GRIFFITHS MOTORS (HINTON) LTD.

INTRODUCTION

To Employees Covered under the CADA 360 - Employee Benefits Plan:

GRIFFITHS MOTORS (HINTON) LTD.

Group Benefits Plan Nos. 341549 and 341550

All Employees

This booklet is a summary of your benefit details effective September 1, 2015.

Why is this booklet important

The purpose of this Booklet is to provide a description of your benefits. We urge you to read it carefully so that you will understand the Plan and what it means to you and your family. This booklet contains important information and should be kept in a safe place known to you and your family.

Welcome to Great-West Life!

Great-West Life is a leading Canadian life and health insurer. Great-West Life provides CADA 360 plan participants with insurance and delivery of your coverage by providing administration and claims payment services.

Liability for Benefits

Benefits are provided under the Benefits 360° Health & Welfare Trust in accordance with the terms of that trust (the "Trust") and the CADA 360 Group Employee Benefit Program (the CADA 360 - Employee Benefits Plan). The Canadian Automobile Dealers Association, as the trustee of the Benefits 360° Health and Welfare Trust, has entered into an agreement with The Great-West Life Assurance Company (Great-West Life) whereby Great-West Life will provide claims processing and payment services in relation to Short Term Disability (STD), Healthcare and Dentalcare benefits offered under the CADA 360 - Employee Benefits Plan. These benefits are funded from contributions received by the Trust from dealers and their employees and are not insured by Great-West Life. However, Great-West Life does provide the Trust with a form of risk protection ("stop loss and/or high amount pooling insurance") in relation to these benefits. The Long Term Disability (LTD), Life and Accidental Death, Dismemberment & Specific Loss (AD&D) coverages provided under the CADA 360 - Employee Benefits Plan are insured by Great-West Life.

If you need more information

For inquiries on your CADA 360 - Employee Benefits Plan:

Claim Enquiries: 1.877.650.0003
Plan Information, Forms and Cards:
Member's Section **www.greatwestlife.com**

Please have your plan number and your personal identity number available.

Great-West Life Online

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website **www.greatwestlife.com**.

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.

The insured plan is underwritten by
and other coverage is administered by

08-15

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

The Canadian Automobile Dealers Association, as the trustee of the Benefits 360° Health and Welfare Trust, has entered into an agreement with Great-West Life whereby Great-West Life will provide claims processing and payment services only in relation to some of the benefits in the plan. We may exchange personal information with your health care providers, your plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us when necessary to administer the plan.

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

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

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

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Benefit Summary

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

Employee Basic Life Insurance	150% of annual earnings to a maximum of $150,000, reducing by 15% of the original amount at age 65 and further reducing by 15% of the original amount for each of the next 4 years until your amount of insurance is 25% of the original amount
Dependent Basic Life Insurance	
Spouse	$5,000
Child	$2,500
Optional Life Insurance	Available for you and your spouse, subject to approval of medical evidence, in $10,000 units to a maximum of $1,000,000 for Optional and Basic Life Insurance combined. If you are covered under this plan as both an employee and a spouse, you are limited to the $1,000,000 maximum

Employee Basic Accidental Death, Dismemberment and Specific Loss (Principal Sum)	An amount equal to your Basic Life Insurance
Optional Accidental Death, Dismemberment and Specific Loss (Principal Sum)	An amount equal to Optional Life Insurance, automatically included with approval for Optional Life Insurance
Short Term Disability Benefits	
Waiting Period	
Injury	No waiting period
Illness	7 days If you are hospitalized or have day surgery before the last day of the waiting period, benefits will begin on the day you are hospitalized or the surgery is performed
Maximum Benefit Period	17 weeks
Amount	66 2/3% of weekly earnings to a maximum of $900

Long Term Disability Benefits

Waiting Period	119 days
Amount	67% of the first $2,250 of your monthly earnings plus 50% of the remainder to a maximum of $3,000 or 85% of your pre-disability take-home pay, whichever is less

Healthcare

Covered expenses will not exceed customary charges

Deductible	Nil
Reimbursement Level	100%
Basic Expense Maximums	
Healthcare Maximum	$2,000,000 per person in a lifetime

The healthcare maximum does not apply to Out-of-Province and Out-of-Country Emergency Care or Travel Assistance expenses.

Hospital	Semi-private room
Home Nursing Care	
- under age 65	$25,000 per person each calendar year
- age 65 and over	$10,000 per person each calendar year to a maximum of $25,000 per person in a lifetime
In-Canada Prescription Drugs	Included
Dispensing Fee Limit	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $15

Hearing Aids	$1,000 every 3 calendar years per person
Custom-fitted Orthopedic Shoes	one pair per person each calendar year
External Breast Prosthesis	1 per side per person every two calendar years
Surgical Brassieres	2 per person each calendar year
Surgical Stockings	2 pairs per person each calendar year
Wigs for Cancer Patients or Alopecia Totalis	$250 per person in a lifetime
Diagnostic x-rays and lab tests	$1,500 per person each calendar year

Paramedical Expense Maximums

Acupuncturists	$500 per person each calendar year
Chiropodists or Podiatrists	$500 per person each calendar year
Chiropractors	$500 per person each calendar year
Clinical Psychologists	$1,000 per person each calendar year
Massage Therapists	$500 per person each calendar year
Naturopaths	$500 per person each calendar year
Osteopaths	$500 per person each calendar year
Physiotherapists	$500 per person each calendar year
Speech Therapists	$1,000 per person each calendar year

Out-of-Province and
Out-of-Country Care Maximums

- Emergency Expenses	$1,000,000 per person each emergency
- Non-Emergency Expenses	$10,000 per person in a lifetime

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered. Specialists' charges are limited to general practitioner fees
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	50%
Plan Maximums	
Basic Treatment	Unlimited
Major Treatment	$1,500 per person each calendar year

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan after 3 months of continuous employment. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period. This is provided you work at least 20 hours per week on a regular basis.

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide medical evidence for you and your dependents before you can participate.

  You may waive health and/or dental coverage if you are already covered for these benefits under your spouse's plan. If you lose spousal coverage you must apply for coverage under this plan. If you do not apply within 31 days of loss of such coverage, or you were previously declined for coverage by Great-West Life, you and your dependents may be required to provide medical evidence acceptable to Great-West Life to be covered for health benefits, and may be declined for or offered limited dental benefits.

- You must be actively at work and on your employer's payroll when coverage takes effect, otherwise the coverage will not be effective until you return to work.

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

- Temporary, part-time and seasonal employees may not join the plan.

The minimum hours and actively at work requirements do not apply to you if you are a dealer principal. A dealer principal is:

- the president of an incorporated dealer, associated dealer or member company in a local association
- a full-time employee who owns at least 25% of the shares of an incorporated dealer, associated dealer or member company in a local association
- a partner who has at least a 25% interest in an unincorporated dealer, associated dealer or member company in a local association
- the owner of an unincorporated dealer, associated dealer or member company in a local association, or
- a person who owns at least 25% of a holding company that owns 51% or more of the shares of a dealer, associated dealer or member company in a local association.

Unless expressly stated otherwise, the term employee will also mean principal.

Your coverage terminates when your employment ends, you are no longer eligible, your employer stops participating in the CADA 360 – Employee Benefits Plan, you stop making the required contributions, or the plan terminates, whichever is earliest.

Your coverage may be continued until the last day of the month following the month your absence began if you are absent from work due to a temporary lay-off or until the end of the 12th month after the date of an approved leave of absence. The period may be longer if required by law. Coverage will not be extended beyond 31 days for Short Term or Long Term Disability Income benefits.

If you are disabled and age 65 or over when your coverage terminates, your Life, Accidental Death, Dismemberment and Specific Loss, Healthcare and Dentalcare benefits may be extended until the earliest of the date your disability ends, 12 months after your coverage terminates or the date you or your dependent becomes eligible for coverage under another plan.

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

Survivor Benefits

If you die while your coverage is still in force, the Healthcare and Dentalcare benefits for your dependents will be continued for a period of 2 years or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

- Your unmarried children under age 22, or under age 25 if they are full-time students.

  Children under age 22 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  A child is considered a full-time student if he has been registered at an elementary, high school, university or similar educational institution for 15 hours a week or more sometime in the last 6 months.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 22, or while they are students under 25, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this plan 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.

EMPLOYEE BASIC LIFE INSURANCE

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

- Your life insurance terminates when you retire.

- You are entitled to waiver of premium benefits after you have been continuously disabled for 119 days. You will be considered disabled during the period you are entitled to receive Long Term Disability benefits.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 60 days after your group insurance terminates. See your employer for details.

DEPENDENT BASIC LIFE INSURANCE

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

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

- If you are disabled and the premiums for your employee life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.

- If your spouse's insurance terminates on or before his or her 65th birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 60 days after the group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

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

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

- If you are under age 65, you are entitled to waiver of premium benefits on your optional life insurance, and your spouse's, after you have been continuously disabled for 119 days. You will be considered disabled during the period you are entitled to receive Long Term Disability benefits.

- If your optional life insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of insurability. If your spouse's optional life insurance terminates on or before his or her 65th birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 60 days after the group insurance terminates. See your employer for details.

- Your optional life insurance terminates the earlier of when you reach age 70 or retirement. Your spouse's coverage terminates at the same time, or when he or she reaches age 70 or is no longer your spouse, whichever comes first.

Limitation

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

BASIC ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Great-West Life will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	Amount Payable
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use

Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

- Loss by dismemberment means:
  - for hands and feet, complete severance through or above the wrist or ankle joints,
  - for arms and legs, complete severance through or above the elbow or knee joints,
  - for thumb and big toe, complete severance of one entire phalange,
  - for fingers and other toes, complete severance of two entire phalanges.

- Loss of sight, speech, or hearing means total and irrecoverable loss beyond correction by surgical or other means.

- Loss of use means total and irrecoverable loss of the ability to perform every action the arm, leg, or hand was able to perform before the accident occurred, beyond correction by surgical or other means. No benefits will be paid for loss of use if benefits for loss by dismemberment of the same arm, leg, or hand are paid or payable as a result of the same accident.

Your AD&D insurance terminates when you retire.

Surgical Reattachment

If you suffer the loss of a limb that is surgically reattached, Great-West Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation

If you die as the result of an accident that is at least 150 kilometres away from your home, Great-West Life will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation less any amounts paid under this plan's Travel Assistance benefit.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Great-West Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death, or he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

Great-West Life will pay up to 5% of the Principal Sum, or $5,000, whichever is less, for each year of full-time post-secondary school enrolment. Great-West Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

No benefits will be paid for tuition expenses incurred before the accident, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Great-West Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's Travel Assistance coverage, up to $2,000, for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Great-West Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Great-West Life will pay up to 10% of the Principal Sum, or $10,000, whichever is less.

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Great-West Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Great-West Life will pay up to $10,000.

A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Great-West Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Great-West Life will pay the actual expense incurred less any amount paid for the same expenses under this plan’s healthcare benefit, up to $10,000 for all home and vehicle modifications combined.

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

Limitations

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment, except surgical reattachment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

- To claim benefits for yourself, ask your employer for a claim form. Complete it and return it to your employer.
- If you die accidentally, your employer will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

OPTIONAL ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS (AD&D) INSURANCE

Optional Accidental Death, Dismemberment and Specific Loss Insurance provides you with additional coverage. Coverage for your spouse includes all benefits except the Educational Benefit for Dependent Children and the Occupational Training Benefit for Spouses. Check the **Benefit Summary** for the amount of Optional AD&D available to you and your spouse. For benefit details, refer to your Basic AD&D section.

Your optional AD&D insurance terminates the earlier of when you reach age 70 or retirement.

SHORT TERM DISABILITY (STD) INCOME BENEFITS

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

- STD benefits are payable after the waiting period if disease or injury prevents you from performing the essential duties of your own occupation.
- If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.
- Separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 2 weeks of continuous full-time work.
- Because you pay the entire cost of STD coverage, benefits are not taxable.
- Your STD coverage terminates when you retire.

Other Income

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

- disability benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts

- benefits under any Workers' Compensation Act or similar law
- benefits under a legislated automobile insurance plan where permitted by law

Earnings received from an approved rehabilitation plan are not used to reduce your STD benefit unless 50% of those earnings, together with your income from this plan and the other income listed above, would exceed 100% your weekly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

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

Medical Coordination Benefits

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

Limitations

No benefits are paid for:

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

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

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

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

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

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

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

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

- Disability due to or associated with cosmetic treatment.

- Any period of confinement in a prison or similar institution.

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

How to Make a Claim

Notify your employer of your disability as soon as possible. Obtain a Short Term Disability Income Benefits – Employee Statement (form M5454) from your employer and follow the guide's instructions. Please ensure that your claim is submitted to Great-West Life within 10 days after the onset of your disability.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled or you reach age 65, whichever comes first. However, if you reach age 65 and have been entitled to benefits for less than 12 months, benefits will continue until the end of 12 months. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 30 days and the disabilities arise from the same disease or injury.

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

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 67% of your monthly earnings before you became disabled.

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

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

- Because you pay the entire cost of LTD coverage, benefits are not taxable.

- Your LTD insurance terminates the earlier of when you reach age 65 or retirement.

Other Income

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

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

- benefits under any Workers' Compensation Act or similar law

- 50% of earnings received from an approved rehabilitation plan

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

- your income under this plan

- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

- the wage loss portion of any criminal injury award

- disability benefits under a plan of insurance available through an association except for benefits that were payable for each of the 12 months prior to a disability period

- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

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

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

Vocational Rehabilitation

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

Medical Coordination

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

Survivor Benefit

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

Limitations

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 12 months, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

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

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

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

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

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

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

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

- The scheduled duration of a leave of absence.

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

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

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

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

How to Make a Claim

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

HEALTHCARE

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Except to the extent otherwise required by law, your healthcare coverage terminates when you retire.

Covered Expenses

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

- Semi-private room and board in a hospital in your home province. Hospital confinement is covered if it represents acute, convalescent, chronic or palliative care. Any hospital facility fee related to dental surgery is also covered. Benefits for hospital confinement outside your home province are payable only as provided under the out-of-province and out-of-country care provision.

  A hospital is an institution that is legally termed a hospital, is open at all times, offers in-patient accommodation, has a staff of one or more physicians available at all times, and continuously provides 24-hour nursing by graduate registered nurses. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care

- Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident in any other province who is not a member of your family, when services are provided in Canada, but only if the patient requires the specific skills of a trained nurse. Home nursing services are covered if they represent acute, convalescent, chronic or palliative care.

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

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

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

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

  - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

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

New prescriptions for selected drugs are subject to an initial trial quantity and monitoring by the dispensing pharmacist to ensure the medication is effective and tolerated by the patient.

For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a doctor, including but not limited to:
  - respiratory equipment including oxygen
  - braces and casts
  - prostheses including standard artificial limbs and eyes
  - canes, walkers and crutches
  - wheelchairs
  - contact lenses or glasses following non-refractive surgery
  - colostomy supplies
  - blood-glucose monitoring machine
  - mozes detectors
  - TENS machines
  - hospital beds
- Custom-fitted orthopedic shoes, including modifications to orthopedic footwear when prescribed by a physician, podiatrist or chiropodist, when no other method can correct the problem. Orthotics and off-the-shelf orthopedic shoes are not covered.
- Hearing aids, repairs, tubing and ear molds provided at the time of purchase, when prescribed by a physician

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs

- Diagnostic x-rays and lab tests performed in your province of residence when prescribed by a physician, where it is not prohibited by provincial health insurance plan legislation and has not been paid by the provincial health plan

- Treatment of injury to sound natural teeth. Treatment must start within 90 days after the accident unless delayed by a medical condition. If treatment is scheduled to start more than 90 days after the accident, a treatment plan must be submitted to the plan administrator before the end of the 90 days.

  The amount payable will be based on the least expensive treatment that is adequate to correct the damage.

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

  No benefits are paid for:

  - accidental damage caused by objects or food placed in the mouth

  - accidental damage to dentures

  - dental treatment completed more than 12 months after the accident

  - orthodontic diagnostic services or treatment, except when required for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability

- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital treatment by a registered clinical psychologist who does not live with the person to whom the treatment is provided
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist
- Out-of-hospital treatment of foot disorders by a licensed podiatrist or a qualified chiropodist, including diagnostic x-rays by a licensed podiatrist
- Out-of-hospital treatment of speech impairments by a qualified speech therapist who does not live with the person to whom the treatment is provided

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. Services required while travelling for health reasons will not be covered.

When you or your dependents travel, please take the Travel Emergency Medical Passport 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: Any pregnancy related eligible charges which are incurred outside of Canada within nine weeks of the expected delivery date will not be covered. Eligible charges 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 provided that the charges are submitted for pre-approval:

- 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.

Great-West Life is not legally responsible for the actions or advice of any physician or attorney that you may be referred to.

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

Please contact the Travel Assistance Centre using the telephone number in the Travel Emergency Medical Passport.

Out-of-Province and Out-of-Country Care

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

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

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

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

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

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

No benefits are paid for:

- any further medical care related to a medical emergency after the initial acute phase of the treatment

- any further medical care if the treating physician or service provider advises you or your dependent to return home or move to a different facility and you or your dependent do not follow that advice

- medical care outside Canada that is associated with pregnancy if you or your dependent travel outside Canada within 9 weeks of the expected delivery date

• **Non-emergency care** outside your home province is covered for you and your dependents if:

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

  - it is not available in your home province, but is available elsewhere in Canada or in the United States

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

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

  No benefits will be paid for:

  - investigational or experimental treatment

  - transportation or accommodation charges.

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

- for emergency care only:

  - hospital accommodation at the semi-private rate payable for such accommodation if it had been provided in Canada
  - hospital services and supplies
  - out-patient diagnosis and treatment by a physician outside Canada, if the treatment would have been covered by your provincial medical plan
  - prescription drugs

- for non-emergency care only:

  - hospital accommodation in a standard ward at the rate payable for such accommodation if it had been provided in Canada, if the confinement begins while you or your dependent is covered
  - hospital services and supplies
  - treatment by a physician

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

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

- Expenses private benefit plans are not permitted to cover by law

- Services or supplies for which a charge is made only because you have coverage

- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan

- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (“government plan”), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:

  - treatment performed only for cosmetic purposes

  - recreation or sports rather than with other daily living activities

  - the diagnosis or treatment of infertility

  - contraception, other than contraceptive drugs, intrauterine devices (IUDs) and products containing a contraceptive drug

- Services or supplies not listed as covered expenses unless determined by the plan administrator to be covered expenses

- Extra medical supplies that are spares or alternates

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

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

  This limitation does not apply to Travel Assistance

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

In addition under the prescription drug coverage, no benefits are paid for:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

- Preventative immunization vaccines and toxoids
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Smoking cessation products
- Fertility drugs, whether or not prescribed for a medical reason
- Drugs in an oral format used to treat erectile dysfunction

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, the plan administrator maintains a limited list of services and supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the GWL website as follows:

http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, you or your dependent may be required to provide medical evidence to the plan administrator why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, the plan administrator may contact you to participate in health case management. Health case management is a program recommended or approved by the plan administrator that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison, with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the person's attending physician.

In determining whether to implement health case management, the plan administrator may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as the plan administrator determines, where:

- the plan administrator has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where the plan administrator has recommended or approved health case management, the plan administrator can require that a service or supply be purchased from or administered by a provider designated by the plan administrator, and:

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

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, you or your dependent may be required to apply to and participate in such a program. Where financial assistance is available from a patient assistance program the plan administrator requires participation in, the covered expense for a service or supply may be reduced by the amount of financial assistance you or your dependents are entitled to receive for that service or supply.

How to Make a Claim

- Out-of-province and out-of-country claims

  - When you return home, contact the Assistance Centre for the forms you need to submit a claim.

  - Submit claims to the Assistance Centre and include your original receipts.

  - Forward the claim to the Assistance Centre:

Assistance Centre – Claims Department
P.O. Box 97, Station A
Mississauga, ON L5A 2Y9

Phone: 1-866-530-6025 or 905-816-1990

Out-of-province and out-of-country claims should be submitted to the Assistance Centre as soon as possible upon incurring the expense. It is very important that your claims are submitted promptly upon your return to Canada because your provincial health plan has very strict time limitations for submission. The provincial plan time limits apply to your group health plan claim as well. We suggest you contact your provincial health plan prior to leaving the country to determine the extent of your provincial health plan coverage. If your provincial health plan refuses payment, you may be asked to reimburse the Assistance Centre for any amount already paid on behalf of the provincial health plan.

In most cases, the Assistance Centre will pay your provincial health plan's share of the claim on the province's behalf. The Assistance Centre will then be reimbursed directly from your provincial health plan for their share of the expenses.

To obtain the forms needed to submit an out-of-province and out-of-country claim or for information on your coverage, please contact our Out-of-Country Claims Unit at 1-866-530-6025 or 905-816-1990.

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

  Claims must be submitted to Great-West Life as soon as possible, but no later than June 30th of the year after you incur the expense.

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

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

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than June 30th of the year after you incur the expense.

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

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

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

PREFERRED VISION SERVICES (PVS)

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

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

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

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

Using PVS:

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

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

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

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

DENTALCARE

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to a deductible, plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

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

Your dentalcare coverage terminates when you retire.

Treatment Plan

- Before incurring any large dental expenses equal to or in excess of $500, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one initial (complete) oral examination per dentist every 9 months
  - one recall examination every 9 months
  - one specific examination every 9 months
  - emergency examinations as required
  - consultations with the attending dentist
  - complete series of x-rays every 24 months
  - a panorex x-ray every 9 months
  - periapical x-rays to a maximum of 16 films every 36 months (combined with bite-wing and bite x-rays)
  - bite-wing x-rays to a maximum of 16 films every 36 months (combined with periapical and bite x-rays)
  - bite x-rays to a maximum of 16 films every 36 months (combined with periapical and bite-wing x-rays)
- Tests including:
  - biopsy of oral tissue as required
  - pulp vitality tests as required

- Preventive services including:
    - polishing once every 9 months, limited to one time unit per visit

      A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
    - scaling, once every 9 months, limited to one time unit per visit
    - topical application of fluoride once every 9 months
    - one pit and fissure sealant treatment on bicuspids and permanent molars every 5 years
    - space maintainers, including maintenance, limited to one space maintainer per space in a calendar year
    - appliances for the control of harmful habits, as required
    - adjustment of appliances, as required
- Minor restorative services including:
    - caries, trauma, and pain control as required
    - amalgam and tooth-coloured fillings once every 24 months per tooth. Coverage for bonded amalgam fillings is limited to the cost of non-bonded amalgam fillings.
    - veneer applications once every 24 months per tooth
    - retentive pins for fillings once every 24 months per tooth
    - prefabricated crowns for primary teeth once every 36 months per tooth

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth in a person's lifetime

- Periodontal services including:

  - scaling and root planing, limited to a combined maximum of twelve time units in a calendar year

  - occlusal adjustment and equilibration, limited to a combined maximum of eight time units in a calendar year

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

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

  - denture relines

  - denture rebases

  - resilient liner in relined or rebased dentures

  - denture repairs and additions and resetting of denture teeth

  - denture adjustments

- Oral surgery, including:

  - extractions and residual root removal

  - alveoloplasty, gingivoplasty, stomatoplasty and vestibuloplasty

  - surgical excision and incision

  - treatment of fractures

  - frenectomy, sialothotomy and antral surgery

  - post surgical care including hemorrhage control

Major Coverage

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

- Inlays and onlays. Coverage for tooth-coloured inlays or onlays on molars is limited to the cost of metal inlays or onlays

  Replacement crowns, inlays and onlays are covered when the existing restoration is at least 60 months old and cannot be made serviceable.

  If crowns, inlays or onlays are provided when the tooth could have been restored using other procedures, benefits will be based on an approved alternate treatment plan

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

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 60 months old and cannot be made serviceable. If the existing appliance is less than 60 months old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

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

- Implantology. Coverage for implantology is limited to the lowest cost alternative that represents reasonable treatment

Limitations

If you do not apply for dentalcare coverage within 31 days after you become eligible, benefits are limited to $250 during the first 12 months of your coverage, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect.

No benefits are paid for:

- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan

- Services or supplies that do not represent reasonable treatment

- Services or supplies you are entitled to receive through provincial workers compensation legislation or similar legislation

- Endodontic treatment that started before you became covered under this plan

- Replacement of dental appliances that are lost, misplaced or stolen.

- Crowns, bridges or dentures for which tooth preparations started before the person became covered under this plan.

- Charges for appointments that the person does not keep.

- Charges for completing claims forms.

- Services or supplies associated with:

  - treatment for cosmetic purposes only
  - treatment to correct temporomandibular joint dysfunction
  - vertical dimension correction (changing the height of the teeth)
  - correcting attrition problems (worn down teeth)
  - orthognathic surgery (remodelling or reconstruction of the jaw)

How to Make a Claim

Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than June 30th of the year after the dental treatment.

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both an employee and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.