



**INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES  
LOCAL 667/669 HEALTH AND WELFARE FUND**

**Great-West Life**  
*your Benefits Solutions People*



## **GENERAL INFORMATION ABOUT YOUR BENEFIT PLAN**

Your benefit plan is sponsored by the I.A.T.S.E. Local 667/669 Health & Welfare Trust Fund. The Health & Welfare Plan began in 1990 and since then has seen a large array of benefits that have been made available to members of Local 667 and Local 669.

The basic requirement to become eligible and continue to be eligible, for benefit coverage is membership 'in good standing' in either I.A.T.S.E. Local 667 or 669 as determined by the respective Constitution and By-Laws of each Local Union and Constitution and By-Laws of the International Alliance.

The Health & Welfare Fund has eight Trustees, 4 Trustees represent Local 667 and 4 Trustees represent Local 669.

The I.A.T.S.E. Local 667/669 Health & Welfare Plan is a national plan, and we are pleased to be able to provide documents to members in both official languages. Our Plan currently has 1575 members enrolled ranging in age between 21 and 83.

Our Health and Welfare Plan has 6 benefit levels: Benefit 01, Benefit 02, Benefit 03, Benefit 04, Golden level for members age 75 and over, and a Quebec member only benefit level which includes life insurance, the member and family assistance plan and prescription drug coverage in keeping with legislated requirements in Quebec. For the Golden level any producer contribution balances will be placed in a health spending benefit and can be used for reimbursement of any qualifying medical or dental expenses.

The weekly disability benefit is only available through producer contributions; therefore if you were in benefit level 01 and upgraded your benefits to a higher benefit level, you will not qualify for weekly disability.

Please note that some prescription drugs will require a prior authorization be sent to Great-West Life. Great-West Life's prior authorization process is designed to provide an effective approach to managing claims for specific prescription drugs. Approval for coverage of certain drugs is required in order to provide members with coverage for appropriate drug treatment. If you or your dependents potentially require an expensive medicine it is recommended that you submit a prior authorization to Great-West Life.

The Fund has both a dedicated Plan Administrator and Benefit Coordinator who are available to assist members and dependents with any questions or concerns they may have. The life insurance, accidental death & dismemberment, travel, dental, health, vision care and weekly disability benefits are underwritten by The Great-West Life Assurance Company. The critical condition benefit is underwritten by Blue Cross, and the member and family assistance program is provided through Family Services. The I.A.T.S.E. Local 667/669 Health & Welfare Member Benefits Booklet will be divided into 3 parts to accommodate the benefits provided by the four different service Providers. Provider contact and plan information is available on the following page.

## I.A.T.S.E. LOCAL 667/669 HEALTH & WELFARE BENEFITS

### PLAN ADMINISTRATION

Leta Kennedy, Plan Administrator  
I.A.T.S.E. Local 667/669 Health & Welfare Fund  
217-3823 Henning Drive  
Burnaby, BC V5C 6P3  
Tel: 778-329-4455  
Toll Free (Canada wide): 1-866-366-9667  
E-mail : hwadmin@iatse667-669healthplan.com

Mary Miskic, Benefits Co-ordinator  
I.A.T.S.E. Local 667  
229 Wallace Avenue  
Toronto, ON M6H-1V5  
Tel: 416-368-0072  
Toll Free (Eastern Canada): 1-877-368-1667  
E-mail: mary@iatse667.com

[www.iatse667-669healthplan.com](http://www.iatse667-669healthplan.com)

### THE GREAT-WEST LIFE ASSURANCE COMPANY

(Life Insurance, Accidental Death & Dismemberment, Dental & Health Care Benefits, Weekly Disability)  
Group Policy # 164609

Great-West Life Group Claims – English  
Winnipeg Benefits Payments  
P.O. Box 3500, Stn. Main  
Winnipeg, MB R3C-0E6  
Tel : 1-855-729-1839

Great-West Life Group Claims – French  
Montréal Benefits Payment  
Place Bonaventure, Suite 5800  
800 de la Gauchetière St. W  
Montréal, QC H5A-1B9  
Tel : 1-855-729-1839

### Global Medical Assistance

(Emergency out-of-country travel assistance)  
Group Policy #: 164609

Within Canada or the US  
Outside Canada or the US  
Mexico  
Cuba

1-800-527-0218  
410-453-6330 (call collect)  
001-800-101-0061  
905-816-1901 (call collect)

If there are any issues calling collect from the country you are in, you can opt to pay the phone charges, get your receipt of payment and submit to Great-West Life for reimbursement.

**Best Doctors**

Group Policy# 164609

1-877-419-2378

Within Canada or the US

**Family Services**

(Member & Family Assistance Program, Alcohol & Drug Counseling)

English

1-800-668-9920

French

1-800-561-1128

[www.myfseap.com](http://www.myfseap.com)

Group name: TOIATSE667-669

Password: CENTRE003

E-mail: [help@fseap.com](mailto:help@fseap.com)

**Blue Cross Life Insurance Company of Canada**

(Critical Condition Benefit)

Group Policy # 37011

Claims through the I.A.T.S.E. Local 667/669 Health & Welfare Fund Office

## 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](http://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](http://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 1-855-729-1839.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 164609** issued by Great-West Life is the governing document. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail.

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

**The Plan is underwritten by**



## **Access to Documents**

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

## **Legal Actions**

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, Quebec Civil Code).

## **Appeals**

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

## **Benefit Limitation for Overpayment**

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

## **Protecting Your Personal Information**

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

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

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

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

As 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), contact Great-West Life's Chief Compliance Officer or refer to [www.greatwestlife.com](http://www.greatwestlife.com).



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# Benefit Summary for Level 01 Members, Golden Level and QC Drugs only

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

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<b>Life Insurance</b>	\$25,000, reducing to \$10,000 at age 70
<b>In-Canada Prescription Drugs (Members with QC Drugs only)</b>	Quebec residents only, 75% reimbursement
<b>Health Care Spending Account Benefits (Members with Golden Level only) (HCSA) – Health Solutions Plus</b>	See Benefit Description
<b>Other carriers' coverage not underwritten by Great-West Life</b>	
<b>Member &amp; Family Assistance</b>	Counseling available through FSEAP for you and your family

# Benefit Summary for Level 02 Members

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

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<b>Life Insurance</b>	\$25,000, reducing to \$10,000 at age 70
<b>Accidental Death, Dismemberment and Specific Loss (Principal Sum)</b>	\$25,000, reducing by 50% at the end of the plan year (March 31 <sup>st</sup> ), coinciding with or next following your 65 <sup>th</sup> birthday and terminating when you reach age 70
<b>Weekly Disability Income Benefits</b>	
Waiting Period	14 days
Maximum Benefit Period	15 weeks
Amount	\$700 per week
Benefit Integration	Plan payments will be made for occupational disabilities only if the member is denied Workers Compensation Benefits
Termination	At the end of the plan year (March 31 <sup>st</sup> ) coinciding with or next following your 75 <sup>th</sup> birthday

To be eligible for Weekly Disability Income Benefits, you must have been actively at, or available for work, or have been actively looking for work with a contributing employer. You must also have:

- worked for a contributing employer for a minimum of 5 days in the 30-day period immediately preceding the date of disability;
- worked for a contributing employer for a minimum of 10 days in the 60-day period immediately preceding the date of disability;
- become disabled within 30 days of the date you were scheduled to work for a contributing employer for either 5 days in the forthcoming 30 days or 10 days in the forthcoming 60 days (a written proof of such work commitment must be provided), or
- had patterns of employment with any of the contributing employers for specific calendar months or specific contributing employers during the 24 months immediately preceding the date of disability that demonstrates that you would have been working for a contributing employer if you had not been disabled, in which case your waiting period would begin on the date you would have been so scheduled to work.

**NOTE:** Members cannot voluntarily upgrade for Weekly Disability Benefit. This benefit is based on Producer Contributions only.

## Healthcare

### Covered expenses will not exceed reasonable and customary charges

#### Deductibles

In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge
All Other Expenses	Nil

#### Reimbursement Levels

Out-of-Country Emergency Care Expenses	100%
Global Medical Assistance Expenses	100%
All Other Expenses	70%

#### Basic Expense Maximums

Hospital	Semi-private room to a maximum of \$10,000 each plan year
Home Nursing Care	\$5,000 each plan year
Victorian Order of Nurses	\$450 each plan year
Medical Travel in Canada	Included
In-Canada Prescription Drugs	Included
Smoking Cessation Products	\$500 lifetime or as otherwise required by law
Fertility Drugs	\$5,000 lifetime or as otherwise required by law
Hearing Aids	\$1000 per ear every 5 plan years
Custom-fitted Orthopedic Shoes	\$300 each plan year
Custom-made Foot Orthotics	\$450 every 2 plan years
Splints (including shoes attached to a splint)	Included
Orthopedic Equipment	Included
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines	1 every 4 years
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	4 pairs each plan year
Incontinence Supplies	Included
Wigs or hairpieces for permanent hair loss as a result of an injury or disease, or temporary hair loss as as result of medical treatment for any disease	\$600 every 5 plan years
Intrauterine Devices (IUDs)	2 each plan year
Colostomy and Ileostomy Supplies, Oxygen, Medicated Dressings and Custom-made Burn Garments	Included
Prosthetic Equipment including:	
Myoelectric Arms	Included
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 each plan year
	All prosthetic equipment is limited to a lifetime maximum of \$10,000

### **Paramedical Expense Maximums**

Acupuncturists	\$600 each plan year
Audiologists	\$600 each plan year
Chiropractors	\$600 each plan year
	\$25 for x-rays each plan year
Christian Science Practitioners	\$600 each plan year
Dieticians	\$600 each plan year
Registered Massage Therapists	\$600 each plan year
Naturopaths	\$600 each plan year
Osteopaths	\$600 each plan year
	\$25 for x-rays each plan year
Physiotherapists/Athletic Therapists	\$600 each plan year combined
Occupational Therapists	\$600 each plan year
Podiatrists	\$600 each plan year
	\$25 for x-rays each plan year
Chiropodists	\$600 each plan year
Psychologists/Social Workers	\$600 each plan year combined
Psychoanalysts (for Quebec residents only)	\$600 each plan year
Speech Therapists/Speech Language Pathologists	\$600 each plan year combined

### **Visioncare Expense Maximum**

Eye Examinations	\$75 every 24 months
Global Medical Assistance Program (GMA)	Included
Best Doctors	Included
Out-of-Country Emergency Care Expense Maximums	\$1,000,000 lifetime

### **Healthcare Maximums**

- under age 70	Unlimited
- age 70 and above	\$3,000 each plan year

**Plan year is April 1<sup>st</sup> to March 31<sup>st</sup>**

## Dentalcare

### Covered expenses will not exceed reasonable and customary charges

**Payment Basis** The dental fee guide on the date treatment is rendered for the province in which treatment is rendered

**Deductible** Nil

### Reimbursement Levels

Basic Coverage 50%  
Accidental Dental Injury Coverage 70%

### Plan Maximums

Accidental Dental Injury Treatment \$5,000 per accident  
Basic Treatment \$1,000 each plan year

**Plan year is April 1<sup>st</sup> to March 31<sup>st</sup>**

### Other carriers' coverage not underwritten by Great-West Life

Member & Family Assistance Counseling available through FSEAP for you and your family

Critical Condition Benefit (Member Only) \$50,000 for eligible members under age 65  
(underwritten by Blue Cross)

# Benefit Summary for Level 03 Members

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

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<b>Life Insurance</b>	\$75,000, reducing to \$10,000 at age 70
<b>Accidental Death, Dismemberment and Specific Loss (Principal Sum)</b>	\$75,000, reducing by 50% at the end of the plan year (March 31 <sup>st</sup> ), coinciding with or next following your 65 <sup>th</sup> birthday and terminating when you reach age 70
<b>Weekly Disability Income Benefits</b>	
Waiting Period	14 days
Maximum Benefit Period	15 weeks
Amount	\$700 per week
Benefit Integration	Plan payments will be made for occupational disabilities only if the member is denied Workers Compensation Benefits
Termination	At the end of the plan year (March 31 <sup>st</sup> ) coinciding with or next following your 75 <sup>th</sup> birthday

To be eligible for Weekly Disability Income Benefits, you must have been actively at, or available for work, or have been actively looking for work with a contributing employer. You must also have:

- worked for a contributing employer for a minimum of 5 days in the 30-day period immediately preceding the date of disability;
- worked for a contributing employer for a minimum of 10 days in the 60-day period immediately preceding the date of disability;
- become disabled within 30 days of the date you were scheduled to work for a contributing employer for either 5 days in the forthcoming 30 days or 10 days in the forthcoming 60 days (a written proof of such work commitment must be provided), or
- had patterns of employment with any of the contributing employers for specific calendar months or specific contributing employers during the 24 months immediately preceding the date of disability that demonstrates that you would have been working for a contributing employer if you had not been disabled, in which case your waiting period would begin on the date you would have been so scheduled to work.

**NOTE:** Members cannot voluntarily upgrade for Weekly Disability Benefit. This benefit is based on Producer Contributions only.

## Healthcare

### Covered expenses will not exceed reasonable and customary charges

#### Deductibles

In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge
All Other Expenses	Nil

#### Reimbursement Levels

Out-of-Country Emergency Care Expenses	100%
Global Medical Assistance Expenses	100%
All Other Expenses	80%

#### Basic Expense Maximums

Hospital	Semi-private room to a maximum of \$10,000 each plan year
Home Nursing Care	\$5,000 each plan year
Victorian Order of Nurses	\$450 each plan year
Medical Travel in Canada	Included
In-Canada Prescription Drugs	Included
Smoking Cessation Products	\$500 lifetime or as otherwise required by law
Fertility Drugs	\$5,000 lifetime or as otherwise required by law
Hearing Aids	\$1000 per ear every 5 plan years
Custom-fitted Orthopedic Shoes	\$300 each plan year
Custom-made Foot Orthotics	\$450 every 2 plan years
Splints (including shoes attached to a splint)	Included
Orthopedic Equipment	Included
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines	1 every 4 years
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	4 pairs each plan year
Incontinence Supplies	Included
Wigs or hairpieces for permanent hair loss as a result of an injury or disease, or temporary hair loss as as result of medical treatment for any disease	\$600 every 5 plan years
Intrauterine Devices (IUDs)	2 each plan year
Colostomy and Ileostomy Supplies, Oxygen, Medicated Dressings and Custom-made Burn Garments	Included
Prosthetic Equipment including:	
Myoelectric Arms	Included
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 each plan year
	All prosthetic equipment is limited to a lifetime maximum of \$10,000



## Paramedical Expense Maximums

Acupuncturists	\$600 each plan year
Audiologists	\$600 each plan year
Chiropractors	\$600 each plan year
	\$25 for x-rays each plan year
Christian Science Practitioners	\$600 each plan year
Dieticians	\$600 each plan year
Registered Massage Therapists	\$600 each plan year
Naturopaths	\$600 each plan year
Osteopaths	\$600 each plan year
	\$25 for x-rays each plan year
Physiotherapists/Athletic Therapists	\$600 each plan year combined
Occupational Therapists	\$600 each plan year
Podiatrists	\$600 each plan year
	\$25 for x-rays each plan year
Chiropodists	\$600 each plan year
Psychologists/Social Workers	\$600 each plan year combined
Psychoanalysts (for Quebec residents only)	\$600 each plan year
Speech Therapists/Speech Language Pathologists	\$600 each plan year combined

## Visioncare Expense Maximums

Eye Examinations	\$75 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	
- for your spouse or a dependent child	\$150 every 24 months
- for members	\$300 every 24 months
Global Medical Assistance Program (GMA)	Included
Best Doctors	Included
Out-of-Country Emergency Care Expense <b>Maximums</b>	\$1,000,000 lifetime
Healthcare <b>Maximums</b>	
- under age 70	Unlimited
- age 70 and above	\$3,000 each plan year

**Plan year is April 1<sup>st</sup> to March 31<sup>st</sup>**



# Benefit Summary for Level 04 Members

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

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<b>Life Insurance</b>	\$100,000, reducing to \$10,000 at age 70
<b>Accidental Death, Dismemberment and Specific Loss (Principal Sum)</b>	\$100,000, reducing by 50% at the end of the plan year (March 31 <sup>st</sup> ), coinciding with or next following your 65 <sup>th</sup> birthday and terminating when you reach age 70
<b>Weekly Disability Income Benefits</b>	
Waiting Period	14 days
Maximum Benefit Period	15 weeks
Amount	\$700 per week
Benefit Integration	Plan payments will be made for occupational disabilities only if the member is denied Workers Compensation Benefits
Termination	At the end of the plan year (March 31 <sup>st</sup> ) coinciding with or next following your 75 <sup>th</sup> birthday

To be eligible for Weekly Disability Income Benefits, you must have been actively at, or available for work, or have been actively looking for work with a contributing employer. You must also have:

- worked for a contributing employer for a minimum of 5 days in the 30-day period immediately preceding the date of disability;
- worked for a contributing employer for a minimum of 10 days in the 60-day period immediately preceding the date of disability;
- become disabled within 30 days of the date you were scheduled to work for a contributing employer for either 5 days in the forthcoming 30 days or 10 days in the forthcoming 60 days (a written proof of such work commitment must be provided), or
- had patterns of employment with any of the contributing employers for specific calendar months or specific contributing employers during the 24 months immediately preceding the date of disability that demonstrates that you would have been working for a contributing employer if you had not been disabled, in which case your waiting period would begin on the date you would have been so scheduled to work.

**NOTE:** Members cannot voluntarily upgrade for Weekly Disability Benefit. This benefit is based on Producer Contributions only.

## Healthcare

### Covered expenses will not exceed reasonable and customary charges

#### Deductibles

In-Canada Prescription Drug Expenses	An amount equal to the dispensing fee portion of the drug charge
All Other Expenses	Nil

#### Reimbursement Levels

Out-of-Country Emergency Care Expenses	100%
Global Medical Assistance Expenses	100%
All Other Expenses	90%

#### Basic Expense Maximums

Hospital	Semi-private room to a maximum of \$10,000 each plan year
Home Nursing Care	\$5,000 each plan year
Victorian Order of Nurses	\$450 each plan year
Medical Travel in Canada	Included
In-Canada Prescription Drugs	Included
Smoking Cessation Products	\$500 lifetime or as otherwise required by law
Fertility Drugs	\$5,000 lifetime or as otherwise required by law
Hearing Aids	\$1000 per ear every 5 plan years
Custom-fitted Orthopedic Shoes	\$300 each plan year
Custom-made Foot Orthotics	\$450 every 2 plan years
Splints (including shoes attached to a splint)	Included
Orthopedic Equipment	Included
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines	1 every 4 years
Transcutaneous Nerve Stimulators	\$700 lifetime
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	4 pairs each plan year
Incontinence Supplies	Included
Wigs or hairpieces for permanent hair loss as a result of an injury or disease, or temporary hair loss as as result of medical treatment for any disease	\$600 every 5 plan years
Intrauterine Devices (IUDs)	2 each plan year
Colostomy and Ileostomy Supplies, Oxygen, Medicated Dressings and Custom-made Burn Garments	Included
Prosthetic Equipment including:	
Myoelectric Arms	Included
External Breast Prosthesis	1 every 12 months
Surgical Brassieres	2 each plan year
	All prosthetic equipment is limited to a lifetime maximum of \$10,000

## Paramedical Expense Maximums

Acupuncturists	\$600 each plan year
Audiologists	\$600 each plan year
Chiropractors	\$600 each plan year
	\$25 for x-rays each plan year
Christian Science Practitioners	\$600 each plan year
Dieticians	\$600 each plan year
Registered Massage Therapists	\$600 each plan year
Naturopaths	\$600 each plan year
Osteopaths	\$600 each plan year
	\$25 for x-rays each plan year
Physiotherapists/Athletic Therapists	\$600 each plan year combined
Occupational Therapists	\$600 each plan year
Podiatrists	\$600 each plan year
	\$25 for x-rays each plan year
Chiropodists	\$600 each plan year
Psychologists/Social Workers	\$600 each plan year combined
Psychoanalysts (for Quebec residents only)	\$600 each plan year
Speech Therapists/Speech Language Pathologists	\$600 each plan year combined

## Visioncare Expense Maximum

Eye Examinations	\$75 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	
- for your spouse or a dependent child	\$250 every 24 months
- for members	\$500 every 24 months
Global Medical Assistance Program (GMA)	Included
Best Doctors	Included
Out-of-Country Emergency Care Expense <b>Maximums</b>	\$1,000,000 lifetime
Healthcare <b>Maximums</b>	
- under age 70	Unlimited
- age 70 and above	\$3,000 each plan year

**Plan year is April 1<sup>st</sup> to March 31<sup>st</sup>**

## Dentalcare

### Covered expenses will not exceed reasonable and customary charges

**Payment Basis** The dental fee guide on the date treatment is rendered for the province in which treatment is rendered

**Deductible** Nil

### Reimbursement Levels

Basic Coverage	90%
Major Coverage	60%
Orthodontic Coverage	50% (eligible dependents under age 19)
Accidental Dental Injury Coverage	90%

### Plan Maximums

Basic Treatment	\$1,500 each plan year
Major Treatment	\$1,500 each plan year
Orthodontic Treatment	\$2,500 lifetime (eligible dependents under age 19)
Accidental Dental Injury Treatment	\$5,000 per accident

**Plan year is April 1<sup>st</sup> to March 31<sup>st</sup>**

### Other carriers' coverage not underwritten by Great-West Life

Member & Family Assistance Counseling available through FSEAP for you and your family

Critical Condition Benefit (Member Only) \$50,000 for eligible members under age 65 (underwritten by Blue Cross)

## **Information About Your Benefit Plan**

You cannot elect a lower benefit level than the benefit level based on your Health and Welfare Account at the end of the calendar year before the start of the plan year, unless you opt down one level with a Health Care Spending Account.

### **Annual Benefit Level Classification**

You will receive the highest benefit level for the plan year beginning April 1 based on your individual Health and Welfare account balances as of December 31 of the preceding year.

You will be eligible for the highest level of benefits that your individual account balance can support. The account balance must be able to support at least 12 months of benefit costs and administrator service charge requirements in effect at the start of the plan year (April 1).

There will be no voluntary opting to elect a lower benefit level than that determined based upon your account balance at the end of the previous calendar year.

## **Benefit Level 01 Coverage**

If you are in good standing of I.A.T.S.E., Local 667 or 669, you will be covered for the minimum benefit or Benefit 01, as determined by the Trustees from time to time.

The premiums for the Benefit 01 coverage, if you are in good standing, may be paid from the Health and Welfare Trust Fund reserves.

When you become a member of I.A.T.S.E., Local 667 or 669, Benefit 01 coverage or the benefit level you will qualify for through producer contributions, will be provided from the first of the month following the effective date of union membership. Any producer contributions made in the year before becoming a plan member will be applied to the account balance for the next plan year. An application for Plan Membership will be sent to each new member which must be completed and returned to the Union or Health & Welfare Administration Office.

If you have a Health and Welfare account balance at the beginning of the plan year that will provide only the Benefit 01 coverage, you will have that account balance pay the Benefit 01 coverage costs and administration service charges in full for one complete plan year. If the account balance is less than the benefit costs for one complete plan year, the balance will be funded through the Trust Fund reserves.

You will continue to be covered for Benefit 01 until the account balance at the end of the previous calendar year is sufficient to provide a higher level of benefit (or until termination of plan membership occurs).

## **Benefit Level Golden Level, QC Drugs, 02, 03 or 04 Coverage**

If you are in good standing of I.A.T.S.E. Local 667 or 669, you will be eligible for Benefit QC Drugs, 02, 03 or 04 for a plan year if the Health and Welfare account balance at December 31 of the preceding year is at least equal to 12 months of deductions for QC Drugs, 02, 03 or 04. The account balance includes the producer contributions, if any, received in the year prior to becoming a plan member.

The account balance will then be reduced each month by the deduction amount as long as you continue to meet the requirements in this booklet.

Each deduction will equal a month of Benefit Level QC Drugs, 02, 03 or 04 coverage costs plus administration service charges.

If you are eligible for Benefit Level 04 and your account balance exceeds 36 months of deductions, you will have excess deductions transferred to a Health Care Spending Account. The maximum amount that can be transferred for any one year is limited to 12 months of the current year's Benefit Level 04 deduction amount. Your account balance will immediately be reduced by the amount transferred. Unused amounts cannot be transferred back. Reimbursement of expenses from the Health Care Spending Account are administered by Great-West Life and are payable from the funds allocated to your Health Care Spending Account.

If you voluntarily upgrade to a higher benefit level and later downgrade to a lower benefit level, you forfeit the right to voluntarily upgrade to a higher benefit level for 36 months.



## **Members Who Reside Outside of Canada**

If you or your dependents are eligible to receive Benefits Level 01, QC Drugs, 02, 03 or 04 coverage but you are a member who resides outside of Canada, your coverage is modified as follows (qualifying benefits):

- Life Insurance
- Accidental Death, Dismemberment and Specific Loss (AD&D) Insurance
- Dentalcare benefits for services incurred outside Canada
- Member & Family Assistance Counselling

You and your dependents are not eligible to receive coverage for:

- Weekly Disability Income Benefits
- Healthcare
- The Critical Condition Benefit
- Best Doctors

## **COMMENCEMENT, TERMINATION AND REINSTATEMENT OF COVERAGE**

If you are a qualifying member in good standing, you are eligible for a 12-month term of coverage starting April 1 and ending March 31 of the following year. The benefit coverage will be decided at the start of the plan year and will be based on the total contributions in your Health and Welfare Account at the end of the calendar year before the start of the plan year.

Your coverage terminates when you cease to be a member in good standing or the policy terminates, whichever is earliest.

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

### **Survivor Benefits**

If you die while your dependents are insured under the Healthcare and/or Dentalcare benefits, your dependents will continue to be insured for such benefits until the earliest of:

- 24 months after the date of your death,
- the termination of the group policy,
- the remarriage of the spouse (children will continue to be insured for up to a total of 2 years),
- the date the dependent child ceases to qualify as a dependent, or
- the date coverage for your dependents terminates for any reason.

### **When is benefit coverage reinstated?**

If you return to become a member in good standing of I.A.T.S.E. Local 667 or 669, benefit coverage will begin as shown previously in the "Information About your Benefit Plan – Benefit Level 01 Coverage".

However, if you return within 12 months of the date your membership was originally terminated, then the previous Health and Welfare account balance including any Health Care Spending Account will be restored to your credit. Coverage for the remainder of the plan year will be based upon the value of the restored account balance.

The Health Care Spending Account limitation dates, regarding the 24 month maximum cannot be extended once they are established. This is a requirement under The Income Tax Act.

## 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 21, or under age 25 if they are full-time students. Proof of full-time student must be submitted at the beginning of each academic year for coverage to apply.

**Note:** If you are a Quebec resident, full-time students are covered for prescription drug benefits until age 26.

Children under age 21 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 21, or while they are students under 25, and the disorder has been continuous since that time.

- You must designate your spouse and children in writing before they can become your dependents under this plan.

## 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 plan sponsor.

## 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 plan administrator will explain the claim requirements to your beneficiary.

- If, for any reason, your life insurance or any part of the insurance terminates, the terminated amount (up to a maximum of \$200,000) may be converted to an individual life insurance plan offered by Great-West Life:
  - no evidence of insurability is required
  - the amount may not be greater than the amount of coverage you were covered for under this plan at the time of termination (less any age related reductions).

Written application and first month's premium payment for an individual policy must be received by Great-West Life within 31 days of termination of your group life insurance coverage.

Your plan administrator or Great-West Life can be contacted for details. Conversion applications may be obtained through the Health and Welfare Administration Office.

## 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.

<b>Loss</b>	<b>Amount Payable</b>
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

### **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 global medical 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 enrolls as a full-time student at a post-secondary institution within 365 days after the accident.

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 global medical assistance benefit, 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 for Plan Member**

If benefits are payable under this benefit provision for an injury that requires the plan member 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.

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 plan administrator for a claim form. Complete it and return it to your plan administrator.
- If you die accidentally, your plan administrator 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.



**THE CRITICAL CONDITION BENEFIT**  
(Underwritten by Blue Cross Life Insurance Company of Canada)

**Qualifying Critical Conditions**

A benefit will be paid if, as a result of sickness or disease (or accident if it is a severe burn) a Plan Member suffers from one of the following critical conditions that are severe and meet the degrees of severity in the contract:

Alzheimer's Disease	Major Organ Failure Requiring Transplant
Blindness	Motor Neuron Disease
Burns	Multiple Sclerosis
Coma	Paralysis
Deafness	Parkinson's Disease
Life Threatening Cancer	Senile Dementia
Loss of speech	Severe Heart Attack
Major Organ Failure	Severe Stroke

For example, only the most severe level of heart attack is covered (a Class 4 heart attack as classified by the Canadian Cardiovascular Society) i.e. unable to carry on any physical activity without discomfort.

**The Benefits**

The benefit amount for a critical condition is a lump sum non-taxable benefit payment of \$50,000.

Benefit restrictions include:

- a) Coverage is provided prior to the earlier of the Member's 65th birthday or retirement.
- b) A 30 day waiting period. The Member must survive the critical condition for 30 days and still meet the definition of critical condition.
- c) One payment of \$50,000 can be paid for each type of critical condition.
- d) Up to two payments or \$100,000 can be paid during a Member's lifetime. The two occurrences must be unrelated.

**Pre-Existing Conditions Restriction**

If a Member is disabled when this benefit was introduced on April 1, 1997, the critical condition benefit coverage does not begin until the disability stops and the Member is available to return to work.

Any medical conditions for which the Member has received medical treatment, consultation, care or services (including diagnostic measures) and/or for which he or she has been prescribed medication during the 24 months immediately before coverage begins is not covered unless the critical condition begins after 24 consecutive months or more of coverage.

**Waiting Period**

The critical condition benefit is a living benefit, which means the Member must survive the onset of the critical condition for a period of 30 days before the benefit will be paid. At the end of this 30 day period, the Member must still meet the definition of critical condition and provide satisfactory medical proof within 365 days.

**Overview of Critical Conditions**

- All conditions, with the exception of burns, must be the result of illness or disease.
- Conditions resulting from an accident (except in the case of burns) will not be covered.

## Covered Conditions

- 1) **Alzheimer's Disease:** Definite diagnosis of a progressive degenerative disease of the brain made by a certified neurologist or gerontologist acceptable by the Company, where there is a significant reduction in mental and social functioning as demonstrated by:
  - a) a loss of intellectual capacity and cognitive impairment,
  - b) impaired memory and sense of judgement, and
  - c) required continuous adult supervision for health and safety, whether medicated or not.
- 2) **Blindness:** Definite diagnosis made by a certified ophthalmologist acceptable by the Company, of the permanent loss of sight in both eyes. The loss of sight must be such that:
  - a) visual acuity cannot be corrected beyond 20/200 in both eyes, or
  - b) the field of vision must be less than 20 degrees in both eyes.
- 3) **Burns:** Third degree burns, as a result of a single event, covering at least 20% of the body surface
- 4) **Coma:** State of unconsciousness with no reaction to external stimuli or response to internal needs, for a continuous period of 30 days.
- 5) **Deafness:** Definite diagnosis made by a certified otolaryngologist acceptable by the Company, of the permanent loss of hearing in both ears. The loss of hearing in each ear must be such that sounds of 90 decibels or less cannot be distinguished.
- 6) **Life Threatening Cancer:** Incontrovertible evidence of a malignant tumor, as evidenced on a pathology report, characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue with distant metastasis and which is not listed in the exclusions, or any malignant tumors (with or without metastasis) listed as follows:
  - a) oral cavity
  - b) pharynx (including larynx)
  - c) oesophagus
  - d) stomach
  - e) level IV Melanoma
  - f) liver
  - g) pancreas
  - h) gallbladder and bile ducts
  - i) lungs and respiratory tracts

The following forms of cancer or conditions are excluded from coverage:

- a) benign tumors or polyps;
  - b) pre-malignant lesions;
  - c) stage T1 prostate cancer;
  - d) cancer-in-situ cancers (cancer has not spread outside the tissue in which it developed);
  - e) Melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion;
  - f) basal cell and squamous cell carcinoma of the skin.
- 7) **Loss of Speech:** Total and irreversible loss of speech as a result of physical disease as diagnosed by a medically appropriate specialist acceptable by the Company.

- 8) **Major Organ Failure:** Advanced or rapidly progressing incurable terminal kidney, liver, lung or heart failure where the insured is not a candidate for organ transplant, as determined by a medically acceptable specialist approved by the Company.
- 9) **Major Organ Failure Requiring Transplant:** The irreversible failure of the kidneys, liver, lungs or heart requiring receipt of a transplant of that organ. To qualify, the insured must be accepted in a transplant program satisfactory to the Company.
- 10) **Motor Neuron Disease:** Definite diagnosis of motor neuron disease made by a certified neurologist acceptable by the Company, resulting in the inability to perform at least two of the five Activities of Daily Living without assistance, as determined by an occupational therapist acceptable by the Company.
- 11) **Multiple Sclerosis:** Definite diagnosis, made by a certified neurologist acceptable by the Company, of having at least two episodes of well-defined neurological deficit with persisting neurological abnormalities to a degree that results in the inability to perform at least two of the five Activities of Daily Living without assistance, as determined by an occupational therapist acceptable by the Company.
- 12) **Paralysis:** The complete and permanent loss of use of two or more limbs resulting from a neurological deficit with measurable objective impairment that cannot be corrected by surgery or any other means, as diagnosed by a medically appropriate specialist acceptable by the Company.
- 13) **Parkinson's Disease:** Definite diagnosis of Primary Idiopathic Parkinson's disease made by a certified neurologist acceptable by the Company, resulting in:
  - a) neurological impairment to a degree that requires continuous adult supervision for health and safety, whether medicated or not, or
  - b) an inability to perform at least two of the five Activities of Daily Living without assistance, as determined by an occupational therapist acceptable by the Company.
- 14) **Senile Dementia:** Definite clinical diagnosis, made by a certified neurologist or gerontologist acceptable by the Company, of a progressive degenerative disease of the brain resulting in a significant reduction in mental and social functioning as demonstrated by:
  - a) a loss of intellectual capacity and cognitive impairment,
  - b) impaired memory and sense of judgement, and
  - c) required continuous adult supervision for health and safety whether medicated or not.
- 15) **Severe Heart Attack:** A heart attack, based on symptoms and diagnostic investigations, resulting in a permanent functional classification of at least a CCSC Class IV as evidenced by:
  - a) a reduced ejection fraction (<40%) on echocardiogram or nuclear study with a large or multiple wall motion defects and reduced function as evidenced by stress testing as indicated above, or
  - b) severe left ventricular dysfunction and/or left ventricular aneurysm, reduced ejection fraction (<40%) and left main or 3 vessel disease (>70% narrowing) as seen on the coronary angiogram.
- 16) **Severe Stroke:** Cerebrovascular event producing objective evidence of neurological sequelae lasting more than 30 days caused by intracranial thrombosis, hemorrhage or embolism from an extra-cranial source to a degree that requires continuous adult supervision for health and safety, whether medicated or not, or an inability to perform at least two of the five Activities of Daily Living without assistance, as determined by an occupational therapist acceptable by the Company.

## WEEKLY DISABILITY INCOME BENEFITS

The plan provides you with 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.

- Weekly disability income benefits are payable after the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.
- If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.
- Separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 2 weeks of continuous full-time work.
- Because your employer contributes to the cost of the weekly disability income coverage, benefits are taxable.
- Your weekly disability income benefits will terminate at the end of the plan year (March 31<sup>st</sup>) coinciding with or next following your 75<sup>th</sup> birthday.

### Other Income

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

- benefits under a legislated automobile insurance plan where permitted by law

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

### Vocational Rehabilitation Benefits

Vocational rehabilitation involves part-time work with your employer that is intended to help you return to your job or other gainful employment with your employer on a full-time basis. A plan will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

### Medical Coordination Benefits

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

## **Limitations**

No benefits are paid for:

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

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

- Any day you do any kind of work for pay or profit
- Illness or injury for which benefits are payable under the Quebec Automobile Insurance Act
- Any disability covered under any Worker's Compensation Law or
- Any illness or accidental injury sustained prior to becoming eligible for coverage or prior to the effective date of the plan
- The scheduled duration of a lay-off or leave of absence.

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

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

If you become disabled, contact your Plan Administrator who will provide information concerning Weekly Disability benefit claims and required documentation. Satisfactory written proof of claim must be submitted within 6 months of the date you become disabled.

## 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 reasonable and 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 the diagnosis or management of the disease or injury.

You are covered for only the healthcare benefits that apply to the level that you are in as shown in the **Benefit Summary**.

- Your healthcare coverage terminates when you no longer qualify for healthcare coverage through the plan.

### Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Semi-private room and board in a hospital or the government authorized co-payment for accommodation in a nursing home is covered when provided in Canada and the treatment received is acute, convalescent or palliative care.
  - Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.
  - Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.
  - Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

Semi-private room and board in an out-of-province hospital is covered when the treatment received is acute, convalescent or palliative care. For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is also covered.

The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in your home province.

Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- Home nursing services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province, when services are provided in Canada. No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse

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

- Drugs and drug supplies described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care provision.
  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives
  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered when medically necessary
  - 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.

Great-West Life can limit the covered expense to the cost of the lowest priced interchangeable drug.

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

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician including dental sleep apnea appliances.
- Orthopedic equipment, including braces, cervical collars, casts, splints external electrospinal stimulators for the correction of scoliosis, non-union bone stimulators, prone standers
- Custom-made foot orthotics, when prescribed by a chiropractor
- Custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when attached to and form part of a splint, when prescribed by a chiropractor
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician
- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs
- Blood-glucose monitoring machines prescribed by a physician
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan
- Out-of-hospital services of a qualified acupuncturist
- Out-of-hospital services of a qualified audiologist
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified Christian Science Practitioner
- Out-of-hospital treatment of nutritional disorders by a registered dietician

- Out-of-hospital services of a registered 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 or a qualified athletic therapist
- Out-of-hospital treatment of movement disorders by a qualified occupational therapist
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist
- Out-of-hospital services of a qualified chiroprapist
- Out-of-hospital treatment by a registered psychologist or qualified social worker
- Out-of-hospital treatment by a registered psychoanalyst (for Quebec residents only)
- Out-of-hospital treatment of speech impairments by a qualified speech therapist or speech language pathologist

### **Visioncare**

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

### **Medical Travel In Canada**

The plan will pay for the following expenses if you are referred away from home by your physician for treatment by another physician within your own province or elsewhere in Canada and the round trip distance is 1,000 kilometres or more.

- Travelling expenses for the person requiring the treatment and one companion if recommended by the attending physician. Benefits are limited to either round trip economy class travel or automobile fuel expenses. Taxicab, car rental charges and automobile repair charges are not covered.
- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred. Telephone and meal expenses are not covered.



## Global Medical Assistance Program

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

- On-site hospital payment when required for admission, to a maximum of \$1,000
- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

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

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to \$1,500 and for a round trip economy class ticket
- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of \$1,500
- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation
- In case of death, preparation and transportation of the deceased home
- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary
- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of \$1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

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

## **Out-Of-Country Emergency Care**

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

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

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

## **Limitations**

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

- Expenses private insurers are not permitted to cover by law
- Services or supplies for which a charge is made only because you have insurance coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

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

- Services or supplies that do not represent reasonable and customary treatment

- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than prescribed drugs
  - contraception, other than prescribed oral contraceptives and intrauterine devices (IUDs)
- Services or supplies not listed as covered expenses
- Extra medical supplies that are spares or alternates
- Services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province

This limitation does not apply to Global Medical Assistance

- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care
- Visioncare services and supplies required by an employer as a condition of employment

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment note: these are covered under the healthcare plan and not the prescription drug plan
- 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 dispensed by a dentist or clinic or by a non-accredited hospital pharmacy

- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- 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
- Drugs used to treat erectile dysfunction
- Drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec

**Note:** If you are age 65 or older and reside in 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*, 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 plan administrator by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident 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*.

“Basic prescription drug coverage” means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

## How to Make a Claim

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

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

If you are a resident of the Territories, you must submit your out-of-country claims to your territorial government for processing before submitting the claim to Great-West Life. When you receive your Explanation of Benefits back from the territory, please send the following to the Great-West Life Out-of-Country Claims Department (be sure to keep copies for your own records):

- a copy of the payment from your territory
- a completed Statement of Claim Out-of-Country Expenses form (form M5432)
- all required information
- copies of all original receipts

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

Out-of-country claims must be submitted within a certain time period that varies by province. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-855-729-1839.

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

Claims must be submitted to Great-West Life as soon as possible, but no later than 12 months after you incur the expense.

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

- For all other Healthcare claims, access GroupNet for Plan Members to obtain a personalized claim form or obtain claim forms from your plan administrator. 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 12 months after you incur the expense.

- **For drug claims**, your plan administrator 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 plan administrator.

## 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

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 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 and customary treatment. Treatment is considered reasonable and customary 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.

**Reimbursement for certain procedures could be limited to the cost of an alternative service.**

You are covered for only the dentalcare benefits that apply to the level that you are in as shown in the **Benefit Summary**.

- Your dentalcare coverage terminates when you no longer qualify for dentalcare coverage through the plan.

### Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to Great-West Life. Great-West Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

### Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination every 24 months
  - limited oral examinations twice every 12 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations twice every 12 months
  - complete series of x-rays every 24 months
  - intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 24 months. Services provided in the same 12 months as a complete series are not covered.



- Preventive services including:
  - polishing and topical application of fluoride each twice each calendar year
  - scaling, limited to a maximum combined with periodontal root planing of 12 time units each plan year
 

A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - pit and fissure sealants for a dependent child under age 18
  - space maintainers including appliances for the control of harmful habits
  - finishing restorations
  - interproximal disking
  - recontouring of teeth
- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 12 time units each plan year
  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months
 

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

- Denture maintenance, after the 3-month post-insertion care period, including:
  - denture relines for dentures at least 6 months old, once every 36 months
  - denture rebases for dentures at least 2 years old, once every 36 months
  - resilient liner in relined or rebased dentures, once every 36 months
- Oral surgery
- Adjunctive services

### **Major Coverage**

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

Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

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

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

- Denture-related surgical services for remodelling and recontouring oral tissues
- Denture and bridgework maintenance following the 3-month post-insertion period including:
  - denture remakes, once every 36 months
  - denture adjustments, once every 12 months
  - denture repairs and additions, tissue conditioning and resetting of denture teeth
  - repairs to covered bridgework
  - removal and recementation of bridgework

## **Orthodontic Coverage**

- Orthodontics are covered for children age 6 to 18 when treatment starts

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 you or your dependent receive the service or supply.

## **Accidental Dental Injury Coverage**

- Treatment of injury to sound natural teeth. Treatment must start within 90 days after the accident unless delayed by a medical condition

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

## **Limitations**

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

If overdentures are provided, coverage will be limited to standard complete dentures.

If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided

- Expenses covered under another group plan's extension of benefits provision

- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage
- Services or supplies that do not represent reasonable and customary treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

### **How to Make a Claim**

- Some dental offices will submit your claim electronically directly to Great-West Life.
- Claims for expenses incurred in Canada may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain claim forms 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.

In the event your dentist provides you with a generic claim form that you wish to mail in to Great-West Life, you will need to complete all required information (eg policy number, personal information, etc.)

Claims must be submitted to Great-West Life as soon as possible, but no later than 12 months after the dental treatment.

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

- For all other Dentalcare claims, access GroupNet for Plan Members to obtain a personalized claim form or obtain claim form 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 12 months after the dental treatment.

## **HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA) – Health SolutionsPlus**

For qualifying members, a Health Care Spending Account (HCSA) is an account through which you may be reimbursed for healthcare and dental expenses up to a predetermined annual credit amount. The Trustees of your Health & Welfare Plan will establish the credits for your benefit level 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.

How will I know the balance of my HCSA?

To check your current account balance, contact a customer service representative at Great-West Life toll-free at 1-877-883-7072. Hours of service are 7 a.m. to 6 p.m. CST for service in English and 7 a.m. to 5 p.m. CST for service in French.

### **Eligibility**

You and your dependents are eligible for HCSA credits through your Benefits Plan if you are covered for basic healthcare 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).

### **Termination**

Your HCSA coverage terminates when your basic healthcare coverage terminates or when your Trustees discontinue the plan.

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

### **Covered Expenses**

Coverage is provided for those expenses:

- that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time, or
- that Great-West Life deems to be eligible medical expenses under a private health services plan, as defined by the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Great-West Life toll-free at 1-877-883-7072.

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 you or your dependent receives the service or supply.

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 have been paid under your basic health plan, another group plan or a government plan

### **How to Make a Claim**

You have the option of submitting a claim by using the Health SolutionsPlus card, or by using the Health SolutionsPlus claim form. Claims for paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

The Health SolutionsPlus card is made available to you for use for covered expenses in accordance with the terms and conditions set out in your cardholder agreement.

You may submit a claim against the HCSA plan first, or you may choose to first submit it to a government plan or another private insurance plan under which you or any eligible dependents are covered. If other plans have paid first, you may submit a claim for any remaining balance of the expense to the HCSA plan online or by using the Health SolutionsPlus claim form.

If you use the Health SolutionsPlus card:

- For drug expenses, you must first use your Pay Direct drug card to claim benefits from your basic plan. You would then use your Health Solutions Plus card to claim benefits for any balance from your HCSA plan
- For dental expenses for which your dental office submits your claim electronically, your claim will be considered first under your basic plan. You would then use your Health SolutionsPlus card to claim benefits for any balance from your HCSA plan
- **WARNING** - For other expenses, your claim will be considered first under your HCSA plan, even though a portion of the expense may be covered under the basic plan sponsored by your employer

If you choose to use your Health SolutionsPlus card to pay for an expense, the amount will be drawn from the credits in your account whether or not coverage is available for the expense under another plan. However, if the expense would have been partially or completely covered under the basic plan sponsored by your plan administrator, you should submit a claim for the expense to the basic plan.

The amount that would have been paid under the basic plan may be credited back to your account and paid instead under the basic plan if:

- No other coverage is available for that expense except under the basic plan, or
- Other coverage is available for that expense under another plan, but the basic plan would pay benefits before the other plan

Using the Health SolutionsPlus card:

- You must activate the card in order to use it, following the card activation instructions on the card
- To use your card to pay for prescriptions, you must activate your card at least one full business day before ordering or dropping off a prescription at the pharmacy
- The card is intended for use in Canada and can only be used at merchants who accept VISA<sup>®</sup>, and are included in the Health SolutionsPlus approved provider network
- The card will not work at automated teller machines (ATMs) or retail stores
- The card will not work if the expense exceeds your current account balance. Ask your provider if you can split the cost at the register. Use the balance on your card, and then pay the remaining amount using another method of payment
- 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
- Great-West Life may, in its own discretion, suspend or terminate the use of your Health SolutionsPlus card at any time, with or without cause, and without prior notice
- If your card is lost or stolen, notify your plan administrator immediately by contacting a customer service representative at Great-West Life toll-free at 1-877-883-7072
- If your card is declined, use the claim form or online option

Using the Health SolutionsPlus claim form:

If you elect to use the claim form, use form M445D(HSPT) for dental claims, and form M635D(HSPT) for all other claims.

Claim submission deadlines:

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

- 6 months 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

## 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 a member and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.
- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:
  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

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

## DIAGNOSTIC AND TREATMENT SUPPORT SERVICES (BEST DOCTORS<sup>®</sup> SERVICE) FOR LEVEL 02, 03 AND 04 MEMBERS

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

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

### How it works

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free.
- The person accessing the service will be connected with a member advocate who will be dedicated to his or her case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.
- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the covered person's health needs, and can help identify individual community supports and resources available.
- If it is appropriate, the member advocate may arrange for an in-depth review of the covered person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Timeframes may vary depending on the complexity of the case and amount of medical records to collect.



- If the covered person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet his or her specific medical needs. Expenses incurred for travel and treatment are not covered by this service.
- If the covered person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process. Expenses incurred for travel and treatment are not covered by this service.
- The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

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

**THE MEMBER & FAMILY ASSISTANCE PROGRAM**  
Provided by Family Services Employee Assistance Programs (FSEAP)

The Member & Family Assistance Program (MAP) is designed to provide you and your family with direct access to experienced professionals who will help you resolve your problems - before they affect your health, family life or job performance.

At some point in our lives we all face problems. Usually we can cope with them, or solve the problems ourselves. However, now and then, a problem becomes too difficult for us to manage on our own. We may need assistance, advice, or just someone to listen. Problems which bother us often affect our lives, our family, our friends, and our work performance.

**Concerns dealt with**

The Member & Family Assistance Program (MAP) is a confidential counselling and referral service for you and your family. This program offers support in dealing with a variety of stressful situations. Personal and work related concerns which may affect you or your family are covered, such as:

- Personal and/or job stress
- Eldercare and childcare
- Addictions (including gambling)
- Separation and loss
- Financial and/or legal
- Depression/anxiety
- Relationship issues
- Harassment
- Parenting issues
- Distress
- Balancing work and family
- Anger management
- Substance Abuse

**Confidentiality**

Anything you or your family member discusses with the counsellor is kept absolutely confidential. Counsellors will not release any information to anyone without your consent except where legally required.

**To Access The Program**

Immediate access to professional counsellors is available by phone 24/7 through the toll-free line. If face-to-face counselling is required, an appointment will be scheduled. You can also arrange e-counselling, video, or two-way chat/email counselling for convenience.

These services are provided by FSEAP through **confidential**, off-site counselling at offices across Canada and the U.S. Counsellors are highly experienced professionals including psychologists and social workers.

If long term or specialized counselling is required, the counsellor will assist you with a referral to another resource within the community. This referral may involve a fee.

For assistance at anytime, please call **1-800-668-9920 (English) or 1-800 561-1128 (French)**.

## **Our Services**

### **Teen/Parent Helpline**

If you have a dependent who is a teen, who needs confidential, free, quick counselling and resource information, our Counsellors are available to talk to you or your teen about problems your teen is having with friends, school or family relationships such as:

- Answering questions about dating, drugs or alcohol,
- If your teen is in crisis, or
- If your teen just wants someone to listen

### **Family Connexions**

Family Connexions specialists offer information and consultation to families who need help with their childcare and eldercare needs. The specialist will discuss your situation with you, and provide information you need right away, during your phone call, or later, in writing by fax or by mail.

Written information includes a Personal Information Package that contains contact information and program descriptions of resources available in the location you've selected, as well as guides to help you choose the appropriate type of care. The specialist will follow up with you to find out if you need any additional information and to get feedback on how satisfied you were with the service.

Family Connexions service provides information on the following Childcare services:

- Day Care Centres and Nursery Schools
- Nanny Agencies
- Private Home Care Agencies
- School-Age Childcare Programs (after school, summer, school holidays)
- Care for Children with special needs
- Temporary and Emergency Care Agencies

Family Connexions service provides information on the following Eldercare services:

- Home Support Services
- Long Term Care and Seniors Housing
- Day Programs
- Health Services
- Social and Educational Programs

Family Connexions specialists are available Monday to Friday 8:00 a.m. EST to 7:00 p.m. EST.

## **Legal Services**

This service offers telephone access to experienced lawyers practising across Canada and the United States. They can help you and your family members with issues such as:

- Consumer law and protection
- Wills and estate planning
- Civil and criminal law
- Family law
- Motor vehicle law
- Real estate law
- Immigration law, and
- General legal services

Services are private and confidential. If further action is required, referrals to lawyers for in-person consultation can also be provided. Legal fees for in-person consultation are offered at a discounted rate.

## **Financial Services**

This service offers telephone access to financial professionals to help you and your family members with credit counselling, budgeting and financial planning. Consultations assist clients with budgeting, setting financial goals, managing changes in personal situation and debt management, as well as guidance in issues of retirement or education savings, estate planning and taxes.

## **Life Coaching**

Achieve personal and professional growth through telephone consultations with a qualified Life Coach. You can make positive changes in almost any area of your life including communication, relationships, parenting, grief, work/life balance, conflict resolution, supervisory skills, organizational change, career planning, retirement planning, health and wellness, and stress management.

## **Career Connexions**

Vitalize your career with Career Connexions! Our Career Consultation Specialists offer personalized consultations to address your specific career needs including: vocational assessments; resume and interview preparation skills; and career transition.

## **For assistance please call**

<b>English</b>	<b>1-800-668-9920</b>
<b>French</b>	<b>1-800-561-1128</b>
<b>TTY:</b>	<b>1-888-234-0414</b>

## **FSEAP Website**

Visit [myfseap.com](http://myfseap.com) for additional information and resources including articles, self-assessment tools, blogs, podcasts, webinars, wellness strategies, polls, frequently asked questions and so much more!

**Username: TOIATSE667-669**

**Password: CENTRE003**

**THE ALCOHOL & DRUG COUNSELLING PROGRAM**  
Provided by Family Services Employee Assistance Programs (FSEAP)

**Counselling Includes**

The Alcohol & Drug Counselling is available to provide confidential, professional, alcohol, drug and addiction counselling and referral services for Plan Members and their families (spouses and dependent children as defined in the Plan).

These services include assessment, referral, crisis and/or emergency counselling, tailoring recovery programs to the specific needs of the individual and ongoing individual and family counselling and education. Under certain circumstances a portion of the fees for residential treatment may be covered by the Health and Welfare Plan.

When needed, referral services to community resources such as treatment facilities with the appropriate follow-up are provided.

**Confidentiality**

Members and their families using the Alcohol & Drug Counselling Program are assured of the strictest privacy. Whatever you discuss with the counsellor is kept absolutely confidential.

**To Access The Program**

Phone FSEAP directly at **1-800-668-9920 (English)**, **1-800 561-1128 (French)** or **1-888-234-0414 (TTY)**. A Counsellor will work with you immediately to determine the best approach to use regarding your alcohol or drug related concerns. All services provided by the Counsellors are **strictly confidential**.