THE Great-West Life ASSURANCE COMPANY

My Group Benefits Plan

Local 1460 Alberta Millwrights

Retired Members
(Aged 64 and Under)

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.

RETIREES

If you are a covered Member of the Plan in good standing with the Union 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 based on your current age, and differs from the coverage provided to non-retired Members. If you are considering retirement, you should carefully review this retiree benefit booklet prior to making a retiree benefits decision.

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 self-payment must be made prior to the date your Plan coverage would otherwise cease.

For applications on and after January 1, 2017, your monthly retiree 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

DEPENDANT COVERAGE

Coverage for your existing eligible dependants continues once you are approved for retiree coverage, 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.

COVERAGE TERMINATION

Plan coverage relies on your monthly retiree self-payment and your continued Union membership. Should you choose not to make a monthly self-payment, prior to the coverage month for which it applies, when permitted to do so, your Plan coverage will be terminated.

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

FAMILY COVERAGE FOR DECEASED MEMBERS

If you die, your spouse and dependants will be eligible for continued coverage for twenty-four months following the month of your death.

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. **Plan Document No. 58536** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the plan document, the 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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Legal Actions

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

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

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

TABLE OF CONTENTS

Benefit Summary

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

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
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

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.

- Increases in benefits while you or your dependents are in hospital will not become effective until you or your dependents are released from hospital.

Your coverage terminates when you are no longer eligible or the plan terminates, whichever is earlier.

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

- 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 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 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 your plan administrator.

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 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

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

- 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 plan administrator 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 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

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable 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, partial overdentures and dentures and bridgework related to implants are provided

- 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.