OUR FLEX BENEFITS PROGRAM

- ADDED FLEXIBILITY
- MORE OPTIONS

Going Places Together.

RED RIVER COLLEGE
OF APPLIED ARTS, SCIENCE AND TECHNOLOGY

BENEFIT DETAILS

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at **www.greatwestlife.com**. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Healthcare, Dentalcare and Health Care Spending Account sections of this booklet
- extensive health and wellness content

Using our GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

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

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777.
- for assistance with your Health Care Spending Account, please call 1-877-883-7072.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 160733 (Global Medical Assistance)** and **Plan Document No. 57353 (Healthcare, except Global Medical Assistance, and Dentalcare)** issued by Great-West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policy or plan document, the policy or plan document will prevail.

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

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

and arranged by

HUB International | STRATA

HUB International STRATA Benefits Consulting
Unit B2- 1150 Waverley Street
Winnipeg, MB R3T 0P4

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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

Insured benefits

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

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

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.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

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.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by your employer. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit your employer's right to use other legal means to recover the overpayment.

Protecting Your Personal Information

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

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

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

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

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

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

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

Liability for Benefits

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

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Benefit Summary

This summary must be read together with the benefits described in this booklet. You are only covered for the benefits that apply to the option that you choose.

	OPTION 1 (Classes 1 and 6)	OPTION 2 (Classes 2 and 7)	OPTION 3 (Class 3)	OPTION 4 (Class 4)	OPTION 5 (Class 5)
HEALTHCARE*					
Deductible					
In-Canada Prescription Drug Expenses	Nil	Nil	Not covered	An amount equal to the dispensing fee portion of the drug charge	$4 per prescription
All Other Expenses	Nil	Nil	Nil	Nil	Nil
Reimbursement Levels					
Ambulance Expenses	100%	100%	100%	100%	100%
In-Canada Hospital Expenses	100%	100%	100%	100%	100%
Out-of-Country Emergency Care Expenses	100%	100%	100%	100%	100%
In-Canada Prescription Drugs Expenses	80%	80%	Not covered	50%	90%
Visioncare Expenses	80% (Part-time employees – 40%)	80% (Part-time employees – 40%)	Not covered	50%	100%
Global Medical Assistance Expenses	100%	100%	100%	100%	100%
All Other Expenses	Not covered	80%	Not covered	50%	90%

Basic Expense Maximums	**OPTION 1 (Classes 1 and 6)**	**OPTION 2 (Classes 2 and 7)**	**OPTION 3 (Class 3)**	**OPTION 4 (Class 4)**	**OPTION 5 (Class 5)**
Ambulance - air ambulance - non-emergency medical transportation	Included Included $250 lifetime	Included Included $250 lifetime	Included Included $250 lifetime	Included Included $250 lifetime	Included Included $250 lifetime
Hospital	Semi-private room	Semi-private room	Semi-private room	Semi-private room	Semi-private room
Home Nursing Care	Not covered	$3,000 each calendar year	Not covered	$5,000 each calendar year	$10,000 each calendar year
Manitoba Medical Hostel Accommodation	Included	Included	Included	Included	Included
In-Canada Prescription Drugs	$650 each calendar year per family (Part-time employees - $325 each calendar year per family)	$650 each calendar year per family (Part-time employees - $325 each calendar year per family)	Not covered	The maximum allowed under the Manitoba Pharmacare deductible amount	The maximum allowed under the Manitoba Pharmacare deductible amount
Hearing Aids	Not covered	Not covered	Not covered	$500 every 5 years	$750 every 5 years
Cardiac Program	Not covered	$300 lifetime	Not covered	$300 lifetime	$300 lifetime
Intermittent Positive Pressure Breathing Machines	Not covered	Included	Not covered	Included	Included
Respirators	Not covered	Included	Not covered	Included	Included
Custom-fitted Orthopedic Shoes (when part of a brace)	Not covered	1 pair each calendar year	Not covered	1 pair each calendar year	1 pair each calendar year
Orthopedic Shoes (not part of a brace)	Not covered	50% of 1 pair each calendar year	Not covered	50% of 1 pair each calendar year	50% of 1 pair each calendar year
Myoelectric Arms	Not covered	$10,000 per prosthesis	Not covered	$10,000 per prosthesis	$10,000 per prosthesis

Basic Expense Maximums	OPTION 1 (Classes 1 and 6)	OPTION 2 (Classes 2 and 7)	OPTION 3 (Class 3)	OPTION 4 (Class 4)	OPTION 5 (Class 5)
External Breast Prosthesis and Surgical Brassiere	Not covered	$100 per single prosthesis or brassiere each calendar year and $200 per double prosthesis or brassiere each calendar year	Not covered	$100 per single prosthesis or brassiere each calendar year and $200 per double prosthesis or brassiere each calendar year	$100 per single prosthesis or brassiere each calendar year and $200 per double prosthesis or brassiere each calendar year
Mechanical or Hydraulic Patient Lifters	Not covered	$2,000 per lifter once every 5 years	Not covered	$2,000 per lifter once every 5 years	$2,000 per lifter once every 5 years
Blood Glucose Monitoring Machine	Not covered	1 every 4 years	Not covered	1 every 4 years	1 every 4 years
Outdoor Wheelchair Ramps	Not covered	$2,000 lifetime	Not covered	$2,000 lifetime	$2,000 lifetime
Wheelchairs, including repairs	Not covered	$1,000 lifetime	Not covered	$1,000 lifetime	$1,000 lifetime
Hospital Beds	Not covered	$1,000 lifetime	Not covered	$1,000 lifetime	$1,000 lifetime
Transcutaneous Nerve Stimulators	Not covered	$700 lifetime	Not covered	$700 lifetime	$700 lifetime
Extremity Pumps for Lymphedema	Not covered	$1,500 lifetime	Not covered	$1,500 lifetime	$1,500 lifetime
Custom-made Compression Hose	Not covered	Included	Not covered	Included	Included
Wigs or Hairpieces	Not covered	$1,000 lifetime	Not covered	$1,000 lifetime	$1,000 lifetime
Diagnostic Supplies	Not covered	Included	Not covered	Included	Included
Other Medical Supplies	Not covered	Included	Not covered	Included	Included
Dental Accident Treatment	Not covered	Included	Not covered	Included	Included

Paramedical Expense Maximums	OPTION 1 (Classes 1 and 6)	OPTION 2 (Classes 2 and 7)	OPTION 3 (Class 3)	OPTION 4 (Class 4)	OPTION 5 (Class 5)
Audiologists	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Athletic Therapists	Not covered	$10 per visit $100 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Chiropractors	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Dieticians	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Massage Therapists	Not covered	$350 each calendar year	Not covered	Not covered	$450 each calendar year
Naturopaths	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Osteopaths	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Physiotherapists	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Podiatrists/ Chiropodists	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Psychologists/Social Workers	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year
Speech Therapists	Not covered	$350 each calendar year	Not covered	$350 each calendar year	$450 each calendar year

Visioncare Expense Maximum	**OPTION 1 (Classes 1 and 6)**	**OPTION 2 (Classes 2 and 7)**	**OPTION 3 (Class 3)**	**OPTION 4 (Class 4)**	**OPTION 5 (Class 5)**
Eye Examinations, Glasses, Contact Lenses and Laser Eye Surgery	$225 every 24 months (Part-time employees - $114 every 24 months)	$225 every 24 months (Part-time employees - $114 every 24 months)	Not covered	$225 every 12 months for dependent children and $225 every 24 months for any other person	$225 every 12 months for dependent children and $225 every 24 months for any other person
Out-of-Country Emergency Care Expenses	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Global Medical Assistance (GMA)	Included	Included	Included	Included	Included
Healthcare Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
	Covered expenses will not exceed customary charges				
	*** All maximums are per person unless otherwise noted**				

	OPTION 1 (Classes 1 and 6)	OPTION 2 (Classes 2 and 7)	OPTION 3 (Class 3)	OPTION 4 (Class 4)	OPTION 5 (Class 5)
DENTALCARE*					
Payment Basis	The dental fee guide in effect in your province of residence on the date treatment is rendered. In Alberta, Great-West Life will use the 1997 Alberta Dental Association Fee Guide plus inflationary adjustment as determined by Great-West Life.				
Deductible	Nil	Nil	Not covered	Nil	Nil
Reimbursement Levels					
Basic Coverage	80%	80%	Not covered	50%	100%
Major Coverage	60%	60%	Not covered	50%	50%
Orthodontic Coverage	50%	50%	Not covered	50%	Not covered
Plan Maximums					
Basic and Major Treatment	$1,475 each calendar year (Part-time employees - $738 each calendar year)	$1,475 each calendar year (Part-time employees - $738 each calendar year)	Not covered	$1,500 each calendar year	$1,500 each calendar year
Orthodontic Treatment	$1,675 lifetime (Part-time employees - $838 lifetime)	$1,675 lifetime (Part-time employees - $838 lifetime)	Not covered	$2,000 lifetime	Not covered
	*** All maximums are per person unless otherwise noted**				

	OPTION 1 (Classes 1 and 6)	OPTION 2 (Classes 2 and 7)	OPTION 3 (Class 3)	OPTION 4 (Class 4)	OPTION 5 (Class 5)
HEALTHCARE SPENDING ACCOUNT (HCSA)	$850 every 12 months (Part-time employees - $425 every 12 months)	$850 every 12 months (Part-time employees - $425 every 12 months)	$1,850 every 12 months	$900 every 12 months	$450 every 12 months

Information About Your Flex Plan

- This flex plan is a modular style. All benefits chosen must be from the same option level. If you choose Option 1, then you will have all the benefits eligible under Healthcare - Option 1, Dentalcare - Option 1 and Healthcare Spending Account - Option 1. You can change to another option at the re-enrollment (two year enrolment) which is every second January 1.

- You can change options every second January 1, unless the change results from a Life Event. If it does, the option change will take effect on the date the application for the change is made, as long as it is made within 60 days of the status change. Otherwise, the change will not take effect until the following January 1.

- If you experience a Life Event during a plan year that affects your coverage needs, you may make changes to your benefit options that directly relate to your status change without waiting for the next re-enrollment period. Any of the following is considered a Life Event:

  - acquiring a spouse
  - acquiring a child (birth, adoption or step-child)
  - gain or involuntary loss of similar coverage through your spouse's group benefit program (for example, because of a change in your spouse's employment status)
  - death of your spouse or child
  - your spouse or child ceasing to qualify for coverage (for example, through divorce or your child's attainment of a limiting age – see Dependent Coverage in this booklet)

  Note: See Human Resources Services immediately when a Life Event occurs.

COMMENCEMENT AND TERMINATION OF COVERAGE

If you are a:

- regular full-time employee, you are eligible to participate in the plan immediately. If you are a full-time term employee, you are eligible to participate in the plan after 12 months of continuous employment

- regular part-time employee, you are eligible to participate in the plan immediately. If you are a term part-time employee, you are eligible to participate in the plan after the completion of 1,885/2,080 hours from your date of employment.

You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- You must apply for coverage no later than 60 days after you become eligible. After 60 days, you must provide evidence of insurability for you and your dependents before you can participate.

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

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

- Contract and casual employees may not join the plan.

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

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

- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. Your employer will provide you with details.

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

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued for a period of 24 months or until they no longer qualify, whichever happens first.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

  Children are not covered if they have coverage as an employee under this plan or any other group benefits plan.

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

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

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

HEALTHCARE

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

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

You are covered for only the Healthcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

Covered Expenses

- Ambulance transportation, including air ambulance, to the nearest centre where adequate treatment is available

  Services of non-emergency transportation are also covered when recommended by a physician, if they are provided by a qualified medical transfer service

- 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.

  - The following drugs are covered if they are listed in the Manitoba Drug Benefits and Interchangeability Formulary in effect on the date of purchase, or have been approved for you under the Manitoba Pharmacare Exception Drug Status Program:

    (a) drugs which require a written prescription
    (b) injectable drugs including vitamins and insulins
    (c) extemporaneous preparations or compounds if one of the ingredients is a covered drug
    (d) certain other drugs that do not require a prescription by law may be covered when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense

  - The following diabetic supplies are covered:

    (a) insulin syringes
    (b) disposable needles for use with non-disposable insulin injection devices
    (c) lancets and test strips

  Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic 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 the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician

- Custom-fitted orthopedic shoes when part of a brace as well as orthopedic shoes when not part of a brace are eligible when prescribed by a physician or a podiatrist

- 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

- 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.

No benefits are paid for:

- accidental damage to dentures
- dental treatment completed more than 12 months after the accident
- orthodontic diagnostic services or treatment

- Treatment under a cardiac rehabilitation program approved by the Heart and Stroke Foundation of Canada or the Canadian Cardiovascular Society when prescribed by the attending physician after a heart attack, coronary bypass surgery or valve replacement
- Out-of-hospital services of a qualified audiologist
- Out-of-hospital services of a qualified athletic therapist who is a member of the Canadian Athletic Therapists Association
- Out-of-hospital treatment of muscle and bone disorders by a licensed chiropractor, in-Canada and out-of-country on a non-emergency basis. If treatment is received out-of-country on a non-emergency basis the provider must meet Great-West Life's criteria and the calendar year maximum will apply
- Out-of-hospital treatment of nutritional disorders by a registered dietician
- Out-of-hospital services of a qualified massage therapist, in-Canada and out-of-country on a non-emergency basis. If treatment is received out-of-country on a non-emergency basis the provider must meet Great-West Life's criteria and the calendar year maximum will apply
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist, excluding x-rays; in-Canada and out-of-country on a non-emergency basis. If treatment is received out-of-country on a non-emergency basis the provider must meet Great-West Life's criteria and the calendar year maximum will apply
- Out-of-hospital treatment of foot disorders, excluding x-rays, by a licensed podiatrist or chiropodist in-Canada and out-of-country on a non-emergency basis. If treatment is received out-of-country on a non-emergency basis the provider must meet Great-West Life's criteria and the calendar year maximum will apply
- Out-of-hospital treatment by a registered psychologist or qualified social worker
- Out-of-hospital treatment of speech impairments by a qualified speech therapist

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.

Manitoba Medical Hostel Accommodation

The plan will pay for the following expenses if you are referred away from home by your physician for diagnostic testing or treatment at a Manitoba hospital located more than 60 kilometres from your home and you are placed in a recognized medical hostel associated with the hospital.

Benefits are limited to moderate quality accommodation for the area in which the treatment is rendered or testing performed.

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. The plan extends coverage to students attending school out-of-province/out-of-country when an exception has been approved by the student's provincial health plan. 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. The plan extends coverage to students attending school out-of-province/out-of-country when an exception has been approved by the student's provincial health plan. 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
  - dental accident treatment if it would have been covered in Canada

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. No benefits are paid for expenses incurred more than 90 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 90-day period, benefits will be extended to the end of the confinement.

Limitations

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

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

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

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

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

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

- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:

  - treatment performed only for cosmetic purposes

  - recreation or sports rather than with other daily living activities

  - the diagnosis or treatment of infertility, other than drugs
  - contraception, other than oral contraceptives

- 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 benefits would have been paid under this plan 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
- 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 normally used for contraception
- Any single purchase of drugs which would not reasonably be used within 100 days
- 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
- Allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason
- Smoking cessation products
- Drugs used to treat erectile dysfunction

How to Make a Claim

- **Out-of-country claims (including 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 or Territorial 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 employer. 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.

  You 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 or Territorial Medical Plan portion. Your Provincial or Territorial 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 or territory. 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 1-800-957-9777.

- **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.

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

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

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

  Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

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

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

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

PREFERRED VISION SERVICES (PVS)

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

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

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

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

Using PVS:

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

DENTALCARE

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

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

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

You are covered for only the Dentalcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

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 the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination each calendar year
  - limited oral examinations twice each calendar year, separated by an interval of at least 5 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 each calendar year separated by an interval of at least 5 months
  - complete series of x-rays every 24 months
  - bite-wing x-rays twice each calendar year separated by an interval of at least 5 months
  - other intra-oral x-rays to a maximum of 15 films every 24 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
  - consultation required by attending dentist with the patient
- Preventive services including:
  - polishing, limited to a maximum combined with scaling, of twice each calendar year separated by an interval of at least 5 months
  - topical application of fluoride twice each calendar year separated by an interval of 5 months
  - pit and fissure sealants on bicuspids and permanent molars every 60 months
  - space maintainers including appliances for the control of harmful habits
  - 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.

- Periodontal services including:
  - root planing
  - 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
- 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, inlays and veneers. Coverage for tooth-coloured onlays or inlays on molars is limited to the cost of metal

  Replacement crowns, onlays, inlays and veneers 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 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 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 relines for dentures at least 6 months old, once every 3 calendar years
  - denture rebases for dentures at least 2 years old, once every 3 calendar years
  - resilient liner in relined or rebased dentures, once every 3 calendar years
  - 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 who are under age 19. Treatment must start before their 18th birthday

Dentalcare Limitations

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction, nutritional counselling and finishing restorations

- 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 - desensitization, 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

- The provision of general anaesthetic facilities, equipment and supplies when a separate anaesthetist is required

- Recontouring existing crowns and staining porcelain

- Crowns, onlays, inlays or veneers if the tooth could have been restored using other procedures. If crowns, onlays, inlays or veneers 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

- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare

- Expenses private benefit 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 coverage

- Services or supplies that do not represent reasonable 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
- Dentures which have been lost, mislaid or stolen
- Appliances which have been lost, broken or stolen
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D 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.

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

  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 Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

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

Eligibility

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

Termination

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

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

Covered Expenses

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

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

Covered expenses that exceed the maximum annual payment can be carried forward and submitted for payment in the following plan year. Covered expenses can also be carried forward if credits have been forfeited.

Credits are automatically forfeited 90 days after the end of a plan year.

Limitations

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

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

Any claim against the HCSA must be submitted on a custom form M635D (57353) for healthcare claims and custom form M445D (57353) for dentalcare claims.
Claims against the HCSA must be submitted to the Great-West Life Benefit Payment Office before the earliest of the following:

- the end of the plan year following the plan year in which the expenses were 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

The standard Great-West Life claim forms should be used when you do not want benefits reimbursed from your HCSA.

COORDINATION OF BENEFITS

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

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

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

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