THE Great-West Life ASSURANCE COMPANY

STUDENTS' ASSOCIATION OF BOW VALLEY COLLEGE

STUDENT'S PLAN

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
- online claims submission

GroupNet for Plan Members

As a Great-West Life plan member, you can register for GroupNet™ for Plan Members at **www.greatwestlife.com/register**. Follow the instructions to register. Make sure to have your plan and ID numbers available when registering.

GroupNet™ makes it easier to access benefits information from any device, including:

- access to your benefits information and claims history
- your personal benefit cards
- online claim submission for most of your claims
- extensive health and wellness content

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, text keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

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

Great-West Life's Toll-Free Number

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

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 330760** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the policy, the policy 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

and arranged by

Gallivan & Associates Student Networks
470 Weber Street North
Waterloo ON N2L 6J2

Access to Documents

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

Legal Actions

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

Appeals

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

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

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

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

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

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

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

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

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

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Welcome to Great-West Life!

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

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

Why is this booklet important

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

Definitions

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

Child

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

A child must be under age 21 and depend on you for support and maintenance. We will continue coverage while the child is under age 25 and attending an accredited college or university on a full-time basis. We must receive confirmation that the child is a full-time student and remains dependent on you for support and maintenance.

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

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

Dependent

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

Emergency

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

Family

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

Illness

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

Insured person

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

Member

Member means a qualified student who attends Bow Valley College. A qualified student is a student who meets the eligibility criteria at the time of enrolment, which included but is not limited to a full-time, a part-time or a non-credit student.

Benefit year (referenced as "policy year" throughout the booklet)

Benefit year for an eligible member who enrols in:

- January is January 1st to December 31st of each year;
- February is February 1st to January 31st of each year;
- March is March 1st to February 28th or 29th of each year;
- April is April 1st to March 31st of each year;
- May is May 1st to April 30th of each year;
- June is June 1st to May 31st of each year;
- July is July 1st to June 30th of each year;
- August is August 1st to July 31st of each year;
- September is September 1st to August 31st of each year;
- October is October 1st to September 30th of each year;
- November is November 1st to October 31st of each year;
- December is December 1st to November 30th of each year.

Policy anniversary

Policy anniversary means September 1.

Premium due date

Premium due date means the first day of each month.

Proof of insurability

Proof of insurability is the additional information that we need about a person's health, job and leisure activities to decide if the requested coverage will be provided.

Spouse

A spouse is a person to whom you are legally married or with whom you have a common-law spouse relationship. Common-law spouse means a partner of the same or different gender who has lived with you for at least 12 months.

Only one spouse can be covered at a time.

Waiting period for coverage

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

We, our and us

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

General Terms

Waiting period for coverage

There is no waiting period for coverage.

When your coverage begins

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

When you enrol

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

Coverage will begin on the day after the waiting period for coverage ends.

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

If you enrol within 31 days of the end of the waiting period for coverage, coverage will begin on the day after the waiting period for coverage ends.

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

You can waive coverage if you have similar coverage through your parents' group benefit plan.

When you enrol and apply for family coverage

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

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

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

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

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

Coverage for a dependent who is not hospitalized will begin on the date your coverage begins. If at the time your coverage begins, a dependent other than a newborn child is hospitalized, coverage for that dependent will begin on the first day after the dependent is discharged from the hospital.

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

What changes to report to your employer

You can change to any plan if you have been covered in your current plan for 1 policy year.

You must report the following changes immediately to your employer:

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

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

Any resulting change in your coverage will take effect on the date the above changes occur.

When your coverage ends

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

Your coverage ends

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

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

Your dependent coverage ends

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

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

Beneficiary designation

You may make, alter or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

Medical examinations and autopsies

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

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

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

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

Recovering damages from a third party

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

Incontestability

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

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

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

Your Health Care coverage

What is Your Health Care coverage

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

We will only cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made.
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care.
- Services and supplies that we are legally allowed by the government to cover. We will not cover any portion of services or supplies which the insured person is entitled to receive, or for which the insured person is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.
- Charges for services and supplies that are incurred while the person is insured.
- Charges for services and supplies for the least expensive treatment that is medically adequate.

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

- Drugs
- Eye examinations, eyeglasses or contact lenses
- Medical services and equipment
- tutorial services
- Paramedical services

How much we will pay

Balanced Plan

All Members except Members covered under the Enriched Plan

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

There is no deductible for covered drug costs.

For all other Health Care coverage there is no deductible, unless otherwise shown below.

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

For drug expenses, 80% of the covered costs with no deductible. We will cover up to $3,000 for each insured person every policy year.

For eyeglasses and contact lenses, 100% of the covered costs up to $100 in any 24 consecutive month period with no deductible.

For eye examinations, 100% of the covered costs up to $60 in any 24 consecutive month period with no deductible.

For all other expenses, 80% of the covered costs with no deductible, unless otherwise indicated in the description of the benefit.

Enriched Plan

All Students electing the Enriched Drug and Paramedical Plan

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

There is no deductible for covered drug costs.

For all other Health Care coverage there is no deductible, unless otherwise shown below.

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

For drug expenses, 90% of the covered costs with no deductible. We will cover up to $3,000 for each insured person every policy year.

For eye examinations, 100% of the covered costs up to $60 in any 24 consecutive month period with no deductible.

For all other expenses, 80% of the covered costs, unless otherwise indicated in the description of the benefit.

All Students electing the Enriched Paramedical and Vision Plan

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

There is no deductible for covered drug costs.

For all other Health Care coverage there is no deductible, unless otherwise shown below.

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

For drug expenses, 70% of the covered costs with no deductible. We will cover up to $3,000 for each insured person every policy year.

For eyeglasses and contact lenses, 100% of the covered costs up to $150 in any 24 consecutive month period with no deductible.

For eye examinations, 100% of the covered costs up to $60 in any 24 consecutive month period with no deductible.

For all other expenses, 80% of the covered costs, unless otherwise indicated in the description of the benefit.

All Students electing the Enriched Dental Plan

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

There is no deductible for covered drug costs.

For all other Health Care coverage there is no deductible, unless otherwise shown below.

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

For drug expenses, 70% of the covered costs with no deductible. We will cover up to $3,000 for each insured person every policy year.

For eye examinations, 100% of the covered costs up to $60 in any 24 consecutive month period with no deductible.

For all other expenses, 80% of the covered costs, unless otherwise indicated in the description of the benefit.

When your Health Care coverage ends

When you reach age 70.

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

What you are covered for

Drugs

We cover the cost of drugs and serums that are listed under the current National Formulary and that can only be obtained with a prescription. They must be prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them.

If a generic drug can be substituted for a brand name drug, we will only cover the cost of the generic substitute with the lowest price. If the prescription states that there can be no generic substitute, we will cover the cost of the brand name drug. We also cover disposable needles, syringes, lancets and testing materials for monitoring diabetes.

In the event that the drugs covered are not effective in treating the condition, an exception process is in place. To be eligible for an exception, you must have tried one alternative drug listed on the National Formulary.

We cover up to a 34 day supply of therapeutic drugs, and up to a 100 day supply for maintenance drugs.

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

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

An insured person cannot use the drug card to purchase the following items but they may be covered. You must use a claim form for the following:

- alcohol swabs
- appliances
- certain equipment
- blood glucose monitor (We will pay up to $150 in any period of five consecutive policy years)
- prosthetic devices

The deductible and the percentage (if any) paid for “other expenses” under “How much we will pay” will apply.

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

We will not pay for the following:

- alcohol
- bandages
- contraception, other than contraceptive drugs and products containing a contraceptive drug
- cosmetic items
- hair growth stimulants
- sunscreens
- cotton
- vitamins (except injectible), minerals, dietary supplements
- disinfectants
- homeopathic medicines
- fertility drugs
- immunizations and vaccines (except Hepatitis B – DIN 749486 and DIN 1919431)
- non-disposable insulin injectors
- products which can be bought without a prescription
- products used to quit smoking
- products used to lose weight
- spring loaded devices used to hold lancets

Eye examinations, eyeglasses or contact lenses

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

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

Medical services and equipment

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

- walkers, braces (provided solely not for athletic use), trusses, artificial limbs and eyes, and other prosthetic devices that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a device. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover.

- crutches and splints.

- T.E.N.S. machine (for chronic pain) up to $700 in your lifetime

- T.E.S. units, respiratory units, berathing units

- one insulin pump for each insured person per lifetime and its related supplies for each insured person

- breast prosthesis after a mastectomy, including replacement(s) every two policy years.

- custom-made orthopaedic shoes, prescribed by a physician, podiatrist chiropodist or chiropractor, provided they are not solely for athletic use. We will cover modifications, repairs and adjustments without a prescription, to custom-made orthopedic shoes. We will pay up to a maximum of $150 per policy year.

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

- rental charges for standard manual or electric wheelchairs, hospital beds, traction kits and other temporary therapeutic equipment that we approve. We may cover the cost of purchasing this equipment if we determine that it is more economical than renting. We must approve the purchase before it is made. We will pay for the least expensive device that is medically adequate. Spare parts or alternative supplies are not covered. We will pay up to $250 in a person's lifetime for wheelchair repairs.

- charges for the rental of, at our option, the purchase of continuous positive airway pressure machines, provided they are approved and required due to a proven medical condition.

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

- compressors
- blood glucose monitor (We will pay up to $150 in any period of 5 consecutive policy years)
- grab bars
- Mozes detector
- raised toilet seats
- transfer bench

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

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

Ambulance services

We will cover the cost of a licensed ambulance or other emergency service that transports the insured person to the nearest hospital that is able to give the necessary emergency treatment. This covers travel between hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the insured person, if it is medically necessary. We will pay up to $250 for each insured person for all covered costs related to any one occurrence.

Dental accident

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

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

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

We will pay up to $1,000 for each insured person for covered costs related to any one accident.

Tutorial Services (Applicable to the member only)

If an insured member becomes disabled or confined to their home or hospital due to illness or injury, for a minimum of 15 consecutive school days, such member is eligible for the services of a qualified tutor. An insured member must have a written letter

from the Group Policyholder or a professor validating the qualification of a tutor. We will pay a maximum of $15 per hour up to $2,000 every policy year.

Paramedical services

Balanced Plan

We will pay up to $20 per visit, up to $300 in a policy year, for the services of each of the following:

- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist*

We will pay up to $300 in a policy year, for the services of clinical psychologists or qualified social workers*.

Students electing Enriched Drugs and Paramedical Plan

We will pay up to $35 per visit, up to $400 in a policy year, for the services of each of the following:

- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist*

We will pay up to $400 in a policy year, for the services of clinical psychologists or qualified social workers*.

Students electing Enriched Paramedical and Vision Plan

We will pay up to $50 per visit, up to $500 in a policy year, for the services of each of the following:

- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist*

We will pay up to $500 in a policy year, for the services of clinical psychologists or qualified social workers*.

Students electing Enriched Dental Plan

We will pay up to $20 per visit, up to $300 in a policy year, for the services of each of the following:

- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist*

We will pay up to $300 in a policy year, for the services of clinical psychologists or qualified social workers*.

*An insured person must have a written referral from a physician.

We will cover the cost of one laboratory test and one x-ray recommended by a licensed chiropractor or osteopath every policy year.

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

What you are not covered for under any Health Care coverage

We will not pay for the cost of:

- health care services or supplies that the insured person is eligible to claim under Workers' Compensation legislation in the insured person's province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the insured person is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, the insured person's employer, a school or anyone other than the insured person's physician. (For example, the insured person's employer requiring a doctor's note or a court requiring that the insured person receive psychological services.)
- treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called the temporomandibular joint.)
- cosmetic treatments
- "in vitro" or "in vivo" procedures, or any other infertility procedures, unless otherwise specifically covered in this policy
- any service that we are not legally allowed to pay for
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- health care services or supplies required for recreation or sports, but not for regular daily living activities

Co-ordination of benefits with your spouse's plan

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

Here are the procedures to follow:

Claiming your expenses

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

Claiming your spouse's expenses

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

Claiming your child's expenses

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

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

Submitting a claim

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

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

Make sure that your receipts include:

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

We must receive satisfactory proof of claim by the earlier of the following dates:

- 18 months following the date of service or the date of purchase, or
- 90 days after the date the policy terminates.

Your Dental coverage

What is Your Dental coverage

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

If treatment is given by a specialist, the amount we pay will be limited to the amount stated for that treatment in the Dental Association Suggested Schedule of Fees for General Practitioners as described in the "How much we will pay" section.

How much we will pay

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

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

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

There is no deductible for covered dental costs. The following is an overview of what we will pay. Please see the “What is covered” section for specific details.

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

Balanced Plan

Preventive coverage

Part 1
80% of Preventive covered costs with no deductible.

Part 2
70% of Preventive covered costs with no deductible.

Part 3
50% of Preventive covered costs with no deductible.

Maintenance coverage

Part 1
20% of Maintenance covered costs with no deductible.

Part 2
15% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is $750 in a policy year.

Students Electing Enriched Drug and Paramedical Plan

Preventive coverage

Part 1
80% of Preventive covered costs with no deductible.

Part 2
50% of Preventive covered costs with no deductible.

Part 3
30% of Preventive covered costs with no deductible.

Maintenance coverage

Part 1
20% of Maintenance covered costs with no deductible.

Part 2
15% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is $500 in a policy year.

Students Electing Enriched Paramedical and Vision Plan

Preventive coverage

Part 1
80% of Preventive covered costs with no deductible.

Part 2
60% of Preventive covered costs with no deductible.

Part 3
30% of Preventive covered costs with no deductible.

Maintenance coverage

Part 1
20% of Maintenance covered costs with no deductible.

Part 2
15% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is $750 in a policy year.

Students Electing Enriched Dental Plan

Preventive coverage

Part 1
80% of Preventive covered costs with no deductible.

Part 2
80% of Preventive covered costs with no deductible.

Part 3
80% of Preventive covered costs with no deductible.

Maintenance coverage

Part 1
20% of Maintenance covered costs with no deductible.

Part 2
15% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is $1,000 in a policy year.

When your Dental coverage ends

When you reach age 70.

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

When your Dental treatment will cost more than $500

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

We may also need the following information:

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

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

What you are covered for

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

Preventive coverage

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

Part 1

1. Examinations

A. Initial or Complete Examinations

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

One complete examination is covered per dentist in a lifetime.

B. Recall Examinations

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

Recall examinations are covered once every 6 months for students electing the Enriched Dental Plan, and one recall examination is covered every policy year for students electing any other plan.

C. Specific Examinations

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

D. Emergency Examinations

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

2. X-rays

A. Full Mouth Series X-rays

Full mouth x-rays are a series of at least 16 films including bitewings. One series is covered every 36 months. The insured person must be 12 or older to be covered.

B. Panorex X-rays

A panorex is one view of the entire mouth and is covered once every 36 months.

C. Periapical X-rays

Periapical x-rays are x-rays of single teeth and 16 periapical x-rays are covered every 36 months.

D. Bitewing X-rays

A bitewing x-ray is used to detect decay in molar teeth and one set (4 films) is covered in a policy year.

E. Bite X-rays

Bite x-rays are x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact.

3. Tests

A. Biopsy of Oral Tissue

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

B. Pulp Vitality Test

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

4. Cavity Prevention

A. Polishing or Cleaning Teeth

One unit (15 minutes) is covered every policy year.

B. Scaling

Two units (15 minutes per unit) are covered every policy year.

C. Fluoride

Only children 18 or younger are covered for this treatment. A child is covered for one treatment every policy year.

E. Oral Hygiene Instruction

This is instruction on how to brush and floss. One instruction is covered in a lifetime.

F. Pit and Fissure Sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Only children 18 or younger are covered for up to one for each molar every 36 months.

Part 2

1. Space Maintainers

A. Space Maintainers

A space maintainer is an appliance that a dentist uses to maintain a space where a tooth has been removed. Only children under age 15 are covered for one space maintainer per space in a policy year.

B. Maintenance of space maintainers

Maintenance of a space maintainer means adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed. Only children under age 15 are covered.

2. Fillings

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

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

A. Silver Fillings

A silver filling is only covered if 24 months have passed since the last restoration to the same tooth. If a bonded silver filling is installed, we will only cover the cost of a non-bonded silver filling.

B. White Fillings

A white filling is only covered if 24 months have passed since the last restoration to the same tooth.

C. Retentive Pins

These are pins used to make sure that a restoration or filling stays in place. The insured person is covered for the cost of one set of retentive pins per tooth in 24 months.

D. Sedative Fillings for Caries, Trauma and Pain Control

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

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

E. Stainless Steel, Plastic and Polycarbonate Caps

This is a cap that is installed to cover the whole tooth or teeth. Only children under the age of 15 are covered for this treatment and are covered for up to one treatment per tooth every 36 months.

3. Denture Maintenance

A. Denture Adjustments

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

B. Denture Repairs

Repairing dentures means fixing broken or damaged dentures. The insured person is covered for unlimited denture repairs.

C. Denture Rebasing and Relining

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

One rebase or reline is covered every 36 months as long as the rebasing or relining is done more than three months after the dentures were first inserted.

D. Tissue Conditioning

Tissue conditioning means applying a conditioner to the alveolar ridge that ensures a proper denture fit and is covered once every 36 months.

4. Fixed Prosthetics Recementation

The recementation of an existing crown or bridge.

Part 3

1. Extractions

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

Extraction means removing a tooth, including an impacted tooth. There is a limit of two wisdom teeth extractions in any policy year.

2. Minor Oral Surgery

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

A. Residual Root Removal

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

3. Major Oral Surgery

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

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

A. Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty

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

B. Surgical Excision

This includes the removal of cysts or a foreign body.

C. Surgical Incision

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

D. Fractures

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

E. Frenectomy

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

F. Sialolithotomy

This is the partial removal of the salivary duct.

G. Antral Surgery

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

H. Hemorrhage Control

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

I. Post Surgical Care

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

J. Anaesthesia

All necessary anaesthesia during a dental procedure including:

- general anaesthesia (total loss of consciousness),
- deep sedation (where the insured person may be in and out of consciousness during a procedure),
- intravenous sedation (the injection of a sedative into the blood stream) and
- inhalation technique (sedation given using a mask).

Maintenance coverage

Some of the procedures are treatment of gums, root canal therapy, bite adjustment, equilibration, appliance and appliance adjustments.

Part 1

1. Treatment of roots

A. Pulpotomy

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

B. Root Canal Therapy

This procedure includes:

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

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

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

C. Apexification

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

D. Retrofilling

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

E. Apicoectomy

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

F. Root Amputation

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

G. Hemisection

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

H. Intentional Removal, Apical Filling and Re-implantation

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

Part 2

1. Treatment of gums

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

A. Displacement Dressing

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

B. Desensitization

Desensitization means applying fluoride to reduce sensitivity.

C. Gingival Curettage

Gingival curettage means scraping out damaged tissue inside the gums.

D. Gingivectomy

Gingivectomy means removing damaged gum tissue.

E. Flap Surgery

Flap surgery is the opening made for bone removal.

F. Tissue Graft

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

2. Bite Adjustment/Equilibration

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

3. Appliances and Appliance Adjustment

A. Periodontal Appliances

The cost of making the impression and inserting the appliance is covered. One appliance is covered per arch (upper or lower) every 24 months.

B. Adjustment of Periodontal Appliances

Adjustment of appliances are covered for up to 4 adjustments every policy year.

What you are not covered for

We will not pay for:

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

Co-ordination of benefits with your spouse's plan

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

Here are the procedures to follow:

Claiming your expenses

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

Claiming your spouse's expenses

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

Claiming your child's expenses

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

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

Submitting a claim

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

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

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

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

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

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

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

- 18 months following the treatment, or
- 90 days after the date the policy terminates

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