. That personal information is used exclusively for the confidential administration of your benefit entitlements, and it may not be divulged for any other reason without your permission.

The Trustees, who are appointed by the participating employers and Union, are required, by law, to develop and maintain the Plan in a manner that is reasonable and even-handed, while protecting the financial well-being of the Fund.

The revenues of the Fund come from four sources:

- contributions made by contributing employers,
- reciprocal payments from benefit trusts in other union jurisdictions where members of Millwrights Union Local 1460 are working on “travel card”,
- self-payments from Plan members and retired Plan members, and
- earnings on Fund investments.

To a large extent, the size of these revenues cannot necessarily be predetermined by the Trustees. Therefore, the Fund revenues and assets must be prudently and carefully managed.

MEMBERSHIP IN THE PLAN

Initial Eligibility

To be eligible for membership in the Plan you must:

- be a member of the Union in good standing; and
- have a total of at least 360 hours reported to the Administrator for work over a period of not more than four consecutive months.

Initial Plan Membership Date

Your Plan membership begins on the first day of the month after you satisfy the initial Plan membership eligibility requirements. Your Plan coverage begins on the same day.

For example: if you work 390 hours in May, June and July (not-more-than-four consecutive months) and those are reported to the Administrator by August 31st, and you are a member of the Union in good standing, you have met the initial eligibility conditions. Your Plan membership begins September 1st and your coverage begins September 1st.

Dependant Coverage

Coverage for your eligible dependants, as listed on your initial plan registration card, will begin on the same day that your Plan coverage begins, and will cease on the same day your Plan coverage ceases. Any changes to your eligible dependants must be communicated promptly to the Administrator. Delays in advising the Administrator of dependant additions and changes may affect their coverage effective dates.

For example: if you filed a registration card with the Administrator by August 31st, and your coverage began September 1st, then your eligible dependants on that registration card are covered September 1st.

Maintaining Eligibility

Your continuing Plan coverage is based on the operation of an hourbank kept in your name, which is like a bank account, but stores hours instead of dollars.

The hours you work for contributing employers during your initial eligibility period, and future hours, are deposited to your hourbank. Once you become a Plan member, hours are automatically deducted from your hourbank to provide you with Plan coverage.

As long as you have sufficient hours in your hourbank to provide for your current month's Plan coverage, your coverage continues.

How The Hourbank Works

All of your 360 (or more) hours worked for contributing employers, during your initial, not-more-than-four consecutive month eligibility period, and any subsequent hours, are deposited to your hourbank. Those hours create an hourbank balance, before any deduction of hours to provide you with Plan coverage.

For example: if you work 390 hours in May, June and July (ie. not-more-than-four consecutive months) and you meet the other initial eligibility requirements, those hours are deposited to your hourbank, and become your initial hourbank balance, before the deduction of hours for Plan coverage.

390 Hours Worked In May, June and July and meet initial eligibility requirements ----------> Hours deposited to Hourbank

All hours worked in one month are reported to the Administrator during the following month and credited to your hourbank. If you have already met the initial eligibility requirements, then on the first day of the next following month, 120 hours are deducted from your hourbank to provide you with that month's benefit coverage.

For example: if you work 150 hours in July, in August those hours are reported to the Administrator and are credited to your hourbank. On September 1st, 120 hours are deducted from your hourbank to provide you with September Plan coverage.

150 July Worked Hours -----> Deposited to Hourbank in August -----> 120 Hours deducted to provide September coverage

Each subsequent month, additional worked hours will be deposited to, and deducted from, your hourbank to provide you with future months of Plan coverage.

The monthly hourbank deduction is 120 hours. If you work more hours than are needed for immediate coverage, those extra hours will be stored in your hourbank for later use. Those extra hours will provide you with additional Plan coverage during vacations, temporary breaks in employment, and other voluntary absences.

For example: if you work 165 hours in August, in September those hours are reported to the Administrator and are credited to your hourbank. On October 1st, 120 hours are deducted from your hourbank to provide you with October coverage. The remaining 45 hours are stored in your hourbank for later use.

165 August Worked Hours -----> Deposited to Hourbank in September -----> 120 Hours deducted to provide October coverage -----> 45 extra hours stored in hourbank for later use

You may store a maximum of 720 hours, being the equivalent of six months of future coverage, in your hourbank for later use. If you work fewer or no hours during some months, the Administrator will deduct hours previously stored in your hourbank to continue your coverage.

For example: if you worked 100 hours in September, in October those hours are reported to the Administrator and credited to your hourbank. On November 1st, 120 hours are deducted from your hourbank – 100 from your September worked hours, and 20 from the hours previously stored in your hourbank.

Self-Payments

If you are a Plan member in good standing with the Union and less than 120 hours are stored in your hourbank, you can make self-payments to continue your coverage.

As of February 1, 2017 the monthly self-payment is $400. This amount may increase or decrease, from time to time, at the absolute discretion of the Trustees. You can make a maximum of three consecutive monthly self-payments. After that, your coverage will be cancelled unless you have sufficient hours in your hourbank to continue your Plan coverage.

If you choose not to make a self-payment when you are eligible to do so, your Plan coverage will be cancelled. In that case, you will need to store at least 360 hours in your hourbank, over any period of time, before your Plan coverage can re-commence.

Coverage Cancellation and Termination

Plan coverage relies on your hourbank and your Union membership. Should you have less than 120 hours in your hourbank, or choose not to make a self-payment when permitted to do so, your Plan coverage will be cancelled.

Your Plan membership, and coverage, will be terminated immediately if you are suspended from the Union.

SPECIAL COVERAGE PROVISIONS

If you have Plan coverage and are unable to work due to illness, injury, maternity and other leaves, continuing education, or death, your coverage, or that of your dependants, will continue without interruption, subject to the following plan provisions.

Illness And Injury

If you become ill or are injured, and provide evidence of income from Employment Insurance (Medical), Workers Compensation, Canada Pension Plan (Disability), the plan's former Long-Term Disability program, or other disability program approved by the Trustees, your coverage will continue. Your coverage will cease when the income ceases, you reach age 65, you die, or your Union membership ceases.

Maternity, Parental And Other Leaves

If you provide evidence of your government-mandated maternity, parental or other leave, your coverage will continue. This provision will cease at the end of the leave period, age 65 or your death.

Education

If you provide proof of attendance and completion of a Millwrights 1460 union-approved educational program, you will be credited with the number of hours of actual attendance during that educational program.

Family Coverage For Deceased Members

If you die, your spouse and dependants will be eligible for continued coverage for twenty-four months, plus the number of months of coverage left in your stored hour bank at your death.

RETIREES

If you have Plan coverage and retire and commence your pension from the Millwrights Local 1460 Pension Plan, or another pension plan approved by the Trustees, you may be eligible to apply for retiree coverage from this Plan. The retiree coverage is different from the coverage outlined in this benefit booklet. If you are considering retirement, you should request a copy of the retiree benefit booklet prior to making a decision on retiree benefits.

An application for retiree coverage from this Plan must be made no later than three months after your retirement date, and prior to the date your Plan coverage would otherwise cease. If approved, your first retiree coverage self-payment payment must be made prior to the date your Plan coverage would otherwise cease.

For applications on and after January 1, 2017, your monthly self-payment is governed by the following table:

	5 Years but less than 15 Years of Union membership at your retirement date	15 or more Years of Union membership at your retirement date
Under Age 65	$400	$200
Age 65 or older	$200	$100

Accessing Your Plan Details

A new online portal has been developed for plan members. That portal will allow you to check your hourbank, manage your spouse and dependant records, change your mailing address, update your beneficiary, access plan booklets and other plan information, print your drug card, submit claims online, access details about your claims history, and more.

You can access the online portal at any time, day or night, and find immediate answers to common questions you may have about the plan.

In order to access the portal, follow these four easy steps:

1. Go to www.pbas.ca

2. Select the Member Portal

3. Select the Create New Account tab

4. Complete the registration process.

Once you have finished registering, you can immediately start accessing the member portal.

Prior to registering on the portal, make sure you have personal information, such as your social insurance number or H&W Plan certificate number, handy. You will be required to verify your identity, by confirming your name, as spelled in your H&W records, your date of birth, and your SIN or Plan certificate number. You will also need to provide a valid email address and create a secure password.

You can access the Great-West Life Online website from the portal.

If you have questions about the registration process, or how to navigate the portal, call the Administrator at 1-888-525-1460, or email them at mw1460@pbas.ca.

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 Healthcare and Dentalcare 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.

Prudent Benefits Administration Services Toll-Free Number

To contact a customer service representative at PBAS for assistance with your eligibility or to access the Member portal, please call 1-888-525-1460

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 or to access Great-West Life online, please call 1-800-957-9777.

This booklet describes the principal features of the group benefit plan sponsored by the Millwrights` Health and Welfare Trust Fund for Alberta. **Group Policy Nos. 166132** and **166133** and **Plan Document No. 58536** 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 or plan document, the policies or plan document will prevail.

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

This plan is arranged by your plan sponsor
Millwrights' Health and Welfare Trust Fund For Alberta

c/o Prudent Benefits Administration Services Inc.
Suite 101, 46 Hopewell Way N E
Calgary, Alberta T3J 5H7
Toll-free: 1.888.525.1460
Ph: (403) 250.3534
Email: MW1460@pbas.ca
Fax: (403) 250.9236

And adjudicated by

THE Great-West Life ASSURANCE COMPANY

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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 the plan sponsor. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit the plan sponsor’s right to use other legal means to recover the overpayment.

Protecting Your Personal Information

Participation in the group benefits plan depends on the collection, storage, use and, sometimes, destruction of personal information about you and your dependants. Personal information is kept in a confidential file at the offices the plan administrator, Great-West Life or the offices of organizations authorized by them. We may use service providers located within or outside Canada. We limit access to personal information in your file to the plan administrator and Great-West Life staff or persons authorized by them 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

Registration with the group benefits plan involves an authorization to allow the plan sponsor and its service providers to use your personal information. You may revoke that authorization, subject to certain legal constraints; however, doing so precipitates the destruction of your personal information and will result in the termination of your coverage.

A complaint related to the use of personal information may be addressed to the plan administrator's Privacy Officer. If further satisfaction is required, you may contact the office of the Privacy Commissioner of Canada, or, if applicable, the Provincial Commissioner.

Your plan sponsor has an agreement with Great-West Life in which the plan sponsor has financial responsibility for some or all of the benefits in the plan and Great-West Life processes claims on your plan sponsor's behalf. We may exchange personal information with your health care providers, 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 plan sponsor has entered into an agreement with The Great-West Life Assurance Company whereby your plan sponsor will have full liability for Healthcare and Dentalcare benefits outlined in this booklet. This means your plan sponsor has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

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Benefit Summary

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

Member Basic Life Insurance	$100,000, reducing to $10,000 at age 70
Dependent Basic Life Insurance	
Spouse	$20,000
Child	$10,000
Optional Life Insurance	Available in $25,000 units to a maximum of $250,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $250,000 maximum
Member Accidental Death, Dismemberment and Specific Loss (Principal Sum)	An amount equal to your Basic Life Insurance

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
Reimbursement Levels	
Visioncare Expenses:	
- Visual Training and Remedial Therapy	75%
- Laser Eye Surgery	50%
- All Other Visioncare Expenses	100%
Chronic Care Expenses	100%
In-Canada Prescription Drug Expenses	
- Covered Dispense Fee Portion	100%
- All Other Prescription Drug Expenses	80%
Medical Supply Expenses	
- Orthopedic Equipment and Diabetic Supplies	80%
- All Other Medical Supplies	50%
Ambulance	80%
All Other Expenses	80%
Basic Expense Maximums	
Hospital	Private room
Home Nursing Care	$10,000 every 3 calendar years On the January 1 coinciding with or next following the date you reach age 70, the maximum amount payable is a lifetime maximum of $10,000, less any amount paid in the previous 3 calendar years

Chronic Care	$25 per day
In-Canada Prescription Drugs	Included
Drugs Used to Treat Erectile Dysfunction	$500 each calendar year
Fertility Drugs	$5,000 lifetime or as otherwise required by law
Smoking Cessation Products	$500 lifetime or as otherwise required by law
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $10. This does not apply to Quebec employees
Hearing Aids	$1,000 per ear every 4 calendar years
Custom-fitted Orthopedic Shoes	1 pair each calendar year to a maximum of $500
Custom-made Foot Orthotics	
- dependent children under age 19	2 pairs every 2 calendar years to a maximum of $300
- all others	1 pair every 2 calendar years to a maximum of $300
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 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 every 4 years
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	2 pairs each calendar year
Wigs for Cancer Patients	$250 lifetime
CPAP Machine and Supplies	$2,500 every 3 years
Accidental Dental Injury Treatment	$2,500 lifetime
Medical Forms	$150 per form

Paramedical Expense Maximums

Chiropractors	$400 each calendar year
Naturopaths	$400 each calendar year
Osteopaths	$400 each calendar year
Physiotherapists	Included
Podiatrists	$400 each calendar year
Chiropodists	$400 each calendar year
Psychologists/Social Workers	$400 each calendar year
Speech Therapists	$400 each calendar year

Visioncare Expense Maximums

Eye Examinations	$100 every 2 calendar years
Glasses and Contact Lenses	
- dependent children under age 18	$400 every 12 months
- all others	$400 every 2 calendar years
Laser Eye Surgery	$600 per eye lifetime
Safety Glasses	$300 every 2 calendar years

Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The 2014 Alberta dental fee guide. Specialists' charges are limited to the general practitioners' fees
Deductible	Nil
Reimbursement Levels	
Basic Coverage	80%
Major Coverage	75%
Orthodontic Coverage	50%
Plan Maximums	
Orthodontic Treatment	$4,000 lifetime
All Other Treatment	$3,000 each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after you complete the required eligibility waiting period as determined by the plan sponsor.

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

- Changes in insurance take effect as they occur, except that:

  - all increases in optional life insurance are subject to the underwriting provision.

  - decreases in optional life insurance will take effect on the date the application for a decrease is made.

  - no change in disability income insurance will take effect during a disability period.

  - no change in life insurance will take effect during a waiver of premium disability period.

Your coverage terminates when your union membership ceases, you are no longer eligible under the hour bank rules, or the plan terminates, whichever is earliest.

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

- Your coverage may be extended if it would have terminated due to disease or injury. 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.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 2 years plus the number of hours remaining in your hourbank or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months if neither of you has a legal spouse, for at least 36 months if you are prevented by law from marrying or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

  You can only cover one spouse at a time and you must cover the same spouse for all benefits. You many change from one covered spouse to another by submitting a claim for a different spouse. If the claim is for a common-law spouse, the change will take effect on the later of:

  - the date of the loss claimed for the new spouse;
  - one year from the day after the date of the last loss claimed for the previous spouse.

- Your unmarried children under age 22, or under age 26 if they are full-time students.

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

  Children under 14 days are not covered for dependent life insurance.

  Children under age 22 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 22, or while they are students under 26, 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 form available from the plan administrator or through the member portal at pbas.ca.

MEMBER BASIC 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 before the date you retire.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your plan administrator for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

- 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 BASIC 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 dependent life insurance will not continue past the end of the day before the date you retire.

- If you are disabled and the premiums for your employee 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.

- 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.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of insurability, and the application must be approved by Great-West Life. If you or your spouse dies within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

On your death, Great-West Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements. If your spouse dies you will be paid the amount for which he or she was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your spouse will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of 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.

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

Limitation

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

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

AD&D Insurance will be continued without further premium payment during any period your Life Insurance is being continued under the waiver of premium benefit. Your insurance under this waiver of premium will terminate automatically when this benefit terminates.

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.

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 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 $.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.

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.

Covered Expenses

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

- 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.

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

    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

- Chronic care, provided in a hospital, nursing home or for home nursing care in Canada, for a condition where improvement or deterioration is unlikely within the next 12 months

- 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.

  - 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.

The plan will also pay for preventative immunization vaccines and toxoids.

Unless medical evidence is provided to the plan administrator that indicates why a drug is not to be substituted, the covered expense may be limited to the cost of the lowest priced interchangeable 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.

- 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, when prescribed by a physician

- 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

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

- Physician charges for the completion of reports or forms required for life, disability or critical illness claims adjudication purposes

- Treatment of injury to sound natural teeth. Treatment must start within 90 days after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

  No benefits are paid for:

  - accidental damage to dentures

  - 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 licensed naturopath

- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays

- Out-of-hospital treatment of movement disorders by a licensed physiotherapist when referred by a physician

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

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

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

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

- Visual training and remedial therapy to correct faulty visual skills when performed by a licensed ophthalmologist or optometrist

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

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, other than drugs
    - 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
- 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
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Visioncare services and supplies required by an employer as a condition of employment

In addition 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
- 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
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

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

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

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

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

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the plan administrator 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, the plan administrator may contact you to participate in health case management. Health case management is a program recommended or approved by the plan administrator 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, the plan administrator 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 the plan administrator determines, where:

- the plan administrator 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 the plan administrator has recommended or approved health case management, the plan administrator can require that a service or supply be purchased from or administered by a provider designated by the plan administrator, and:

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

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

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

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

- **For drug claims**, your plan administrator will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

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

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

PREFERRED VISION SERVICES (PVS)

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

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

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

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

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program

- Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed

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

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

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 practising independently.

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

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination per dentist every 36 months
  - limited oral examinations twice each calendar year, 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 twice each calendar year
  - specific examinations once every 6 months
  - complete series of x-rays every 36 months
  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing limited to 1 time unit per visit, and 2 time units in a calendar year
  - topical application of fluoride twice each calendar year
  - scaling, limited to a maximum combined with periodontal root planing of 12 time units each calendar year

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - oral hygiene instruction once every 6 months
  - pit and fissure sealants on bicuspids and permanent molars

- space maintainers including appliances for the control of harmful habits, once per tooth each calendar year, for dependent children under age 15

- 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 2 years old or the existing filling was not covered under this plan

  - retentive pins and prefabricated posts for fillings

  - prefabricated crowns for primary teeth for dependent children under age 15

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth.

- Periodontal services including:

  - root planing, limited to a maximum combined with preventive scaling of 12 time units each calendar year

  - occlusal adjustment and equilibration, limited to a combined maximum 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

  - desensitization

- Denture maintenance, including:
    - denture remakes, once every 36 months
    - 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
    - denture repairs and additions, tissue conditioning and resetting of denture teeth after the 3-month post-insertion care period has elapsed
    - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 months
- Oral surgery including denture-related surgical services for remodelling and recontouring oral tissues
- Adjunctive services
    - unmounted diagnostic casts
    - consultation with the patient to a maximum of $50 per consultation

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

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

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

- Standard complete dentures, standard cast or acrylic partial dentures, implant – retained appliances or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance, and for dentures was placed within the last 12 months

  - the existing appliance is at least 3 years old and cannot be made serviceable. If the existing appliance is less than 3 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

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

    - repairs to covered bridgework

    - removal and recementation of bridgework

Orthodontic Coverage

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

Limitations

No benefits are paid for:

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

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

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

- The following oral surgery services - 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.

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

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

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

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

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

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

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

- Expenses covered under another group plan's extension of benefits provision

- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services

- Expenses private 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, except orthodontics

- 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

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan administrator and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

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

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

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan administrator. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 18 months after the dental treatment.

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both 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.