MITEL NETWORKS CORPORATION

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, Dentalcare and Health Care Spending Account 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.
- for assistance with your Health Care Spending Account, please call 1-877-883-7072.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy Nos. 330270** and **166946** and **Plan Document No. 56038** issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail.

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

The Plan is administered by

XX-10-15

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

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. 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 and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

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

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

Liability for Benefits

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby your employer will have full liability for Healthcare (except Global Medical Assistance) and Dentalcare benefits outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

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Benefit Summary

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

Employee Basic Life Insurance	$25,000, reducing by 50% at age 70
Supplementary Life Insurance (additional voluntary insurance)	
Option A	100% of annual earnings to maximum of $400,000, reducing by 50%, to a maximum of $100,000 at age 70
Option B	200% of annual earnings to maximum of $825,000, reducing by 50%, to a maximum of $100,000 at age 70
	Any amount of Supplementary Life Insurance over $475,000 is subject to approval of evidence of insurability

Optional Life Insurance

Employee and Spouse	Available in $10,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum.
Dependent Child	$5,000

Long Term Disability Income Benefits

Waiting Period	182 days
Amount	
Core Plan	60% of your monthly earnings to a maximum benefit of $10,000
Taxability	Taxable

Plan A	75% of your monthly earnings to a maximum benefit of $10,000
Taxability	Taxable
Plan B	60% of your monthly earnings to a maximum benefit of $10,000 or 85% of your pre-disability take-home pay, whichever is less
Taxability	Non-taxable

For all plans, any amount of LTD insurance over $7,500 is subject to approval of evidence of insurability

Managed Health Care Pay Direct Drug and Dental Benefit	See benefit description

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the first day of the month coinciding with or next after your employment begins.

- You and your dependents will be covered as soon as you become eligible.

  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 evidence of good health 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 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 and seasonal employees, and part-time employees who work less than 20 hours per week may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the plan terminates, whichever is earliest.

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

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your employer will provide you with details.

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 or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

- 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.

  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 policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

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.

- If you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself, your spouse and your children. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of insurability, and the application must be approved by Great-West Life. If you or your spouse dies 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 or child dies you will be paid the amount for which he or she was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself, your spouse or your child will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

- Your optional life insurance terminates when you reach age 65. Your spouse's or child's coverage terminates at the same time. Your spouse's insurance will also terminate when he or she reaches age 65 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. This limitation does not apply to coverage for a dependent child.

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 **as defined by the policy** or you reach age 65, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

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

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

- Loss of any license required for work will not be considered in assessing disability except when the loss is strictly due to medical reasons. In this case, you will be considered disabled for a maximum period of 12 months following the waiting period. Benefits will not be payable if you continue to practice any employment except as part of a rehabilitation plan approved by Great-West Life.

- 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.

- If you pay the entire cost of LTD coverage, benefits are not taxable. However, if your employer contributes any portion towards the cost of LTD coverage, benefits are taxable.

- Your LTD insurance terminates when you reach age 65.

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

- employer sponsored short term disability or sick leave benefits

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

- 50% of earnings received from an approved rehabilitation plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 85% for Plan B of your monthly take-home pay or 80% of your gross monthly earnings for Core and Plan A, before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan

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

- the wage loss portion of any criminal injury award

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

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

The balance of any earnings received from an approved rehabilitation plan is not used to further reduce your LTD benefit unless that balance, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings if your plan is taxable or would exceed your indexed monthly take-home pay if your plan is non-taxable, 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.

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 1 year, 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.
- 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.

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Great-West Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your employer for details.

How to Make a Claim

- To submit claims online, go to www.greatwestlife.com / Client Services / Forms for Group Benefits Plan Members / Standard Claim Forms. Click Apply for Disability Income Benefits and follow the instructions provided under Online claim submission.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions.

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

Please ensure that your claim is submitted to Great-West Life as soon as possible, but no later than 3 months after proof of your claim has been requested.

Managed Health Care Pay Direct Drug Benefit

Your deductible per calendar year is nil.

Option A

Reimbursement is 50% provided the charges are listed under a government sponsored drug plan.

For you and your dependents living in the Province of Quebec, your drug coverage will comply with the current rules and regulations of the Régie de l'assurance-maladie du Québec (RAMQ). In addition to this drug coverage, the drug coverage provided under the RAMQ formulary is automatically included.

Option B

Reimbursement is 80% provided the charges are listed under a government sponsored drug plan.

Reimbursement is 50% provided the charges not listed under a government sponsored drug plan.

For you and your dependents living in the Province of Quebec, your drug coverage will comply with the current rules and regulations of the Régie de l'assurance-maladie du Québec (RAMQ). In addition to this drug coverage, the drug coverage provided under the RAMQ formulary is automatically included.

Option C

Reimbursement is 100% provided the charges are listed under a government sponsored drug plan.

Reimbursement is 75% provided the charges not listed under a government sponsored drug plan.

For you and your dependents living in the Province of Quebec, your drug coverage will comply with the current rules and regulations of the Régie de l'assurance-maladie du Québec (RAMQ). In addition to this drug coverage, the drug coverage provided under the RAMQ formulary is automatically included.

Medi-Pack

Your deductible per calendar year is nil.

Core Option

Reimbursement is 100% of Eligible Charges.

The Eligible Charges under this option are limited to Travel Assistance and Out of Country Emergency coverage only.

Option A

Reimbursement is 50% of Eligible Charges.

The maximum amount payable per classification of paramedical practitioner is $250 in any calendar year.

Vision care is not an Eligible Charge under this option.

Option B

Reimbursement is 100% of Eligible Charges, with respect to the vision care.

Reimbursement is 80% of Eligible Charges, with respect to all other benefits.

The maximum amount payable per classification of paramedical practitioner is $400 in any calendar year.

The maximum for laser eye surgery, eye examinations, eye glasses and contact lenses is $250 every 12 consecutive months with respect to dependent children under age 21, and $250 every 24 consecutive months, with respect to all others.

Option C

Reimbursement is 100% of Eligible Charges.

The maximum amount payable per classification of paramedical practitioner is $500 in any calendar year.

The maximum for laser eye surgery, eye examinations, eye glasses and contact lenses is $400 every 12 consecutive months with respect to dependent children under age 21, and $400 every 24 consecutive months, with respect to all others.

Dental

Your deductible per calendar year is nil.

Option A

Payment is in accordance with the prior year's Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee.

Basic Services
Reimbursement is 80% of eligible charges.

The maximum is $1,000 per person in any calendar year.

Option B

Payment is in accordance with the prior year's Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee.

Basic Services
Reimbursement is 90% of eligible charges.

Major Restorative
Reimbursement is 60% of eligible charges.

The overall maximum is $2,000 per person in any calendar year.

Orthodontics
Reimbursement is 50% of eligible charges.
Maximum is $2,000 in the lifetime per person.

Option C

Payment is in accordance with the current year's Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee.

Basic Services
Reimbursement is 100% of eligible charges.

Major Restorative
Reimbursement is 100% of eligible charges.

The overall maximum is $2,500 per person in any calendar year.

Orthodontics
Reimbursement is 50% of eligible charges.
Maximum is $3,500 in the lifetime per person.

Survivor Extension

In the case of your death, Managed Health Care Pay-Direct Drugs, Medi-Pack and Dental coverage, if applicable, will be extended to your eligible dependents until the earlier of the date your spouse remarries or the date of the second anniversary of your death.

Termination of Benefits

If you are 65 or older and reside in the Province of Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the Régie de l'assurance-maladie du Québec (RAMQ), unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to your employer by the end of the 60-day period immediately following:

- the date you reach age 65, or
- the date you become a resident of the Province of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the Régie de l'assurance-maladie du Québec (RAMQ).

INFORMATION ABOUT YOUR FLEX PLAN

- Option changes take effect at every January, unless the change results from a Lifestyle Change. If a Lifestyle Change occurs, the option change will take effect on the date stated in the application, as long as the application for change is received within 30 days of the status change. Otherwise, the change will not take effect until the next re-enrolment period.

- Any of the following is considered a Lifestyle Change:

  - marriage;
  - a divorce or common-law breakdown;
  - the birth or adoption of a child;
  - a change in custody of a dependent child;
  - the death of a spouse or dependent child;
  - the spouse's change in employment status, resulting in the gain or loss of the spouse's coverage; or
  - a dependent child becoming ineligible for coverage.

Note: Employees who elect Option C under the Health benefit or the Dental benefit cannot elect another Health or Dental option until they have been covered under Option C for at least 2 years.

MANAGED HEALTH CARE PAY DIRECT DRUG BENEFIT (PLAN 20)

Any eligible drug charge will be paid if:

1. it is medically necessary.
2. it is reasonable and customary.
3. it represents reasonable treatment.
4. payment is not prohibited by a Government Sponsored plan in your Province or Territory of residence.

Eligible Charges

Fertility drugs are limited to a six cycle lifetime maximum.

Drugs and drug supplies that can only be obtained through a written prescription by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them are eligible, provided such drugs are listed under the Provincial drug benefit plan. Unless medical evidence is provided to Great-West Life that indicates why a drug is not to be substituted, Great-West Life can limit the Eligible Charge to the cost of the lowest priced interchangeable drug.

Applicable under Options B and C only:

Drugs not covered in the first paragraph that can only be obtained through a written prescription and certain life-supporting, non-prescription drugs, approved by Great-West Life, are eligible provided such drugs were prescribed through a written prescription by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, are covered up to the percentage based on the option you have selected. Unless medical evidence is provided to Great-West Life that indicates why a drug is not to be substituted, Great-West Life can limit the Eligible Charge to the cost of the lowest priced interchangeable drug.

Other Services and Supplies

Great-West Life can, on such terms as it determines, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Great-West Life can limit an Eligible Charge for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

Great-West Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Great-West Life.

The following items are not covered whether or not they have been prescribed for medical reason:

- drugs not approved for legal sale to the general public
- vitamins (except injectibles), minerals, food substitutes, health foods and dietary supplements such as proteins, infant food
- medical soaps and creams, cosmetics and shampoos
- skin-lotions, eye and contact-lens solutions, mouth washes
- publicly advertised items
- cough and cold preparations, antihistamines
- laxatives, antidiarrhals (with approved exceptions)
- products commonly considered household remedies
- anti-obesity treatments
- nicotine resin containing products
- fertility drugs
- preventative immunization vaccines and toxoids
- any treatments which can be obtained over the counter without a prescription
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Great-West Life 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, Great-West Life may require you or your dependent to provide medical evidence 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, Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life 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 attending physician.

In determining whether to implement health case management, Great-West Life 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

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Great West Life 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 the 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 Great-West Life has recommended or approved Health Case Management, Great-West Life can require that a service or supply be purchased from or administered by a provider designated by Great-West Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Great-West Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Great-West Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Great-West Life.

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, Great-West Life may require you or your dependents to apply to and participate in such a program. Where financial assistance is available from a patient assistance program that Great-West Life requires participation in, Great-West Life will reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent are entitled to receive for that service or supply.

Pharmacy Benefits Manager

How Does the Pharmacy Benefits Manager Work?

Each time you use your pharmacy benefit manager drug card at a participating pharmacy, your drug claim will be checked for potential problems (such as harmful drug interactions, duplication of medicines, or age associated risks). If a problem is detected your pharmacist will be able to warn you of any dangers. In some cases, where taking the prescribed medicine would be very dangerous to your health, the claim may be declined for your safety. The pharmacy benefits manager's centralized claims data base is available at participating pharmacies across Canada.

Lost or Stolen Cards

Lost or stolen cards should be reported immediately, in writing, to your plan administrator. Upon receipt of written notice, a replacement card will automatically be issued with a new issue number. In most cases, the pharmacist will not honour the lost or stolen card because the name on the prescription will be different from that on the card. However, if you notify Great-West Life immediately it will greatly reduce the risk of fraudulent claims being paid.

MEDI-PACK BENEFIT

You will be paid for any of the charges incurred by you or your dependent provided that the charge meets all of the following conditions.

1. It is medically necessary for the treatment of bodily injury, illness or disease.

2. It is reasonable and customary.

3. It is recommended and authorized by a physician or surgeon legally licensed to practise medicine.

4. It represents reasonable treatment.

5. Payment for services covered under this plan is not prohibited by the Provincial Government (plan) in your province of residence.

6. It is not more than the difference between the actual cost of the charge and the amount you are entitled to apply for and receive under any Government Sponsored plan in your province or territory of residence.

Nursing Care

Charges for the services of a Professional Nurse at the insured individual's residence provided the Professional Nurse is not normally resident in your home, to a maximum of $10,000 per calendar year.

After January 1st coincident with or next following your or your dependent's 65th birthday, the maximum payable is $25,000 lifetime.

Note: Such nursing services are covered to the extent that they are medically necessary. Payment is not made for services which are custodial or for services which do not require the skill level of a Professional Nurse. The services will not be considered as eligible expenses while you or your dependent are residing in a nursing home, home for the aged, rest home or any other facility providing similar care, or confined in a Licensed Hospital.

If extended nursing care is anticipated, it is recommended you contact your Great-West Life Claims Office to determine the amount of nursing care that will be covered.

Ambulance

Licensed ambulance or other emergency service, when medically necessary, to transport you or your dependent from the place where injury, disease, illness, pregnancy or mental disorder is suffered to the nearest hospital where adequate treatment can be rendered, from one hospital to another, and from a hospital to your residence.

Charges for the fare of one attendant to accompany you or your dependent if transportation is not provided by a licensed ambulance service.

Aids, Services & Supplies

Charges incurred in your province or territory of residence for (i) services furnished by a Licensed Hospital and (ii) supplies which are obtained from an out-patient department of a Licensed Hospital or a surgical supply company, while you or your dependent are not confined to the Hospital.

Purchase of braces, crutches, artificial limbs or eyes and prosthetic devices approved by Great-West Life.

An initial pair of frames and one corrective prosthetic lens, for each eye, that is prescribed after cataract surgery.

An initial breast prosthesis following a mastectomy plus a replacement every two calendar years and two surgical brassieres per calendar year.

Rental of a wheelchair, hospital bed including mattresses or other approved durable equipment for temporary therapeutic use. This equipment may be purchased subject to Great-West Life's approval prior to the purchase.

Oxygen.

Custom made Orthopaedic shoes prescribed by a podiatrist or physician up to a maximum of one pair per calendar year. Modifications to any shoes will not be payable.

2 pairs of foot orthotics per calendar year. To be eligible for payment, the orthotic devices must be (i) prescribed by a physician, podiatrist or chiropodist, (ii) made from a plaster cast, (iii) diagnosed as being necessary by a biomechanical examination, (iv) made at a professional podiatry laboratory and (v) Medically Necessary for the Insured's regular daily living activities and not solely for recreation or sports.

Two pairs of surgical stockings per calendar year.

Wigs and hairpieces, up to a lifetime maximum of $250.

The following are examples of items that are payable if they are recommended and authorized by a physician or surgeon legally licensed to practise medicine and approved by Great-West Life:

glucometers, tens machine (chronic pain), crutches, casts, mozes detectors, apnea monitor, diabetic supplies, canes, grab bars, walker, colostomy supplies, aerochambers, oxygen equipment, compressors and braces.

The following are examples of items that are not payable whether or not they have been recommended by a physician or surgeon:

craftmatic or lifestyle beds, mattresses (except standard mattress with approved hospital bed), humidifiers, air conditioners or air purifiers, exercise machines or programs, home/automobile modifications (ex: ramps, lifts), breast pumps, contraceptive devices and spermicides/diaphragms/condoms, blood pressure kit, and obus forme/orthopaedic pillows.

Accidental Dental

Charges by a legally licensed dentist for dental treatment of injuries to natural teeth, or replacement of natural teeth, for accidents suffered by you or your dependent while insured under this benefit.

The charges will be subject to all of the following conditions:

- the treatment is necessitated by a direct accidental blow to the mouth and not by an object or food placed wittingly or unwittingly in the mouth.

- the accidental blow occurs while the person is insured.

- the treatment is received within twelve months after the accidental blow.

- the treatment is the least expensive that will provide a professionally adequate treatment.

- no payment will be made for any part of the charge which exceeds the amount shown for the treatment in the current Dental Association Schedule of Fees for General Practitioners in your province of residence.

- if treatment is to be received more than 90 days after the accidental blow, a treatment plan must be submitted to Great-West Life within 90 days of the accident.

Emergency Treatment

The following Emergency treatment required by you or your dependent while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions. There is a maximum of $1,000,000 for an Emergency for you and each of your dependents under this Emergency Treatment section and the Travel Assistance Benefit. This limitation is not applicable to in-Canada emergency health care benefits When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered. We will only cover the first 60 days of a trip. This limitation is not applicable to in-Canada emergency health care benefits.

Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day of confinement.

Hospital services and supplies furnished by a Licensed Hospital.

Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

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-country coverage and Travel Assistance coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

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-country coverage and Travel Assistance coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

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.

Hospital means an institution having diagnostic facilities that provides active, chronic care or emergency treatment with physicians and registered nurses in attendance 24 hours a day and is licensed by the appropriate governmental authority. It does not include an institution providing convalescent care, a nursing home for the aged, a rest home or any other facility providing similar care.

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

(a) from an accident occurring while the insured person was operating a vehicle, vessel or aircraft, if the insured person:
- i) was 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.

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.

Note: If you are travelling and require medical care, please contact the Assistance Centre using the telephone number on the Travel Assistance card. The Travel Assistance Centre number and services are available 24 hours a day.

Travel Assistance Benefit

The following services with respect to medical and personal emergencies required by you or your dependent while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered. We will only cover the first 60 days of a trip. This limitation is not applicable to in-Canada emergency health care benefits.

- on the spot medical assistance
- emergency medical payments
- telephone interpretation service
- medical evacuation
- assistance with lost documents or luggage
- return of dependent children or a travelling companion
- visit of a family member
- transmission and retention of urgent messages
- help to locate Embassy or Consulate services
- assistance in the event of death to transport the remains
- return of a vehicle to your home or nearest rental agency

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

(a) from an accident occurring while the insured person was operating a vehicle, vessel or aircraft, if the insured person:
  i) was 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.

Note: For specific details, please refer to your Travel Assistance brochure which can be obtained through your employer. Contact must be made as soon as possible.

For instructions on how to make an out-of-province/country claim, please refer to the **How to make an out-of-province/country claim** section at the end of the Medi-Pack Benefit section.

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

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.

Referral Benefit

Charges for the following services provided in Canada and the United States but outside your Province or Territory of residence if they are not available in your Province or Territory of residence and are performed on the written referral of a physician or surgeon regularly attending you or your dependents in your Province or Territory of residence.

1. Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day that you or your dependents are confined in the hospital.

2. Hospital services and supplies furnished by a Licensed Hospital.

3. Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

Full details of the services to be provided must be submitted by the referring doctor to, and approved in advance by, Great-West Life.

The maximum amount payable under this provision with respect to you or your dependents during your lifetime will be $10,000.

Diagnostic X-Ray and Laboratory Expenses

Charges for Diagnostic tests, radiological treatments including X-rays and laboratory tests and radium treatments, excluding dental X-rays, that are performed in your province or territory of residence when coverage is not available under the provincial government plan.

Speech Therapy

The services of a registered speech therapist, who is not normally resident in the insured person's home.

Hearing Aids

The purchase of hearing aids and repairs, excluding batteries, up to an individual maximum of $1200 in four consecutive years, depending on the option chosen. Audio tests are not covered.

Hospital Accommodation

Hospital accommodation is the difference between the public ward allowance under the Provincial Hospital Plan and the private room rate in a Licensed Hospital.

Homeopathic Drugs

Homeopathic Drugs are covered, with a prescription from a registered Naturopath.

Vision Care

Laser eye surgery, an eye examination (including eye refractions), and prescription eye glasses or contact lenses and the fittings of such eyewear for the purpose of correcting vision are subject to a combined maximum provided by the option you select. For dependent children under age 21, the frequency of the combined maximum is every 12 consecutive months, and for any other individual, the frequency is every 24 consecutive months.

A pair of contact lenses up to a lifetime maximum of $200 if visual acuity is improved to at least a 20/40 level and this level of acuity is not possible through wearing eye glasses accompanied by a letter of verification. Otherwise, contact lenses are subject to the maximum as stated for eye glasses.

Note: All charges must be recommended or approved by a legally licensed physician, surgeon, optometrist or opthalmologist.

Services received in Canada for visual training and remedial exercises subject to 50% reimbursement, regardless of the benefit maximum. Diagnosis and treatment received in Canada for accidental injury or disease to eyes.

All claims must be supported by an official receipt indicating name of patient and the date the eyewear was received.

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 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 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.

Paramedical Services

Paramedical Services are limited to a dollar maximum depending on which option you select, per calendar year per insured for each classification of practitioner.

Laboratory tests and X-ray examinations recommended or approved by a legally licensed chiropractor, osteopath or podiatrist.

The services of any of these legally licensed classification of practitioners:

- Chiropractors
- Osteopaths
- Chiropodists or Podiatrists
- Naturopaths
- Masseurs
- Physiotherapists or Athletic Therapists
- Dietician Psychologists
- Psychologists
- Massotherapy - if rendered by a legally licensed Orthotherapist (this charge is applicable only to a Quebec Employee)
- Acupuncturists

Note: The maximum charge for each treatment will be as determined by the Schedule of Fees approved by the Association of which the practitioner is a member, and where there is no approved Schedule of Fees, an amount as determined by Great-West Life.

Extension of Benefits

If you or your dependent are disabled at the time of termination of your employment, Medi-Pack charges as a result of such disability will continue to be paid up to 90 days, provided the benefit remains in force.

How to Submit a Claim

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

This form must be completed in full and submitted within 15 months from the date the claim was incurred.

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 claim form from your employer. This form must be completed in full and submitted with the original bills within 15 months from the date the claim was incurred.

Note: To ensure prompt claims service, any receipts should include:

- your name or your dependent's name receiving the service or treatment
- the date and the type of each service or treatment
- the charge for each date
- the prescription numbers for prescribed drugs and medicine
- the name of the drug or the medicine

How to make an out-of-province/country claim:

There are special rules for claiming the costs of emergency treatment outside of your province or territory of residence or Canada.

- For all medical expenses, you must contact the Travel Assistance provider at the time of the emergency. This will enable the Travel Assistance provider to co-ordinate payment directly with the hospital and/or medical provider involved. In addition, with your approval the Travel Assistance provider will co-ordinate payment with your Provincial Health Care plan.

- If a medical provider or hospital bills you directly, send the bill along with your claim form to the Travel Assistance provider.

Note: If your spouse has insurance with another carrier, please also refer to the "Coordination of Benefits" section for claim submission information.

If the Group Insurance Policy terminates, no payment will be made for any claim unless proof is submitted within 90 days of the termination date.

DENTAL BENEFIT

Fee guides, procedure codes, endodontics, scaling, root planing and occlusal equilibration. It's easy to see why your company dental plan can be the most commonly used but least understood of the benefits your employer provides for you.

To get the most out of your dental plan, read this section of your booklet carefully, and take it with you when you visit the dentist. Discussing your coverage with your dentist and Great-West Life before treatment begins is the best way to ensure that you get the care you need and minimize your out of pocket costs.

Your dental plan has been designed to help you and your dependents maintain a high standard of dental health. It includes these services:

Dental 1 & 2

Basic Services include the diagnostic, preventive and maintenance services required for regular dental care. Some of the insured charges include exams, x-rays, fluoride treatment, fillings, treatment of gum disease, root canal therapy and major surgical procedures.

Dental 3

Major Restorative Services cover dentures, crowns, bridgework and inlays/onlays.

Dental 4

Orthodontic Services provide coverage for orthodontics and all necessary dental treatment which has as its objective the correction of malocclusion of the teeth.

Assignment of Benefits

We reserve the right to refuse any assignment of benefit under this provision.

Important Note

A general overview of the services covered, along with the limitations that apply, can be found on the following pages. Your plan covers these treatments and services provided that the treatment is the least expensive that will produce a professionally adequate result (as determined by Great-West Life). If the charge exceeds the cost of the least expensive service, Great-West Life will pay the cost of the least expensive service.

In some cases, such as undergoing extensive treatment, Great-West Life may require proof from your dentist that the services to be performed meet this criteria. This request is a normal cost control procedure and often just a copy of the x-rays taken is considered acceptable proof.

Pre-Authorization For Treatment Over $500.00

If dental expenses are estimated to be greater than $500.00, you must submit a "Pre-Authorization" to Great-West Life. A Pre-Authorization is simply an outline of the proposed treatment which is prepared, by your dentist, prior to any work being performed. Great-West Life will advise you of the portion that is covered by your company dental plan, enabling you to determine your costs.

Note: In order to determine benefits payable, Great-West Life may require additional information such as:

1. A complete dental chart showing extractions, missing teeth, fillings, prostheses, periodontal pocket depths, and the date of any work previously done.

2. An itemized claim form for all dental care.

3. Pre-operative x-rays, study models, and laboratory reports.

Great-West Life cannot pay the dental claim until the additional information requested is submitted to us.

Basic Services

Refer to the **Pre-Authorization for Treatment Over $500.00** section near the front of the Dental Benefit section.

Basic Services provide coverage for the most common dental expenses such as:

A) Oral Examination

B) X-rays

C) Polishing

D) Fluoride Treatments (for patients under 19 years of age)

E) Extractions, including impacted teeth

F) Fillings

G) Space Maintainers (for dependent children)

H) Root Canal Treatment (endodontics)

I) Treatment of Gum Disease (periodontics)

J) Denture Adjustment, Repairs, Rebasing and Relining

Dental 1

Diagnostic

(1) Clinical (Complete) Examinations (No more than one examination per dentist).

(2) Recall Examinations (No more than 2 examinations in any calendar year).

(3) Specific Examinations.

(4) Emergency Examination.

It is provided, however, that there will be no more than 4 examinations, of any kind, in any calendar year or more than 2 Clinical (Complete) Examinations and Recall Examinations in total in any calendar year.

X-Rays

(1) Full Mouth Series consisting of a minimum of 16 films including bitewings in any period of 36 consecutive months. (Not applicable to the Dependent children of an Employee while they are under 12 years of age, other than for Orthodontia):

(2) Panorex (No more than once in any period of 36 consecutive months).

(3) Periapical (No more than 16 films in any period of 36 consecutive months).

(4) Bitewing (No more than 4 films in any period of 12 consecutive months).

(5) Occlusal.

Tests

(1) Biopsy of Oral Tissue.

(2) Pulp Vitality Test (Not in conjunction with Root Canal Therapy if rendered within 30 days).

Preventive

(1) Polishing (Not more than twice in a calendar year with a maximum of 1 unit per recall visit).

(2) Recall Scaling (Not more than twice in a calendar year with a maximum of 1 unit per recall visit).

(3) Preventive Recall Package (No more than 2 in any calendar year or more than 2 of either Recall Examinations or Preventive Recall Packages in any calendar year).

(4) Fluoride (This applies only to an Insured while he is under 19 years of age. No more than 2 in any calendar year).

(5) Oral Hygiene Instruction (No more than once).

(6) Pit and Fissure Sealants (This applies only to an Insured while he is under 19 years of age. No more than once per posterior tooth in any period of 36 consecutive months).

(7) Space maintainers (This applies only to the Dependent children of an Employee while they are under 15 years of age).

(8) Space maintainers (maintenance) (This applies only to the Dependent children of an Employee while they are under 15 years of age).

Minor Restorative

The fee for restorative procedures will include local anaesthesia, removal of decay, pulp protection, placement of a base and occlusal adjustment.

Charges for finishing or polishing are not an eligible expense.

Multiple restorations on a common surface placed on the same service date will be considered a single restoration.

The maximum Benefit payable will not exceed the fee for a 5 surface restoration regarding the same tooth during one sitting.

(1) Amalgam Restorations (Only if more than 24 consecutive months have elapsed since the last restoration).

(2) Tooth Coloured (Only if more than 24 consecutive months have elapsed since the last restoration).

(3) Retentive Pins.

(4) Caries, Trauma, Pain Control (Only when placed on a separate date from the final restoration).

(5) Veneer Applications, other than for cosmetic purposes (Only if more than 24 consecutive months have elapsed since the last restoration).

(6) Stainless Steel, Plastic and Polycarbonate full coverage restorations (This applies only to the Dependent children of an Employee while they are under 15 years of age. No more than once per tooth in any period of 36 consecutive months).

Minor Surgical

(1) Extractions.

(2) Residual Root Removal.

Major Surgical

The fee for surgical procedures will include local anaesthesia, appropriate radiographs (x-rays), surgery, control of hemorrhage, sutures and routine post-surgical care.

Post-treatment evaluation is not an eligible expense.

(1) Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty.

(2) Surgical Excision.

(3) Surgical Incision.

(4) Fractures.

(5) Frenectomy.

(6) Anaesthesia, used in conjunction with an eligible dental procedure.

Dental 2

Endodontics

The fee for the following procedures will include, where applicable, treatment plan, local anaesthesia, tooth isolation, clinical procedures, sutures, appropriate radiographs (x-rays) and follow-up care:

(1) Pulpotomy (Not in conjunction with restorations or Root Canal Therapy if rendered within 30 days).

(2) Root Canal Therapy.

(3) Apexification.

(4) Periapical Services.

(5) Root Amputation.

(6) Hemisection.

(7) Intentional Removal, Apical Filling and Reimplantation.

Periodontics

The fee for surgical procedures will include local anaesthesia, surgical dressing, sutures and routine post-operative care for one month.

Charges for post-treatment evaluation are not an eligible expense.

(1) Non-Surgical Procedures.

(2) Definitive Surgical Procedures.

(3) Adjunctive Surgical Procedures.

(4) Occlusal Equilibration (not more than 4 units in any calendar year).

(5) Scaling and/or Root Planing (not more than 8 units in any calendar year).

(6) Periodontal Appliances including impression and insertion (No more than one appliance per arch in any period of 24 consecutive months).

(7) Periodontal Appliance repair, maintenance and adjustments (not more than 4 adjustments in any calendar year).

Removable Prosthodontics-Related Treatment

(1) Denture Adjustments (Only if more than 3 months have elapsed since the denture insertion).

(2) Denture Repairs.

(3) Denture Rebasing and Relining including 3 months post-delivery adjustments (No more than one reline or rebase in any period of 36 consecutive months).

(4) Tissue Conditioning including 3 months post-delivery adjustments (No more than one in any period of 36 consecutive months).

Dental 2 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and he had commenced root canal treatment prior to such termination, he will continue to be insured for any charges incurred for such treatment during the 30 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 2 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing root canal treatment, the insurer with the policy in force at the date the canal is closed will be responsible for the charges incurred.

Dental 3

Major Restorative Services

Refer to the **Pre-Authorization for Treatment Over $500.00** section near the front of the Dental Benefit section.

The services included are:

a) Inlays, Onlays and Crowns

b) Removable Prosthodontics

c) Bridgework

The fee for the following procedures will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, insertion, occlusal adjustments and cementation:

Inlays, Onlays, Crowns

(1) Inlay/Onlay Restorations (Only if more than 5 years have elapsed since the last placement).

(2) Retentive pins in Inlays, Onlays and Crowns (Only if more than 5 years have elapsed since the last placement).

(3) Crowns (Only if more than 5 years have elapsed since the last placement).

(4) Veneer Applications, other than for cosmetic purposes (Only if more than 5 years have elapsed since the last placement).

Removable Prosthodontics

The fee for the following procedures will include, where applicable, treatment plan, impressions, jaw relation records, try-in, insertion, occlusal equilibration and 3 months post-insertion care:

(1) Complete Dentures (Only if more than 5 years have elapsed since the last placement).

(2) Transitional Dentures.

(3) Acrylic Dentures (Only if more than 5 years have elapsed since the last placement).

(4) Cast Partial Dentures (Only if more than 5 years have elapsed since the last placement).

Fixed Prosthodontics

The fee for the following procedures will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, splinting, intraoral indexing for soldering purposes, insertion, occlusal adjustments and cementation:

(1) Pontics (Only if more than 5 years have elapsed since the last placement).

(2) Retainers and Abutments (Only if more than 5 years have elapsed since the last placement).

(3) Repairs.

(3) Retentive Pins in Retainers and Abutments (Only if more than 5 years have elapsed since the last placement).

Dental 3 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and he has had a tooth prepared for a crown, inlay, onlay, bridge or denture prior to such termination, he will continue to be insured for any charges incurred with respect to such crown, inlay, onlay, bridge or denture during the 90 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 3 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing crown, inlay, onlay, bridge or denture work, the insurer with the policy in force at the date the appliance is installed will be responsible for the charges incurred.

Dental 3 Limitations

Lab fees associated with the dental plan will be paid on a "reasonable and customary basis".

Charges for replacing an existing crown, inlay, onlay, denture or bridgework will only be paid if it meets one of the conditions shown below:

1. The existing crown, inlay, onlay, denture or bridgework was installed at least 5 years prior to its replacement and cannot be made serviceable.

2. The denture or bridgework replacement is for an equivalent denture or bridgework.

3. The existing denture or bridgework is an immediate temporary denture or bridgework, for which impressions were taken while the Insured is covered under this provision. The permanent replacement denture or bridgework must be placed within 12 months from the date of installation of the immediate temporary denture or bridgework.

4. The existing denture or bridgework is replaced because additional teeth have been extracted after the denture or bridgework insertion, and while the Insured is covered under this provision.

Dental 4

Orthodontic Treatment

Refer to the **Pre-Authorization for Treatment Over $500.00** section near the front of the Dental Benefit section.

Charges incurred with respect to an Insured for all necessary dental services or treatment which has as its objective the correction of malocclusion of the teeth including but not limited to examinations, x-rays, models, photographs, reports and surgical exposure of teeth.

Payment of Orthodontic Claims

We will pay for the charges incurred based on one of the following:

(1) If an estimated cost of treatment is used in place of an itemized statement, benefits for the insured cost of the charge will be payable on a monthly or quarterly basis as billed by the dentist. The average monthly Benefit will be the total estimated cost of treatment, less the initial cost (case diagnosis, initial appliance cost, treatment plan) divided by the number of months in the treatment plan as specified by the dentist.

(2) If a separate estimate of the cost of the initial appliance is included, the first payment will be an amount equal to the insured cost of the appliance. The remainder of the payments will be as calculated in accordance with the terms of clause (1) above.

(3) If a statement is submitted for each treatment as the charge is incurred, payment for the insured cost of the charge will be made as such charge is incurred.

(4) Notwithstanding anything to the contrary in this provision, if an Insured described above incurs charges described in another section of this provision as part of a treatment described in this Dental 4 Charges section, then such charges will be deemed to have been incurred under this Dental 4 Charges section for the purpose of calculating Benefit Amounts and Maximum Benefit Amounts.

Extension of Benefits

Root Canal Treatment:

If your employment terminates and you or your dependent have commenced root canal treatment, you will continue to be insured for any of the charges incurred for such treatment for 30 days after your termination.

If you or your dependent are undergoing root canal treatment, the Insurance Company with the policy in force at the date the canal is closed will be responsible for charges incurred.

Crowns, Bridges or Dentures:

If your employment terminates and you or your dependent have had a tooth prepared for a crown, bridge or in the case of a denture the final impression taken, you will continue to be insured for any of the charges incurred for 90 days after termination.

If you or your dependent are undergoing crown, bridge or denture work, the Insurance Company with the policy in force at the date the appliance is installed will be responsible for the charges incurred.

Exclusions

- intentionally self-inflicted injury while sane or insane.
- war, insurrection or hostilities of any kind whether or not you or your dependent were a participant in such action.
- participation in a riot or civil commotion.
- committing or attempting to commit a criminal offence or provoking an assault.
- any cause for which you or your dependent may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- any Group or Policyholder-Sponsored dental care or treatment.

- any dental care or treatment for which you are not legally obliged to pay.

- any dental care or treatment which is principally for cosmetic purposes.

- any appointments not kept or for the completion of claim forms.

- any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction.

- any endodontic treatment commencing before you or your dependent became insured under this benefit.

- replacement of mislaid, lost or stolen appliances.

- any crowns placed on teeth that are not functionally impaired by incisal or cuspal damage.

- any crowns, bridges or dentures for which tooth preparations were made before you or your dependent became insured under this benefit.

- any charge for a Full Mouth Series of X-rays for your dependent under age 12 or whose policy does not provide for orthodontic benefits.

- any charge for other than "metal" crowns or pontics, posterior to the second bicuspid tooth.

- any procedures, appliances or restorations used to increase vertical dimensions, or to repair or restore teeth damaged or worn due to attrition or vertical wear or to restore occlusion.

- any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants.

- any orthodontic expenses which were incurred prior to the date on which you became insured.

How To Submit 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 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.

This form must be completed in full and submitted within 15 months from the date the claim was incurred.

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 from your employer. This form must be completed in full and submitted with original bills within 15 months from the date the claim was incurred. If you anticipate a delay, please notify Great-West Life in advance.

Since your dental service provider will be required to complete a section of the dental claim form, you should take it with you to your appointment.

If your company benefits plan terminates, you must submit your claim, for any charges already incurred, within 90 days of the termination of the plan.

COORDINATION OF BENEFITS

When payments for benefits provided under this plan are available to you or your dependent under any other insurance plan, benefits will be coordinated. The amount payable under this plan will be pro-rated and limited to the extent that the total amount available under all coverages will not exceed 100% of the allowable expenses.

Order of Benefit Determination

Payment of benefits will be decided in the following manner.

1. If another plan does not contain a Coordination of Benefits provision, the benefits of that plan will be deemed payable prior to the application of benefits under this plan.

2. If another plan does contain a Coordination of Benefits provision, the benefits of that plan will be coordinated with our benefits as follows:

    1. If your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan.

    2. Charges for dependent children should first be submitted to the plan of the parent whose month and date of birth comes earlier in the calendar year (excluding the year of birth).

If priority cannot be established in the above manner, the benefits shall be pro-rated.

CONTACT – EMPLOYEE ASSISTANCE PROGRAM

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact employee assistance program are available by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English: 1-800-387-4765
For service in French: 1-800-361-5676

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: **www.shepellfgi.com**.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

A Health Care Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year. These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

Eligibility

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your basic health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act (Canada).

You may apply for HCSA benefits within 31 days of the date you first become eligible or at your plan's annual enrolment date.

Termination

Your HCSA coverage terminates when your basic health coverage terminates, when you elect to discontinue coverage (at any plan enrolment date) or when your employer discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

The Income Tax Act (Canada) governs the types of expenses that can be reimbursed under the HCSA. Coverage is provided for those expenses that qualify for a medical expense tax credit. For a complete list of covered expenses, contact your Canada Revenue Agency District Office and ask for Income Tax Interpretation Bulletin IT-519R.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

Credits are available for covered expenses incurred in a plan year. Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan year, they are automatically forfeited.

The maximum annual payment available under your account will consist of the amount of the credit directed to it for the plan year plus any unused amount from the previous year.

Limitations

No benefits are paid for:

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

- 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

- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Claims against the HCSA may be submitted on a claim form. Claims for prescription drugs, paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

- To submit claims using a claim form, use form M5429A or form M445D (HCSA) for dental claims, and form M5431A or form M635D (HCSA) for all other claims

- To submit claims online, 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.

Claims against the HCSA must be submitted to the Great-West Life Benefit Payment Office before the earliest of the following:

- 90 days after the end of the plan year in which the expenses are incurred

- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment

- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS® SERVICE)

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

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

How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.

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

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

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

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

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

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