NIPISSING UNIVERSITY

Support Staff and Retired Support Staff

BENEFIT DETAILS

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

Great-West Life Online

Visit our website at www.greatwestlife.com for:

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

Great-West Life Online Services for Plan Members

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

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

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the 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.

Great-West Life's Toll-Free Number

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

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy Nos. 163087 and 163088** issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

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

The Plan is underwritten 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

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 or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, Quebec Civil Code).

Appeals

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

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

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

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

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

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

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

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

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

TABLE OF CONTENTS

Benefit Summary

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

(Retirees are eligible for Basic Life Insurance, Healthcare and Dentalcare benefits)

Employee Basic Life Insurance

- Active Employees	200% of annual earnings to a maximum of $1,500,000 Any amount of Employee Basic Life Insurance over $500,000 is subject to approval of evidence of insurability
- Retirees	200% of pre-retirement annual earnings to a maximum of $1,500,000

Dependent Basic Life Insurance

Spouse	$15,000
Child	$7,500

Optional Life Insurance	Available in $10,000 units to a maximum of $500,000, 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 $500,000 maximum

Short Term Disability Income Benefits

Waiting Period	
Injury	No waiting period
Disease	5 work days If you are hospitalized or have day surgery before the last day of the waiting period for disease, benefits will begin on the day you are hospitalized or the surgery is performed
Maximum Benefit Period	26 weeks
Amount	75% of your weekly earnings to a maximum benefit of $2,100

Long Term Disability Income Benefits

Waiting Period	26 weeks
Amount	75% of your pre-disability monthly earnings to a maximum benefit of $20,000 plus your monthly pension contribution Any amount of LTD insurance over $15,000 is subject to approval of evidence of insurability

Healthcare

Covered expenses will not exceed customary charges. Maximums listed below are based on a per covered person amount.

Deductible	Nil
Reimbursement Level and Expense Maximums For In-Canada Prescription Drug Expenses – Pay Direct	
Tier 1 – Telus Health Solutions NASA drug formulary	100%
Tier 2 – Non-Telus Health Solutions NASA drug formulary	70%
Tier 3 – Lifestyle and Injectable drugs	50%

Tier 3 includes:

Smoking cessation aids	Limited to a lifetime maximum of $500
Drugs used for the treatment of infertility	Limited to a lifetime maximum of $2,400
Drugs used for the treatment of erectile dysfunction	Limited to a calendar year maximum of $1,200
Vaccines not covered by a free Clinic or provincial health plan	Limited to a calendar year maximum of $300
Dispensing Fee Reimbursement for all tiers (to a maximum of $7.50)	100%
Reimbursement Level and Expense Maximums For All Other Expenses	100%
Hospital	Private room
Home Nursing Care	
Services from an RNA	$10,000 each calendar year
Services from an RN	365 days lifetime
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $7.50
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	
- dependent children under age 18	$570 every 12 months
- all others	$570 every 24 months
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
Wheelchair repairs	$250 lifetime
Blood-glucose Monitoring Machines	$150 every 5 years

Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	2 pairs each calendar year
Vaccines	$300 each calendar year
Glasses following cataract surgery	$100 per eye lifetime
Stump Stockings	6 pairs each calendar year

Paramedical Expense Maximums

Chiropractors, Naturopaths Podiatrists/Chiropodists, Osteopaths, Physiotherapists, Occupational Therapists, Psychologists, Speech Therapists, Massage Therapists and Audiologists	$300 combined each calendar year
X-rays for Chiropractors	$45 each calendar year
Podiatrists/Chiropodists	$200 each calendar year for surgical removal of toenails and excision of plantar warts

Visioncare Expense Maximums

Eye Examinations	
- dependent children under age 18	1 every 12 months
- all others	1 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	$300 every 24 months
Contact Lenses for Special Conditions	
Non-surgical Treatment	$200 lifetime
Surgical Treatment	$200 within 6 months of treatment
Visual Training and Remedial Therapy	$10 per half hour

Out-Of-Country Care Expense Maximums	
- Emergency Care	$1,000,000 lifetime
- Non-Emergency Care	$50,000 lifetime
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges. Maximums listed below are based on a per covered person amount.

Payment Basis	The dental fee guide in effect in the province where treatment is rendered one year prior to the date treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	50%
Orthodontic Coverage	50%
Accidental Dental Injury Coverage	100%
Plan Maximums	
Basic Treatment	Unlimited
Major Treatment	$2,000 each calendar year
Orthodontic Treatment	$2,000 lifetime for dependent children under age 18
Accidental Dental Injury Treatment	Unlimited

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 3 months if you are full-time, or after 455 hours if you are part-time of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- Single coverage is mandatory. If your dependents have been covered under another plan and subsequently lose their coverage you may apply for dependent coverage under this plan. If you apply within 31 days coverage will be effective from the date the prior coverage terminated.

  If you do not apply for dependent coverage within 31 days of your eligibility, or within 31 days of their loss of alternate coverage, your dependents will be required to provide evidence of insurability acceptable to Great-West Life to be covered for health benefits, and a waiting period of 12 months will be applied to dental benefits.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  You must regularly work at Nipissing University for more than 24 hours per week if you are full-time and for at least 16 hours per week if you are part-time.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- You and your dependents must be residents of Canada and be eligible for coverage under the provincial health plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the policy terminates, whichever is earliest. If you are still actively employed after age 65, your benefits will terminate on the first day of the month following attainment of age 65.

- Your dependents' coverage terminates when your insurance 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 employer 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 30 months or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  Spouse means your spouse by marriage or under any other formal union recognized by law, or with whom you have continuously cohabitated in a spousal relationship for at least 12 months (common-law) and if neither person is married to any other person, shall include a same sex partner. Only one spouse can be covered at a time.

- Your unmarried children (including adopted and step children) who are under age 21, or under age 27 if they are unmarried, full-time students who are dependent on you for support.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 27, and the disorder has been continuous since that time.

EMPLOYEE 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 employer will explain the claim requirements to your beneficiary.

- Your life insurance terminates when you reach age 65.

- You are entitled to waiver of premium benefits after you have been continuously disabled for 26 weeks. You will be considered disabled during the period you are entitled to receive Long Term Disability benefits.

- 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 employer for details.

DEPENDENT BASIC LIFE INSURANCE

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

- Your dependent life insurance terminates when you reach age 65 or when you no longer have eligible dependents, whichever comes first.

- 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 employer for details.

OPTIONAL LIFE INSURANCE

(not applicable to Retirees)

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 your insurability, and your application must be approved by Great-West Life. If you or your spouse die 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.

You may name a beneficiary for your optional life insurance and change that beneficiary at any time by completing a form available from your employer. On your death, Great-West Life will pay your life insurance to your beneficiary. If your spouse dies you will be paid the amount for which he or she was insured. Your employer will explain the claim requirements.

- 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 employer for details.

- Your optional life insurance terminates on your 65th birthday.

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.

SHORT TERM DISABILITY (STD) INCOME BENEFITS

(not applicable to Retirees)

The plan provides you with regular income to replace income lost because of a disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled or until the end of the benefit period, whichever comes first. Check the **Benefit Summary** for the benefit amount, waiting period and benefit period. Where Worker's Compensation, Workplace Safety and Insurance Act benefits are payable, the waiting period will be equal to the Workplace Safety and Insurance Act's waiting period.

- STD benefits are payable after the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

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

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

- Because your employer contributes to the cost of STD coverage, benefits are taxable.

- Your STD coverage terminates on your 65th birthday.

Other Income

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

- disability benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts
- benefits under any Workers' Compensation Act or similar law
- benefits under a legislated automobile insurance plan where permitted by law

Earnings received from an approved rehabilitation plan or program are not used to reduce your STD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your weekly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

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

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

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

- Disability due to or associated with cosmetic treatment.
- Any period of confinement in a prison or similar institution.
- Disability arising from war, insurrection or voluntary participation in a riot.

How to Make a Claim

- To submit claims online, go to www.greatwestlife.com / Client Services / Forms for Group Benefits Plan Members / Standard Claim Forms. Click Apply for Disability Income Benefits and follow the instructions provided under Online claim submission.
- To submit paper claims, obtain an Employee Claim Submission Guide (form M5454) and follow the guide's instructions.

  You can get this form from your employer, or online from the Great-West Life corporate website. To access the form online, go to www.greatwestlife.com / Client Services / Forms for Group Benefits Plan Members / Standard Claim Forms / Apply for Disability Income Benefits. Under Paper claim submission, click Short Term Disability Income Benefits – Guide.

Please ensure that your claim is submitted to Great-West Life within 20 days after the onset of your disability.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

(not applicable to Retirees)

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or on your 65th birthday, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury. If your STD benefits are still being paid when the waiting period ends, the waiting period will be extended until the end of the STD benefit period, but no later than one year after your disability started.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, **and**, except for any employment under an approved rehabilitation plan, you are **not** employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the Benefit Summary.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 60% of your indexed monthly earnings before you became disabled.

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

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

- Because your employer contributes to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance terminates on your 65th birthday or when you retire, whichever is earlier.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

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

- benefits under any Workers' Compensation Act or similar law

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

- 50% of earnings received from an approved rehabilitation plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan

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

- the wage loss portion of any criminal injury award

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

- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are not included as employment income under this provision)

The balance of any earnings received from an approved rehabilitation plan is not used to further reduce your LTD benefit unless that balance, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

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

Vocational Rehabilitation

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

Medical Coordination

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

Survivor Benefit

If you die while LTD income benefits are being paid, Great-West Life will pay 3 times your monthly LTD benefit 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 employer will explain the claim requirements to your beneficiary.

Limitations

No benefits are paid for:

- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

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

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

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

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

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

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

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

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

How to Make a Claim

Before the end of the short term disability benefit period, Great-West Life will ask your employer to provide information to begin processing your LTD claim. All information must be submitted within 3 months of the request.

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.

Except to the extent otherwise required by law, if you are actively employed your healthcare coverage terminates on the first day of the month following your 65th birthday. If you are retired your healthcare coverage terminates on your 65th birthday.

Covered Expenses

- Ambulance transportation by ground or by air 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, licensed practical nurse or registered nursing assistant who is not a member of your family, when services are provided in Canada, but only if the patient requires the specific skills of a trained nurse

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

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

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

  - 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.

Covered drugs and drug supplies are categorized as either base plan drugs or supplementary plan drugs for benefit payment purposes. Refer to the Benefit Summary for maximums and reimbursement details.

The Tier 1 – Telus Health Solutions NASA drug formulary base drug plan consists of:

- those drugs listed in the National Formulary or Special Authorization (SA) drug list established by the pharmacy benefits manager in effect on the date of purchase including selected injectable drugs, and

- diabetic supplies.

The Tier 2 – Non-Telus Health Solutions NASA drug formulary supplementary drug plan consists of covered drugs, injectable drugs and drug supplies not included in the base drug plan

The Tier 3 – Lifestyle and Injectable drugs consists of

- smoking cessation aids

- drugs used for the treatment of infertility

- drugs used for the treatment of erectile dysfunction

- vaccines not covered by a free clinic or provincial health plan

If you require further information regarding your drug coverage, including coverage for certain drugs and their applicable reimbursement levels please contact a Great-West Life customer service representative at 1-800-957-9777

The plan will cover only the cost of the lowest priced equivalent generic drug plus a professional fee when prescribed, even if the prescriber has prescribed the drug by its brand name and has specified that the product is not to be interchanged.

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 Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician including but not limited to:
  - Wheelchairs
  - Walkers
  - Hospital Beds
  - Traction Kits

  For additional information regarding coverage please contact a Great-West Life customer service representative at 1-800-957-9777

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

  Please Note: A chiropractor is no longer recognised as an eligible prescriber

- Hearing aids, including repairs, 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

- Out-of-hospital services of a qualified audiologist when prescribed by a physician
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist when prescribed by a physician
- 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 movement disorders by a qualified occupational therapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital services of a qualified chiropodist
- Out-of-hospital treatment by a registered psychologist when prescribed by a physician
- Out-of-hospital treatment of speech impairments by a qualified speech therapist when prescribed by a physician

Visioncare

- 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.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

Out-Of-Country Care

- **Emergency care** outside Canada is covered if it is required as a result of a medical emergency arising while you or your dependent is temporarily outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

  A medical emergency is either a sudden, unexpected injury, or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the patient's prior medical condition.

  Emergency care is covered medical treatment that is provided as a result of and immediately following a medical emergency.

  If the patient's condition permits a return to Canada, benefits are limited to the lesser of:

  - the amount payable under this plan for continued treatment outside Canada, and

  - the amount payable under this plan for comparable treatment in Canada plus the cost of return transportation.

No benefits are paid for:

- any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency

- any subsequent and related episodes during the same absence from Canada

- expenses related to pregnancy and delivery, including infant care:

    - after the 34th week of pregnancy, or
    - at any time during the pregnancy if the patient's medical history indicates a higher than normal risk of an early delivery or complications.

- expenses incurred more than 180 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 180-day period, benefits will be extended to the end of the confinement

- **Non-emergency care** outside Canada is covered for you and your dependents if:

    - it is required as a result of a referral from your usual Canadian physician

    - it is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties

    - you are covered by the government health plan in your home province for a portion of the cost, and

    - a pre-authorization of benefits is approved by Great-West Life before you leave Canada for treatment.

No benefits will be paid for:

- investigational or experimental treatment
- transportation or accommodation charges.

The plan covers the following services and supplies when related to out-of-country care:

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

Limitations

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

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance 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 oral contraceptives and Mirena
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates

- Services or supplies received outside Canada except as listed under Out-of-Country Care and Global Medical Assistance

- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance

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

- Chronic care

- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid

- 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(except for Mirena) 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 dispensed by a dentist or clinic or by a non-accredited hospital pharmacy

- 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

- Experimental drugs

- Anti-obesity drugs

How to Make a Claim

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

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Great-West Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government's share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-800-957-9777.

- **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.

  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 employer. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 18 months after you incur the expense or within 90 days of termination.

- **For drug claims**, your employer 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 employer.

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.

Except to the extent otherwise required by law, if you are actively employed your dentalcare coverage terminates on the first day of the month following your 65th birthday. If you are retired your healthcare coverage terminates on your 65th birthday.

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 Great-West Life. Great-West Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination every 36 months
  - limited oral examinations once every 9 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations once every 9 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 5 years. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing and topical application of fluoride each once every 9 months
  - scaling, limited to a maximum combined with periodontal root planing of 20 time units every 12 months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - oral hygiene instruction once in a person's lifetime
  - pit and fissure sealants every 60 months for dependent children under age 18
  - space maintainers for primary teeth, including appliances for the control of harmful habits for dependent children under age 18
  - 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

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months

- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 20 time units every 12 months
  - occlusal adjustment and equilibration, limited to a combined maximum of 8 time units lifetime

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

- Denture maintenance, after the 3-month post-insertion care period, including:

    - denture relines for dentures at least 12 months old, once every 36 months

    - denture rebases for dentures at least 12 months old, once every 36 months

    - resilient liner in relined or rebased dentures, once every 36 months

- Oral surgery

- Adjunctive services

Major Coverage

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns

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

    - the existing appliance is a covered temporary appliance

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

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

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

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

  - denture remakes, once every 36 months

  - denture adjustments, once every 12 months

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

  - repairs to covered bridgework

  - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for children who are under age 18 when treatment starts

Accidental Dental Injury Coverage

- Treatment of injury to sound natural teeth. Treatment must start within 60 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

Limitations

If you do not apply for dependent dentalcare coverage within 31 days after your dependents becoming eligible, no benefits will be payable for them for the first 12 months.

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, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants

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

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

- Hypnosis or acupuncture

- Veneers, recontouring existing crowns, and staining porcelain

- Crowns 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 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 insurance coverage

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

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

- Temporomandibular joint disorders, vertical dimension correction or myofacial pain

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

How to Make a Claim

- **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 employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  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 employer. 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 or within 90 days of termination.

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 an employee 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.

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

This service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents and your and your dependent's physician can access this service if the physician has made a diagnosis of a serious physical illness or condition for which there is objective evidence, or if the covered person or his or her physician suspects that the person has this condition. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.

- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.

- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.

- If it is appropriate, the member advocate may arrange for an in-depth review of the covered person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.

- If the covered person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet his or her specific medical needs. Expenses incurred for travel and treatment are not covered by this service.

- If the covered person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.

- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Note: These services are not insured services. Great-West Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.