

Group Benefit Plan



Great-West Life
your Benefits Solutions People

STUDENTS' ASSOCIATION OF MACEWAN

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
- 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 No. 330754** 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



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 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 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 Grant MacEwan University. 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 is September 1st to August 31 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 opposite sex 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 2 policy years.

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.

Reinstatement

A member who returns within 12 months of coverage ending due to termination of membership will be eligible for coverage on the date of return. An enrollment form must be completed within 31 days of returning for coverage to be reinstated; otherwise you will be treated as a new member and become eligible for coverage as described under the "When coverage begins" section.

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
- Tuition benefit
- Paramedical services
- Emergency out-of-province/country treatment
- Travel assistance

How much we will pay

Balanced Plan

All Students except Students covered under the Flexible 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 under the National Formulary or Special Authorization (SA) drug list 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 per examination in any 24 consecutive month period with no deductible.

For tuition benefit, 100% of the covered costs with no deductible. We will cover up to \$10,000 in an insured person’s lifetime.

For emergency out-of-province/country and travel assistance, 100% of the covered costs above the insured person’s provincial health plan coverage with no deductible. Some reductions may apply.

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

Flexible Plan

All Students electing the Flexible 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 under the National Formulary or Special Authorization (SA) drug list 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 per examination in any 24 consecutive month period with no deductible.

For tuition benefit, 100% of the covered costs with no deductible. We will cover up to \$10,000 in an insured person’s lifetime.

For emergency out-of-province/country and travel assistance, 100% of the covered costs above the insured person’s provincial health plan coverage. Some restrictions may apply.

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

All Students electing the Flexible 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 under the National Formulary or Special Authorization (SA) drug list 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 per examination in any 24 consecutive month period with no deductible.

For tuition benefit, 100% of the covered costs with no deductible. We will cover up to \$10,000 in an insured person’s lifetime.

For emergency out-of-province/country, 100% of the covered costs above the insured person’s provincial health plan coverage. Some reductions may apply.

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

All Students electing the Flexible 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 under the National Formulary or Special Authorization (SA) drug list 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 per examination in any 24 consecutive month period with no deductible.

For tuition benefit, 100% of the covered costs with no deductible. We will cover up to \$10,000 in an insured person’s lifetime.

For emergency out-of-province/country, 100% of the covered costs above the insured person’s provincial health plan coverage. Some reductions may apply.

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 or Special Authorization (SA) drug list and that can only be obtained with a prescription. They must be prescribed by a physician or other person entitled by law to prescribe 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.

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 or Special Authorization (SA) drug list.

We will pay up to \$500 in the insured person's lifetime for products to help them quit smoking.

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 but excluding Recombivax HB preservative free – DIN 02245976 and DIN 02245977)
- non-disposable insulin injectors
- products which can be bought without a prescription
- products used to lose weight
- spring loaded devices used to hold lancets

Eyeglasses or contact lenses

Balanced Plan

All Students except Students covered under the Flexible Plans

We will cover the cost of 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.

For eye examinations, 100% of the covered costs of one eye (including eye refractions) in any 24 consecutive month period.

We will pay up to a lifetime maximum of \$500 for the cost of:

- visual training
- remedial exercises.

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

Flexible Plans

All Students electing the Flexible Drugs & Paramedical Plan

We will cover eye examinations at 100% of the covered costs of one eye examination (including eye refractions) in any 24 consecutive month period.

All Students electing the Flexible Vision & Paramedical Plan

We will cover the cost of 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.

For eye examinations, 100% of the covered costs of one eye (including eye refractions) in any 24 consecutive month period.

All Students electing the Flexible Dental Plan

We will cover eye examinations at 100% of the covered costs of one eye examination (including eye refractions) in any 24 consecutive month period.

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

Preferred Vision Services (PVS) Discount

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

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

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

You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at www.pvs.ca for information about PVS locations and the program
- Arrange for a fitting, an eye examination, a hearing assessment or a hearing aid, if needed
- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Medical services and equipment

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

- walkers, braces provided they are not solely for athletic use, standard non-myoelectric artificial limbs 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, canes 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 foot 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.
- hearing aids and repairs, not including batteries. We will pay up to \$500 in any period of five consecutive policy years.

- rental charges for standard manual or electric wheelchairs, hospital beds, traction kits (if applicable) 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.

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

- casts
- 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 you become disabled or confined to your home or hospital due to illness or injury, for a minimum of 15 consecutive school days, you are eligible for the services of a qualified tutor. You 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.

Tuition Benefit (Applicable to the member only)

If, solely as a result of death or disability, you terminate enrolment in a post-secondary institution, we will reimburse the cost of:

- the paid tuition fee for any course not completed that was forfeited;
- books purchased in relation to a course for which tuition is reimbursed under this benefit provision, up to a total lifetime maximum amount payable of \$1,000; and
- the pro-rated amount of the total mandatory ancillary fees paid as part of the school's enrolment requirements.

We will pay the benefit to you, if the benefit is payable due to a disability or, to your beneficiary, if the benefit is payable due to death, subject to all of the following provisions.

The maximum amount of tuition benefit we will pay in a member's lifetime is \$10,000.

For the purposes of this benefit, you are considered disabled if illness or injury exclusively prevents you from being able to carry on studies for a period of at least 60 days. You must be receiving continuous treatment by a certified specialist for the condition involved.

Pre-existing condition exclusion applicable to disability: We will not pay this benefit if both of the following conditions apply:

- the start date of the disability occurs during the first twelve months of your coverage under this benefit, and
- the disability is directly or indirectly related to a condition for which, within 90 days before this coverage began, you visited or consulted a physician or paramedical practitioner or had tests done or received treatment, regardless of whether a diagnosis was made.

Coordination: If tuition and associated fees described in this benefit are refundable or otherwise reimbursed in whole or in part by the institution or student organization, we will reduce the amount we pay under this provision by the amount of the refund or reimbursement from the institution or student organization. The student or beneficiary are required to make application to the institution and student association for reimbursement of tuition and associated fees. We will not pay any amount under this benefit until documentation of such application and proof of the resulting outcome have been provided to us.

Paramedical services

Balanced Plan

All Students except Students covered under the Flexible Plans

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

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist* or athletic therapists*

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

Students electing Flexible Drugs and Paramedical Plan

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

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist* or athletic therapists*

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

Students electing Flexible Paramedical and Vision Plan

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

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist* or athletic therapists*

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

Students electing Flexible Dental Plan

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

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists*
- naturopaths
- osteopaths
- speech language pathologists*
- physiotherapist* or athletic therapists*

We will pay up to \$500 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, osteopath or podiatrist 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.

Emergency out-of-province/country coverage

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

We will cover the cost of emergency treatment, described below, that is required while temporarily outside the home province, (including outside Canada) on business or vacation. We will not cover emergency treatment while travelling for health reasons. An emergency means any sudden, unexpected illness or injury which requires immediate treatment. We will pay up to \$2,000,000 in the insured person's lifetime for all the covered costs under this emergency out-of-province/country and the Travel Assistance coverage. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

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

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

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

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

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

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

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

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

Travel Assistance coverage

The Travel Assistance coverage includes services that are required due to an emergency which occurs while temporarily outside the home province, (including outside of Canada), on business or vacation. We will not cover services required while travelling for health reasons.

When you or your dependents travel, please take the Travel Assistance card given to you by your employer. It contains the name of your Travel Assistance provider and the telephone numbers to call in case of an emergency.

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

The services under the Travel Assistance coverage include:

- multilingual assistance by telephone, 24 hours a day, 365 days a year, for the insured person or medical providers to obtain aid, assistance, and exchange information, in matters relating to the covered services.
- referrals to physicians or medical facilities, if necessary.
- arrangements for direct payment, wherever possible, for physicians' services, hospitalization and other insured services.
- communication with the physician who is treating the insured person to get an understanding of the situation and monitor the condition.
- telephone interpretation services in most major languages.
- the sending and receiving of urgent messages.
- medical evacuation home or transportation to another medical facility. For transportation home, we will pay for an economy fare ticket.

- arrangements for (including all necessary documents) and the cost of transporting the insured person's remains to their home. We will pay up to a maximum of \$3,500.
- help to locate Embassy or Consulate services.
- help to locate lost documents or luggage.

The Travel Assistance benefit includes the following services but we must approve the charges first:

- the cost of additional commercial accommodation required beyond the original return date, for a companion travelling with the insured person. This includes charges for accommodation, meals, telephone and taxi or rental cars. We will pay a maximum of \$150 per day up to a total of \$1,500.
- the cost of an economy fare ticket home, for a companion who is travelling with the insured person, and who has forfeited their ticket because of a delay caused by the insured person's illness, injury, or death.
- the cost of an economy fare ticket home for each child left alone because of the insured person's illness, injury, or death. The Travel Assistance provider will also arrange for a qualified attendant to accompany the children, if necessary.
- the cost of a round-trip economy fare ticket for a family member to visit an insured person who is travelling alone and must be hospitalized for more than 10 days.
- the cost of returning a vehicle to the insured person's home or the nearest rental agency. We will pay up to a maximum of \$1,000.

We are not legally responsible for the actions or advice of any physician or attorney that we refer the insured person to.

The Travel Assistance benefit does not cover medical emergencies in the home province.

Please contact the Travel Assistance Centre using the telephone number on the Travel Assistance card.

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

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

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

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

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

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

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

Make sure that your receipts include:

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

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

100% of Preventive covered costs with no deductible, when covered costs are performed by a Select Dentist.

70% of Preventive covered costs with no deductible, when covered costs are performed by a Non-Select Dentist.

80% of Restorative covered costs with no deductible.

Maintenance coverage

50% of Maintenance covered costs with no deductible.

Major restorative coverage

15% of Major restorative covered costs with no deductible.

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

Students Electing Flexible Drug and Paramedical Plan

Preventive coverage

100% of Preventive covered costs with no deductible, when covered costs are performed by a Select Dentist.

70% of Preventive covered costs with no deductible, when covered costs are performed by a Non-Select Dentist.

50% of Restorative covered costs with no deductible.

Maintenance coverage

30% of Minor oral surgery covered costs with no deductible.

50% of Maintenance covered costs with no deductible.

Major restorative coverage

15% of Major restorative covered costs with no deductible.

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

Students Electing Flexible Paramedical and Vision Plan

Preventive coverage

100% of Preventive covered costs with no deductible, when covered costs are performed by a Select Dentist.

70% of Preventive covered costs with no deductible, when covered costs are performed by a Non-Select Dentist.

60% of Restorative covered costs with no deductible.

Maintenance coverage

30% of Minor oral surgery covered costs with no deductible.

50% of Maintenance covered costs with no deductible.

Major restorative coverage

15% of Major restorative covered costs with no deductible.

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

Students Electing Flexible Dental Plan

Preventive coverage

100% of Preventive covered costs with no deductible, when covered costs are performed by a Select Dentist.

80% of Preventive covered costs with no deductible, when covered costs are performed by a Non-Select Dentist.

80% of Restorative covered costs with no deductible.

Maintenance coverage

80% of Minor oral surgery covered costs with no deductible.

50% of Maintenance covered costs with no deductible.

Major restorative coverage

15% of Major restorative covered costs with no deductible.

The maximum we will pay for Preventive, Maintenance and Major Restorative 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 space maintainers, fillings and denture maintenance.

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. Amalgam Fillings

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

B. Composite Fillings

These are white fillings that are used to restore teeth.

C. Retentive Pins

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

D. Prefabricated Posts

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

E. 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).

F. 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.

G. Pit and Fissure Sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Coverage is limited to molars only. Only children 18 or younger are covered and once in a policy year.

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 and is unlimited.

C. Denture Rebasing and Relining

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

D. Tissue Conditioning

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

4. Major Restorative Maintenance

A. Repairs and Recementation

Repairing means fixing or repairing damaged inlays, onlays, crowns, or bridgework. Recementation is to recement an existing inlay, onlay, crown or bridge that has become unattached.

Maintenance coverage

Some of the procedures that are covered are for x-rays, root canal therapy, periodontal scaling and extractions.

1. X-rays

A. Periapical X-rays

Periapical x-rays are x-rays of single teeth. There is no limit to the number of periapical x-rays the insured is covered for.

B. Panorex X-rays

A panorex is one view of the entire mouth and is covered once every 36 months if medically necessary in conjunction with the extractions of wisdom teeth.

2. Treatment of roots

A. Pulpotomy

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

B. Pulpectomy

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

C. Root Canal Therapy

This procedure includes:

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

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

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

D. Apexification

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

E. Retrofilling

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

F. Apicoectomy

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

G. Root Amputation

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

3. Treatment of gums

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

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

Scaling means removing calcium deposits on teeth. Root planing means the smoothing of rough tooth surfaces and removing any calcium deposits and is covered for up to 2 units of scaling and/or root planing every policy year.

4. Minor Oral Surgery

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

A. Extractions (not more than two wisdom teeth extractions per policy year)

Extraction means removing a tooth, including an impacted tooth.

Major Restorative Coverage

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

1. Caps and Tooth Coverings

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

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

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

A. Crowns

A crown is a cap that covers the whole tooth. Crowns are covered once every 60 months.

B. Retentive Pins in Crowns

These pins are used to make sure that the crowns stay in place.

C. Build-up/Fillings

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

F. Posts and Cores

These are laboratory-processed posts and cores used for additional support to the tooth after root canal therapy.

2. Dentures

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

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

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

A. Complete Dentures

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

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

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

B. Transitional Dentures

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

C. Acrylic Dentures

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

D. Partial Dentures

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

3. Bridges

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

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

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

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

A. Pontics

A pontic is an artificial tooth that replaces a missing tooth. Pontic replacement is covered only if it has been more than 60 months since the last pontic was installed in that space. A porcelain pontic installed on a molar will be covered at the metal equivalent.

B. Retainers/Abutments

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

C. Posts in Retainers/Abutments

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

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);

Co-ordination of benefits with your spouse's plan

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

Here are the procedures to follow:

Claiming your expenses

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

Claiming your spouse's expenses

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

Claiming your child's expenses

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

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

Submitting a claim

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

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

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

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

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

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

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