

Group Benefit Plan



Great-West Life
your Benefits Solutions People

THE POWER SECTOR BENEFIT TRUST

NUTRA SYSTEMS INC. MEMBERS

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

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

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at www.greatwestlife.com.

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 certain healthcare claims and all dental claims
- extensive health and wellness content

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-800-957-9777.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 330591 and Plan Document No. 56105** 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



Protecting Your Personal Information

At The Power Sector Benefit Trust and 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 or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

The personal information in your file will be kept in The Power Sector Benefit Trust Office as well as the offices of Great-West Life or in the offices of an organization authorized by us. You may request to review or correct the personal information in your file. A request to review or correct your file should be made in writing and sent to

The Power Sector Benefit Trust Administration Office

At

555 Burnhamthorpe Road Suite 603
Etobicoke, ON M9C 2Y3
Or check out our website

At

www.psbtc.ca

Claims submissions should be sent directly to the address on the claim form or contact your plan administrator at 1-888-250-2270 for details.

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

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 Pay Direct Drug, Healthcare 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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DEFINITIONS

Policy Month means the first day of each month.

Common-law Spouse means a person of the same, where applicable by law, or opposite sex whom you publicly represent as your spouse.

Common-law Child means a child of your common-law spouse from another relationship who resides with and is in the care and custody of you and your common-law spouse.

Employment as referred to in this booklet shall mean active membership in The Power Sector Benefit Trust.

Fund means The Power Sector Benefit Trust Plan.

Health & Welfare Plan means all the benefits for which you are eligible under the Fund including benefits which may not be provided by us or any other Insurance Company.

Monthly Draw means an amount equal to the sum of the monthly premium payments required for your benefits under the Health & Welfare Plan.

Health & Welfare Account will consist of all payments made to the Fund on your behalf, excluding all amounts deducted on your behalf.

Hour Bank means the record of hours worked by a Member and hours deducted which is kept by the administrator for the purposes of determining the commencement, continuation and termination of a Member's coverage.

Retired, Retirement or Retire means the Member's cessation of active duties while covered under this plan or voluntarily electing to leave active duties after attaining the age of 55.

Post-Secondary Institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

GROUP BENEFIT PLAN FOR MEMBERS OF

The Power Sector Benefit Trust

**Group Policy Nos. 330591
Plan Document No. 56105**

BENEFIT DESCRIPTION

Life Insurance

Amount of Insurance

\$30,000

Reductions

Member's life insurance will reduce 50% on your 65th birthday. The reduced coverage will continue until your death.

Dependent's Group Life

Spouse: \$10,000
Each Child: \$5,000

Reductions

On your death, spousal and dependant life coverage for your dependant(s) may continue until the death of that spouse, provided that the required contributions for the survivor coverage continue to be paid. Each spouse's life insurance of \$10,000 will reduce 50% on the member's 75th birthday. The reduced coverage of \$5,000 will continue until the spouse's death.

Accidental Death and Dismemberment

Amount of Insurance

\$30,000

Reductions

Your Accidental Death and Dismemberment will reduce 50% on your 65th birthday and will terminate on your 71st birthday.

Pay Direct Drugs

Your deductible per prescription is nil.

Reimbursement is 100% of eligible charges.

Your maximum Dispensing Fee is \$7 per Drug Identification Number (DIN).

Healthcare

Your deductible per calendar year is nil.

Reimbursement is 100% of eligible charges.

Healthcare benefits, excluding Emergency Out-of-Country/Province treatment and Travel Assistance, do not terminate with age.

Emergency Out-of-Country/Province treatment and Travel Assistance benefits terminate at your age 75.

Dental

Great-West Life will pay on the basis of each year's Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide, as of the 1st of the month following the month in which Great-West Life receives the new Fee Guide.

Your deductible per calendar year is nil.

Dental 1 and 2

Reimbursement is 100% of eligible charges.

Maximum is \$2,000 per person in a calendar year.

Dental 3

Reimbursement is 50% of eligible charges.

Maximum is \$1,500 per person in any calendar year.

Dental benefits do not terminate with age.

YOUR ELIGIBILITY

If you are a member or applicant of The Power Sector Benefit Trust, you are eligible to be insured on the first day of the policy month coincident with or next following the day you have accumulated, and there has been recorded, at least two monthly draws in your Health & Welfare Account.

You may elect to have the necessary amount added to your Health & Welfare Account by making the required contribution to the Fund.

Your Health & Welfare Account may not exceed an amount equal to 120 times the Monthly Draw. The Monthly Draw will be deducted from your Health & Welfare Account on the first day of each policy month.

Commencement of Your Coverage

You automatically become covered on your eligibility date, provided you have completed an application.

Changes In Coverage

Changes in coverage due to dependency status will take effect on the first day of the month coincident with or next following the date of the change. You must be a Member in good standing in order for your insurance to increase. In order for the change in benefit to occur, Great-West Life must also be properly notified by the Power Sector Benefit Trust.

YOUR ELIGIBLE DEPENDENTS

Dependents eligible for benefits are either your spouse or common-law spouse and each unmarried child, step-child or common-law child who is under 19 years of age or under 25 years of age if attending an accredited educational institute, college or university on a full-time basis. Anyone who is in full-time service in any naval, military or air force will not be eligible as dependents.

Commencement of Your Dependent's Coverage

Your dependent's coverage will commence on the same date as your coverage if you request dependent coverage on your application.

If you do not request dependent coverage when you become insured and later want such coverage, you must complete an application.

Once you have dependent coverage, an additional child will automatically become insured on the date the child qualifies as your dependent. No application is necessary.

If your dependent other than a new-born is confined in a hospital when coverage should commence, coverage will not begin until your dependent's discharge.

You must complete a new application if you wish to add or change a legally married or common-law spouse, with coverage commencing on the first day of the policy month next following the date such dependant is acquired.

GENERAL HEALTH EXCLUSIONS

No amount of benefit will be payable for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of the following:

- a) intentionally self-inflicted injury while sane or insane,
- b) war, insurrection or hostilities of any kind whether or not you or your dependent were a participant in such action,
- c) participation in a riot or civil commotion,
- d) committing or attempting to commit a criminal offence or provoking an assault.

Additional exclusions are found under the respective Benefit Descriptions in this booklet.

TERMINATION OF INSURANCE

You are no longer insured from the date you have insufficient funds in your Member account to pay for the next month of coverage, or the policy terminates. Insurance terminates the day before you enter service in any naval, military or air force.

If you are a Member of The Power Sector Benefit Trust, your insurance will terminate on the last day of the month in which your Health & Welfare Account does not have an amount equal to at least one Monthly Draw.

For the rules governing reinstatement of Insurance, please see your Policy Administrator.

For benefits on termination see Conversion of Your Life Insurance under Your Life Insurance Benefit and Extension of Benefits following the health benefit description.

Life Insurance benefits may now remain in force until the death of the member at any age as long as premiums are paid through your Health & Welfare Account. As long as you are covered for the Life Insurance Benefit, you may maintain the Healthcare and Dental benefit until the death of the member.

PLEASE NOTE: Out of Country/Province Coverage and Travel Assistance will cease for both members and dependants at the member's Age 75, with a corresponding drop in the premium of the Healthcare benefit.

Survivor Benefits

In the event of the death of the member, the cost of your spouse's and dependant(s') coverage will continue to be drawn from your accumulated fund account until it runs out; where upon Survivor Benefits from the insurer commence for a period of 2 years thereafter. If you are a *pay-direct member* (where the member pays your monthly premium directly to the Trust), Survivor Benefits commence directly upon the death of the member for a period of 2 years.

After the 2 year Survivor period paid by the Insurer, should the surviving spouse wish to continue purchasing benefits on a Pay Direct basis, this option is available through the Power Sector Benefit Trust Fund. Should there be a lapse in payment, coverage is terminated and the surviving spouse cannot be returned to the plan in the future.

YOUR LIFE INSURANCE BENEFIT

Life Insurance

Flat amount of \$30,000.

Your designated beneficiary will be paid a lump sum amount in the case of your death. You may appoint one or more beneficiaries or change your appointment at any time by completing a "Change in Beneficiary Designation" form obtained from your employer. Any amount of coverage for which there is no beneficiary will be payable to your estate.

Reductions

Each Member's Life Insurance will reduce 50% on the Member's 65th birthday. The reduced coverage will continue until the Member's death.

Your designated beneficiary will be paid a lump sum amount in the case of your death. You may appoint one or more beneficiaries or change your appointment at any time by completing a "Change of Beneficiary Designation" form obtained from the Power Sector Benefit Trust. Any amount of coverage for which there is no beneficiary will be payable to your estate.

Extension of Benefits

The termination of the policy will not affect the continuation of your coverage under the Waiver of Premium provision.

Waiver of Premium

Coverage on your life will continue if you become totally disabled for at least 6 consecutive months. You must become disabled while covered before your 65th birthday. No premium payments will be required as of your date of disability.

This coverage will terminate without conversion privileges on your 65th birthday.

"Totally Disabled" means your complete inability to engage in any gainful occupation for which you are reasonably fitted by education, training or experience. Great-West Life must receive initial proof that you are totally disabled no later than 12 months after your date of disability.

Conversion of Your Life Insurance

You may convert your Group Life Coverage to an Individual Life Policy upon termination of your employment or termination of the policy. You must be under age 65 to convert but evidence of good health is not required. The individual policy will be one of the standard life insurance conversion forms available by Great-West Life or any of its affiliates. For limits on the amount of coverage that may be selected please see your employer. It may not include any provision for disability, accidental death or other special benefit.

An application and the first premium due for the individual policy must be received by Great-West Life within 31 days after the termination of your group coverage. In the case of your death during this 31 day period, the amount of coverage, subject to any limits, will be paid to your designated beneficiary.

YOUR DEPENDENT'S LIFE INSURANCE BENEFITS

Dependent's Group Life

Spouse: \$10,000
Each Child: \$5,000

Life Insurance coverage for children will commence 14 days after birth.

Reductions

If the member dies, spousal and dependant life coverage for the member's dependant(s) may continue until the death of that spouse provided that the required contributions for the survivor coverage continue to be paid. Each spouse's life insurance of \$10,000 will reduce 50% on the member's 75th birthday. The reduced coverage of \$5,000 will continue until the spouse's death.

You will be paid a lump sum amount, if living, otherwise your estate, in the case of your insured dependant's death.

Waiver of Premium

Your dependent will continue to be insured if your premiums are being waived. During such period, no premium payment will be required for this benefit. No additional dependent may become insured and there may not be any increases in the amount of insurance on your covered dependents.

Conversion of Your Dependent Life Insurance

You, if living, otherwise your spouse, may ask Great-West Life to issue an Individual Life Policy for your spouse upon termination of your employment, death, or termination of the policy. Evidence of good health is not required. The individual policy for your spouse will be one of the standard life insurance conversion forms available by Great-West Life or any of its affiliates. For limits on the amount of insurance that may be selected please see your employer. The policy may not include any provision for disability, accidental death or other special benefit.

There is no provision for the conversion of the Group Life Insurance on an Insured child.

An application and the first premium due for the Individual Policy must be received by Great-West Life within 31 days after the termination of your group coverage. In the case of your spouse's death during this 31 day period, the amount of insurance, subject to any limits, will be paid to you.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment

Flat amount of \$30,000 for each member

Reductions

Each Member's Accidental Death and Dismemberment insurance will reduce 50% on the Member's 65th birthday.

Accidental Death and Dismemberment Benefits cease on the Member's 71st birthday.

You will be paid a lump sum if you have an accident while you are insured which causes death or a loss. The loss must occur within 365 days of the accident.

In the case of loss of life, the full amount will be paid to your beneficiary as appointed in your Basic Group Life Policy.

These percentage amounts will be paid to you if an accident results in the loss or irrecoverable loss of use of:

The sight of both eyes	100%
Both hands or both feet	100%
A hand and a foot	100%
The sight of an eye and either a hand or a foot	100%
Speech and hearing in both ears	100%
An arm or a leg	75%
A hand or a foot	50%
The sight of one eye	50%
Speech or hearing in both ears	50%
Both arms and both legs (quadriplegia)	200%
Both legs (paraplegia)	200%
One arm and one leg on the same side of the body (hemiplegia)	200%

These percentage amounts will be paid if an accident results in the complete severance of:

A thumb and an index finger of a hand	25%
All four fingers of a hand	25%
All of the toes of a foot	12.5%

In no case will more than the full amount be paid for all losses resulting from one accident. If as a result of one accident you suffer a number of losses for one limb, payment will be made only for the loss providing the largest amount.

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 Travel 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

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

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 Medi-Pack 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.

Exclusions

These exclusions are in addition to those described under "General Health Exclusions":

- e) Bodily or mental infirmity or illness or disease of any kind, or medical or surgical treatment thereof.
- f) Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current airworthiness certificate, and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation. Descent from any aircraft in flight will be deemed to be part of such flight.

Note: Crew members are not covered.

- g) Taking or attempting to take your own life, whether you are in possession of your mental faculties or not at that time.
- h) In the course of operating a motor vehicle, no payment will be made if the loss or injury leading to the loss occurs while
 - i) under the influence of any intoxicant, or
 - ii) if the individual's blood alcohol concentration was in excess of 80 milligrams of alcohol per 100 millilitres of blood.

How to Submit a Claim

Claim forms are available from your employer. This form must be completed in full and submitted within 90 days from the date of loss.

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

PAY-DIRECT DRUG BENEFIT
(PLAN 88G)

Pay Direct Drugs

Your deductible per prescription is nil.

Reimbursement is 100% of eligible charges.

Maximum Dispensing fee is \$7 for each Drug Identification Number (DIN).

Pay Direct Drug benefits do not terminate with age.

The Drug Coverage on your group is being administered by the pharmacy benefits manager appointed by the plan.

Any eligible drug charge will be paid if:

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

Eligible Charges

This is a generic drug plan. The ingredient cost of the lowest priced interchangeable product will be paid unless the prescription written is for a brand name that is directed by the prescriber as not interchangeable. The prescription must bear the notation "DO NOT PRODUCT SELECT", "NO SUB", or "NO SUBSTITUTION" on the actual script in the prescriber's own handwriting in order to be eligible for payment.

Medications, prescribed in writing by a Physician or other person entitled by law to prescribe them, bearing a Drug Identification Number on their labels, listed as prescription requiring in Federal or Provincial Drug Schedules and some other non-prescription requiring drugs are covered. Included are injectable drugs, injectable vitamins, insulins, allergy extracts, oral contraceptives, extemporaneous preparations or compounds, disposable needles, disposable syringes, lancets and testing materials for monitoring diabetes and drugs in the following categories:

antimalarials	nitroglycerine
fibrinolytics	potassium replacements
fluorides, single entity	thyroid agents
iron salts, single entity	topical enzymatic debriding agents

Maintenance Drugs

Any single purchase of drugs or medicines which would be considered reasonable and customary to be consumed or used within a 4-month period.

Charges for the following are not covered whether or not they have been prescribed for medical reasons.

1. Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment, non-disposable insulin delivery devices, delivery or extension devices for inhaled medications, spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages or supplies and accessories for the above.
2. Oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition solutions whether or not prescribed for a medical reason, except where Federal or Provincial law requires a prescription for their sale.
3. Diaphragms, condoms, jellies/foams/sponges/ suppositories, intrauterine devices, contraceptive implants or appliances normally used for contraception, whether or not prescribed for a medical reason.
4. Any drug which does not have a drug identification number as defined by the Food and Drugs Act, Canada.
5. Prescriptions dispensed by a physician, clinic, dentist or in any non-accredited hospital pharmacy, or for treatment as an inpatient or out patient in any hospital, including emergency status and investigational status drugs, unless otherwise approved by Great-West Life.
6. All preventative immunization vaccines and toxoids.
7. All homeopathic preparations.
8. Items deemed cosmetic (even if a prescription is legally required) e.g. topical minoxidil, sunscreens, etc.

9. Any portion of services or supplies which the insured is entitled to receive, or for which the insured is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (“government plan”), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.
10. Smoking cessation products.
11. Supplies for recreation or sports, whether or not medically necessary.
12. Fertility Drugs.
13. Oral antihistamines.
14. Allergy extracts, compounded in a laboratory and not bearing a Drug Identification Number (DIN).

Pharmacy Benefits Manager

How Does the Pharmacy Benefits Manager Work?

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

Exclusion

This exclusion is in addition to those described under "General Health Exclusions":

- e) Any cause which entitles you or your dependent to apply for and receive indemnity or compensation under any Workers' Compensation Act.

Lost or Stolen Cards

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

A temporary card can be printed by going to www.psbtc.ca and registering as a Groupnet member.

HEALTHCARE

Healthcare

Your deductible per calendar year is nil.

Reimbursement is 100% of eligible charges.

Healthcare benefits, excluding Emergency Out-of country/province treatment and Travel Assistance, do not terminate with age.

Emergency Out-of country/province treatment and Travel Assistance benefits terminate at age 75.

Healthcare Coverage includes:

Nursing Care

Nursing Care Outside Your Home

Ambulance

Aids, Services & Supplies

Accidental Dental

Emergency Treatment

Travel Assistance Benefit

Diagnostic Test

Speech Therapy

Massage Therapy

Clinical Psychology

Hearing Aids

Visioncare

Paramedical Services

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

1. It is medically necessary for the treatment of bodily injury, illness or disease.
2. It is reasonable and customary.
3. It is recommended and authorized by a physician or surgeon legally licensed to practise medicine.
4. Payment for services covered under this plan is not prohibited by the Provincial Government (plan) in your province of residence.
5. It is not more than the difference between the actual cost of the charge and the amount you are entitled to apply for and receive under any Government Sponsored plan in your province or territory of residence.

Pre-Authorization For Treatment or Purchases Over \$500.00

If any expense is estimated to be greater than \$500.00, it is recommended that you submit a "Pre-determination" to Great-West Life.

A Pre-determination is simply an outline of the required aid services or supplies which is prepared, by your physician, prior to any treatment or purchase. Great-West Life will advise you of the portion that is covered by the Benefit plan, enabling you to determine your costs.

Nursing Care

The services of a registered nurse or registered nursing assistant at your residence up to an individual maximum of \$5,000 per calendar year; subject to prior approval by Great-West Life. From January 1st coincident with or next following your or your dependant's 65th birthday until his death, the maximum payable is \$25,000 lifetime.

Note: The services will not be considered as eligible expenses while you or your dependant are residing in a nursing home, home for the aged, rest home or any other facility providing similar care, or confined in a Licensed Hospital.

Payment will not be made for services which are for custodial care and do not require the skill of a registered nurse or registered nursing assistant.

The services will not be considered as eligible expenses if the RN or RNA is normally resident in your home.

Nursing Care Outside Your Home

Nursing Care outside your home will be covered, provided that it is for active treatment or convalescent care provided by a legally licensed Nursing Home or other facility on the recommendation of licensed physician. The maximum benefit will be \$5,000 per calendar year.

Ambulance

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

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

Aids, Services & Supplies

Custom made Orthopaedic shoes and adjustments to stock item footwear, as an integral part of a brace and custom-made boots, when prescribed by a podiatrist or physician.

Custom made foot orthotics which are medically necessary for the insured person's regular daily living activities and not solely for recreation or sport.

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

Sleep apnea and heart rate monitor.

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

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

Oxygen.

Blood and blood products when required for transfusion.

Colostomy and ileostomy supplies.

Catheterization equipment.

Neuromuscular stimulants.

Radium and radioactive isotope treatments.

Continuous Passive Motion Equipment (CPM), provided it is recommended by a legally licensed physician. The maximum charge is \$500 per occurrence.

Insulin pumps and/or devices for the automatic injection of insulin when medically required for the treatment of diabetes when alternative methods of injection are inadequate and it has been prescribed by a diabetic specialist. The maximum charge is \$7,000 per lifetime, not subject to the reasonable and customary charge requirement.

Enhanced external counter pulsation therapy, provided it is Medically Necessary for the treatment of acute angina, alternative medical treatments have been pursued, it is recommended by a cardiovascular specialist and it is performed by a fully licensed facility authorized to perform such treatments, up to a maximum of \$7,000 per lifetime for each Person.

Incontinence supplies.

2 pairs of surgical stockings (compression hose) per calendar year.

Wigs for hair loss as a result of illness or injury or as a result of medical treatment for any disease, once every 3 calendar years. A physician's prescription is required.

Accidental Dental

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

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

- The treatment is necessitated by a direct accidental blow to the mouth and not by an object or food placed wittingly or unwittingly in the mouth.
- The accidental blow occurs while the person is insured.
- The treatment is received within twelve months after the accidental blow.
- The treatment is the least expensive that will provide a professionally adequate treatment.
- No payment will be made for any part of the charge which exceeds the amount shown for the treatment in the current Dental Association Schedule of Fees for General Practitioners in your province of residence.
- If treatment is to be received more than 90 days after the accidental blow, a treatment plan must be submitted to Great-West Life within 90 days of the accident.

Emergency Treatment

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

We will cover the first 180 days of a trip. This limitation is not applicable to in-Canada emergency health care benefits.

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

Hospital services and supplies furnished by a Licensed Hospital.

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

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

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

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

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

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

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

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

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

PLEASE NOTE: Out-of-Country/Province Coverage and Travel Assistance will cease for both members and dependents at the member's age 75, with a corresponding drop in the premium of the Healthcare benefit.

Travel Assistance Benefit

The following services with respect to medical and personal emergencies required by you or your dependent while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

We will cover the first 180 days of a trip. This limitation is not applicable to in-Canada emergency health care benefits.

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

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

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

Note: For specific details, please refer to your Great-West Life Travel Assistance brochure which can be obtained through your employer.

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

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

PLEASE NOTE: Out-of-Country/Province Coverage and Travel Assistance will cease for both members and dependents at the member's age 75, with a corresponding drop in the premium of the Healthcare benefit.

Diagnostic Test

Diagnostic tests, which include Prostate Exams [PSA], Ovarian Cancer Exams [CA 125], Anti-Cardiolipin Antibodies tests, Human Papillomavirus (HPV) tests, radium treatments and X-ray examinations, excluding dental X-rays, that are incurred in your province or territory of residence when coverage is not available under the provincial government.

Speech Therapy

The services of a registered speech therapist, who is not normally resident in the covered person's home, up to an individual maximum of \$300 per calendar year.

Massage Therapy

The services of a qualified massage therapist, who is not normally resident in the covered person's home, up to an individual maximum of \$300 per calendar year. The services must be recommended by a licensed physician.

Clinical Psychology

The services, personally performed, by a registered clinical psychologist registered in the province or territory where the services are rendered, up to an individual maximum of \$300 per calendar year.

These services will not be considered as eligible expenses if the registered clinical psychologist is normally resident in your home.

Hearing Aids

The purchase of hearing aids and repairs, fittings and adjustments, excluding batteries, up to an individual maximum of \$300 every 2 calendar years.

Vision Care

Prescription eye glasses or contact lenses and the fittings of such eyewear for the purpose of correcting vision are subject to a combined maximum of \$225 in any two consecutive calendar years

Eye examinations are covered to a maximum of \$80 for each individual every two consecutive calendar years. This is in addition to the \$225 in Vision Care maximum above.

A pair of contact lenses up to a lifetime maximum of \$225 in any 2 consecutive calendar years, if visual acuity is improved to at least a 20/40 level and this level of acuity is not possible through wearing eye glasses accompanied by a letter of verification. Otherwise, contact lenses are subject to the maximum as stated for eye glasses.

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

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

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

Preferred Vision Services (PVS) Discount

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

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

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

You 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 hearing aid is purchased, or at the initial consultation for laser eye surgery
- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Paramedical Services

The maximum amount payable per classification of practitioner is \$300 in any calendar year.

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

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

- Chiropractors
- Osteopaths
- Podiatrist or Chiropodists
- Naturopaths
- Acupuncturists
- Physiotherapists

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

If you live in Ontario, no payment for podiatrists expenses will be made until you or your dependent reach the annual OHIP maximum for such services.

Exclusions

These exclusions are in addition to those described under "General Health Exclusions":

- e) Any cause which entitles you or your dependent to apply for and receive indemnity or compensation under the Workers' Compensation Act.
- f) An examination by, or the services of, a physician or surgeon, if required solely for the use of a third party.
- g) Any treatment to correct temporomandibular joint dysfunction.
- h) Any service or treatment which you or your dependent would receive without being charged.
- i) Any treatment deemed cosmetic.
- j) Any service incurred under this plan for which payment is prohibited by the Provincial Government plan in your province or territory of residence.
- k) Any hospital accommodations.

Extension of Benefits

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

How to Submit a Claim

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

This form must be completed in full and submitted within 180 days after the end of the calendar year in which the claim was incurred.

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

For claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a claim form from your employer. This form must be completed in full and submitted with the original bills within 180 days after the end of the calendar year in which the claim was incurred.

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

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

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

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

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

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

DENTAL BENEFIT

Dental

Great-West Life will pay on the basis of the current year's Dental Association Suggested Schedule of Fees for General Practitioners as of the 1st of the month following the month in which Great-West Life receives the new Schedule.

Your deductible per calendar year is nil.

Dental 1 and 2 Services

Reimbursement is 100% of Insured Charges.

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

Dental 3

Reimbursement is 50% of eligible charges.

The overall maximum is \$1,500 per person in any calendar year.

Dental benefits do not terminate with age.

If you or your dependent require any covered treatments or services, you will be reimbursed for such charges but only to the extent:

- that they are the least expensive service, supply or method of treatment which the plan determines will produce a professionally adequate result,
- that if the charge exceeds the least expensive service, the plan may provide payment based on the cost of alternative services which are defined in this provision as eligible charges,
- that the treatment for it has been performed, recommended or approved by a legally licensed dentist, denturist, or dental hygienist entitled by law to practise independently,
- that the plan is not prohibited from paying it by any applicable law of the jurisdiction where you reside at the time the charge is incurred.

Assignment of Benefits

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

Important Note

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

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

Pre-Authorization For Treatment Over \$500

If dental expenses are estimated to be greater than \$500, you must submit a "Pre-determination" to the plan. A Pre-determination is simply an outline of the proposed treatment which is prepared, by your dentist, prior to any work being performed. The plan will advise you of the portion that is covered by your company dental plan, enabling you to determine your costs.

Note: In order to determine benefits payable, the plan may require additional information such as:

1. A complete dental chart showing extractions, missing teeth, fillings, prostheses, periodontal pocket depths, and the date of any work previously done.
2. An itemized claim form for all dental care.
3. Pre-operative x-rays, study models, and laboratory reports.

The plan cannot pay the dental claim until the additional information requested is submitted to us.

Dental 1 Charges

This coverage includes:

Diagnostic

X-Rays

Tests

Preventative

Minor Restorative

Minor Surgical

Additional Services

A. Diagnostic

- (1) Clinical (Complete) Examinations (not more than 1 examination per dentist):

01101, 01102, 01103, 01201, 01301, 01401, 01501, 01601, 01701, 01801 (other than in the Province of Quebec).

01110, 01115, 01120, 01125, 01130, 01135, 01500, 01605, 01717, 01805 (in the Province of Quebec).

- (2) Recall Examinations (not more than 1 examination in any period of 9 consecutive months for insured age 19 and up, and 1 examination in any period of 6 consecutive months for dependent children of the insured under age 19):

01202, (other than in the Province of Quebec).

01200 (in the Province of Quebec).

- (3) Specific Examinations:
01204, 01302, 01402, 01502, 01602, 01702, 01703, 01802 (other than in the Province of Quebec).

01400 (in the Province of Quebec).

- (4) Emergency Examination:

01205 (other than in the Province of Quebec).

01300 (in the Province of Quebec).

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

B. X-Rays

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

02102 (other than in the Province of Quebec).

The Quebec Dental Association Suggested Fee Guide does not list codes for this procedure.

- (2) Panorex (not more than once in any period of 36 consecutive months):

02601 (other than in the Province of Quebec).

02600 (in the Province of Quebec).

- (3) Periapical (not more than 16 films in any period of 36 consecutive months):

02111 to 02125 inclusive (other than in the Province of Quebec).

02111 to 02116 inclusive (in the Province of Quebec).

- (4) Bitewing (not more than 4 films in any period of 12 consecutive months):

02141 to 02144 inclusive (in all Provinces).

- (5) Occlusal:

02131 to 02134 inclusive (other than in the Province of Quebec).

02131, 02132 (in the Province of Quebec).

C. Tests

- (1) Biopsy of Oral Tissue:

04311 to 04313 inclusive, 04321, 04322, 04323 (other than in the Province of Quebec).

04302, 04311, 04312 (in the Province of Quebec).

- (2) Pulp Vitality Test (not in conjunction with Root Canal Therapy if rendered within 30 days):

04501, 04509 (other than in the Province of Quebec).

The Quebec Dental Association Suggested Fee Guide does not list codes for this procedure.

D. Preventive

- (1) Polishing (not more than once in any period of 9 consecutive months for insured age 19 and up, and not more than once in any period of 6 consecutive months for dependent children of the insured under age 19, with a maximum of 1 unit per recall visit):

11101, 11102, 11107, 11109 (other than in the Province of Quebec).

11100, 11200, 11300 (in the Province of Quebec).

- (2) Recall Scaling (not more than once in any period of 9 consecutive months for insured age 19 and up, and not more than once in any period of 6 consecutive months for dependent children of the insured under age 19, with a maximum of 1 unit per recall visit):

11111 to 11117 inclusive, 11119 (other than in the Province of Quebec).

The Quebec Dental Association Suggested Fee Guide does not list codes for this procedure.

- (3) Preventive Recall Package (not more than one in any period of 9 consecutive months for insured age 19 and up, and not more than one in any period of 6 consecutive months for dependent children of the insured under age 19):

11201 to 11203 inclusive, 11301 to 11303 inclusive (other than in the Province of Quebec). It is provided, however, that 11301 to 11303 inclusive will apply only to an Insured while he is under 19 years of age.

The Quebec Dental Association Suggested Fee Guide does not list codes for this procedure.

- (4) Fluoride (This applies only to a dependent child of the Insured while he is under 19 years of age. Not more than 1 in any period of 6 consecutive months):

12101 (other than in the Province of Quebec).

12400 (in the Province of Quebec).

- (5) Oral Hygiene Instruction (No more than once in a lifetime period):

13211 (other than in the Province of Quebec).

13200 (in the Province of the Quebec).

- (6) Pit and Fissure Sealants (This applies only to an Insured while he is under 19 years of age. Not more than once per posterior tooth in any period of 36 consecutive months):

13401, 13409 (other than in the Province of Quebec).

13401, 13404 (in the Province of the Quebec).

- (7) Space Maintainers (This applies only to the Dependent children of an Member while they are under 15 years of age):

15101 to 15104 inclusive, 15201, 15202, 15301, 15302, 15401 to 15403 inclusive, 15501 (other than in the Province of Quebec).

15100, 15110, 15111, 15120, 15200, 15210, 15400 (in the Province of Quebec).

- (8) Space Maintainers Maintenance (This applies only to the Dependent children of an Member while they are under 15 years of age):

15601 to 15604 inclusive (other than in the Province of Quebec).

The Quebec Dental Association Suggested Fee Guide does not list codes for this procedure.

E. Minor Restorative

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

Charges for finishing or polishing are not an eligible expense.

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

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

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

21111 to 21115 inclusive, 21121 to 21125 inclusive, 21211 to 21215 inclusive, 21221 to 21225 inclusive, 21231 to 21235 inclusive (other than in the Province of Quebec).

21101 to 21105 inclusive, 21121 to 21125 inclusive, 21211 to 21215 inclusive, 21221 to 21225 inclusive, 21231 to 21235 inclusive, 21241 to 21245 inclusive (in the Province of Quebec)
- (2) Tooth Coloured (Only if more than 24 consecutive months have elapsed since the last restoration):

23101 to 23105 inclusive, 23111 to 23115 inclusive, 23211 to 23215 inclusive, 23221 to 23225 inclusive, 23311 to 23315 inclusive, 23321 to 23325 inclusive, 23401 to 23405 inclusive, 23411 to 23415 inclusive, 23501 to 23505 inclusive, 23511 to 23515 inclusive (other than in the Province of Quebec).

23111 to 23115 inclusive, 23118, 23211 to 23215 inclusive, 23221 to 23225 inclusive, 23311 to 23315 inclusive, 23411 to 23415 inclusive (in the Province of Quebec).
- (3) Retentive Pins:

21401 to 21405 inclusive (other than in the Province of Quebec).

21301 to 21304 inclusive (in the Province of Quebec).
- (4) Caries, Trauma, Pain Control (Only when placed on a separate date from the final restoration):

20111, 20119, 20121, 20129 (in all Provinces).
- (5) Veneer Applications, other than for cosmetic purposes (Only if more than 24 consecutive months have elapsed since the last restoration):

23121, 23122 (other than in the Province of Quebec).

23122 (in the Province of Quebec).

- (6) Stainless Steel, Plastic and Polycarbonate full coverage restorations (This applies only to the Dependent children of a Member while they are under 14 years of age. No more than once per tooth in any period of 36 consecutive months):

22201, 22202, 22211, 22212, 22301, 22302, 22311, 22312, 22401, 22411, 22501, 22511 (other than in the Province of Quebec).

27403, 27413, 27421 to 27424 inclusive (in the Province of Quebec).

F. Minor Surgical

- (1) Extractions:

71101, 71109, 71201, 71209, 72111, 72119, 72211, 72219, 72221, 72229 (other than in the Province of Quebec, but the maximum Benefit payable for the extraction of maxillary (upper) third molars will not exceed the fee for procedure code 72211).

71101, 71111, 72100, 72210, 72220, 72230 (in the Province of Quebec, but the maximum Benefit payable for the extraction of maxillary (upper) third molars will not exceed the fee for procedure code 72220).

- (2) Residual Root Removal:

72311, 72319, 72321, 72329, 72331, 72339 (other than in the Province of Quebec).

72300, 72310, 72320 (in the Province of Quebec).

G. Additional Services

- (1) Anaesthesia, used in conjunction with an eligible dental procedure:

92212 to 92219 inclusive, 92301 to 92309 inclusive, 92411 to 92419 inclusive, 92421 to 92429 inclusive, 92431 to 92439 inclusive, 92441 to 92449 inclusive, 92451 to 92459 inclusive (other than in the Province of Quebec).

92201, 92310, 92311 (in the Province of Quebec).

Dental 2 Charges

This coverage includes:

Endodontics

Periodontics

Removable Prosthodontics – Related treatment

A. Endodontics

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

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

32221, 32222, 32231, 32232 (other than in the Province of Quebec).

32201, 32202, 32210 (in the Province of Quebec).

- (2) Root Canal Therapy:

33111, 33121, 33131, 33141, 33401 to 33403 inclusive. (other than in the Province of Quebec)

33100, 33200, 33300, 33400 (in the Province of Quebec)

- (3) Apexification:

33601 to 33604 inclusive. (other than in the Province of Quebec)

33521 to 33523 inclusive (in the Province of Quebec)

- (4) Periapical Services:
34111, 34121, 34122, 34131 to 34133 inclusive, 34141, 34151, 34161 to 34163 inclusive (other than in the Province of Quebec)
34101, 34111, 34201, 34203 (in the Province of Quebec).
- (5) Root Amputation:
34411, 34412. (other than in the Province of Quebec)
34401, 34402. (in the Province of Quebec)
- (6) Hemisection:
34421 to 34423 inclusive. (other than in the Province of Quebec)
39230. (in the Province of Quebec)
- (7) Intentional Removal, Apical Filling and Reimplantation:
34451 to 34453 inclusive. (in all Provinces)
- (8) Retrofilling:
34211, 34221, 34222, 34231 to 34233 inclusive, 34241, 34251, 34261 to 34263 inclusive. (other than in the Province of Quebec)
34201, 34203 (in the Province of Quebec)

B. Periodontics

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

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

- (1) Non-Surgical Procedures:
41101 to 41104 inclusive, 41109, 41301, 41302 (other than in the Province of Quebec).
41200, 41300 (in the Province of Quebec).
- (2) Definitive Surgical Procedures:
42111, 42201, 42311, 42321, 42339, 42411, 42421, 42431, 42441, 42451, 42511, 42521, 42531 (other than in the Province of Quebec).
42001 to 42003 inclusive, 42010, 42100, 42101, 42200, 42300 (in the Province of Quebec).
- (3) Adjunctive Surgical Procedures:
42821, 42822, 42831, 42832 (other than in the Province of Quebec).
42720 (in the Province of Quebec).
- (4) Occlusal Equilibration (not more than 4 units in any calendar year):
43311 to 43314 inclusive, 43317, 43319, (other than in the Province of Quebec).
43300, 43310 (in the Province of Quebec).
- (5) Scaling and/or Root Planing (not more than 10 units in any calendar year):
11111 to 11117 inclusive, 11119, 43421 to 43427 inclusive, 43429 (other than in the Province of Quebec).
43411 to 43414 inclusive, 43417, 43419, 42000, 42001 (in the Province of Quebec).

- (6) Periodontal Appliances including impression and insertion (not more than 1 appliance per arch in any period of 24 consecutive months):

43611, 43612 (in all Provinces).

- (7) Periodontal Appliance Repair, Maintenance and Adjustments (not more than 4 adjustments in any calendar year):

43621 to 43623 inclusive, 43629 (other than in the Province of Quebec).

43622 (in the Province of Quebec).

C. Removable Prosthodontics - Related Treatment

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

54201, 54202, 54209 (other than in the Province of Quebec).

54250 (in the Province of Quebec).

- (2) Denture Repairs:

55101, 55102, 55201 to 55203 inclusive, 55301, 55302, 55401 to 55403 inclusive (other than in the Province of Quebec).

55101 to 55104 inclusive, 55201 to 55204 inclusive, 55520, 55530 (in the Province of Quebec).

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

56211 to 56213 inclusive, 56221 to 56223 inclusive, 56231 to 56233 inclusive, 56241 to 56243 inclusive, 56311 to 56313 inclusive, 56321 to 56323 inclusive, (other than in the Province of Quebec).

56200 to 56202 inclusive, 56210 to 56212 inclusive, 56220 to 56222 inclusive, 56230 to 56232 inclusive, 56260 to 56263 inclusive, 56280, 56290 (in the Province of Quebec).

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

56511 to 56513 inclusive, 56521 to 56523 inclusive (other than in the Province of Quebec).

56270 to 56273 inclusive (in the Province of Quebec).

D. Major Surgical

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

Post-treatment evaluation is not an eligible expense.

- (1) Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty:

73111, 73121, 73151 to 73154 inclusive, 73161, 73171, 73172, 73181 to 73184 inclusive, 73211, 73411 (other than in the Province of Quebec).

73100, 73110, 73133 to 73135 inclusive, 73140, 73150, 73151, 73171 to 73176 inclusive, 73181 to 73186 inclusive, 73381 to 73384 inclusive, 73401 to 73404 inclusive (in the Province of Quebec).

- (2) Surgical Excision:

74111 to 74118 inclusive, 74631 to 74638 inclusive (other than in the Province of Quebec).

74108, 74109, 74408, 74409, 74410 (in the Province of Quebec).

- (3) Surgical Incision:

75111, 75112, 75121, 75122, 75301, 75302 (other than in the Province of Quebec).

75100, 75110 (in the Province of Quebec).

(4) Fractures:

76201 to 76204 inclusive, 76301 to 76305 inclusive, 76911 to 76913 inclusive, 76921 to 76924 inclusive, 76931 to 76934 inclusive, 76941, 76949, 76951, 76952, 76959, 76961, 76962 (other than in the Province of Quebec).

76210, 76310, 76910 to 76913 inclusive, 76950, 76951 (in the Province of Quebec).

(5) Frenectomy:

77801 to 77803 inclusive (in all Provinces).

(6) Miscellaneous:

79111 to 79113 inclusive, 79311 to 79314 inclusive, 79321, 79322, 79331, 79333, 79341, 79343, 79401, 79402, 79602 (other than in the Province of Quebec).

79104 to 79106 inclusive, 79301, 79303 to 79306 inclusive, 79308, 79400, 79401, 79601 (in the Province of Quebec).

Dental 2 Extension of Insurance

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

1. Termination of an Member's employment.
2. The Member ceases to qualify under the definition of Member.
3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 2 Extension of Insurance on Replacement of this Policy

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

Dental 3 Charges

This coverage includes:

Major restorative

Removable Prosthodontics

Fixed Prosthodontics

A. Major Restorative

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

(1) Inlay/Onlay Restorations:

25111 to 25114 inclusive, 25121 to 25124 inclusive, 25131 to 25134 inclusive, 25141 to 25143 inclusive, 25511, 25521, 25531 (other than in the Province of Quebec).

25121 to 25123 inclusive, 25521 (in the Province of Quebec).

(2) Retentive pins in Inlays, Onlays and Crowns:

25601 to 25605 inclusive (other than in the Province of Quebec).

25601 to 25604 inclusive (in the Province of Quebec).

(3) Crowns:

27111, 27131, 27151, 27201, 27211, 27221, 27301, 27311 (other than in the Province of Quebec).

27100, 27110, 27200, 27210, 27300, 27310 (in the Province of Quebec).

- (4) Veneer Applications, other than for cosmetic purposes:

27601, 27602 (other than in the Province of Quebec).

23121 (in the Province of Quebec).

- (5) Other Services:

21301, 21302, 23601, 23602, 25711 to 25713 inclusive, 25721 to 25723 inclusive, 25731 to 25733 inclusive, 25741 to 25743 inclusive, 25751 to 25756 inclusive, 25761 to 25766 inclusive, 27711, 27721, 29101, 29102, 29301, 29302 (other than in the Province of Quebec).

25751 to 25753 inclusive, 27700, 27701, 27710, 27711, 29100, 29300, 29501 to 29503 inclusive, 29600 (in the Province of Quebec).

B. Removable Prosthodontics

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

- (1) Complete Dentures:

51101 to 51103 inclusive, 51301 to 51303 inclusive, (other than in the Province of Quebec).

51100, 51110, 51120, 51300, 51310, 51320 (in the Province of Quebec).

- (2) Transitional Dentures:

51601 to 51603 inclusive, 52101 to 52103 inclusive (other than in the Province of Quebec).

51600, 51610, 51620, 52120, 52121 (in the Province of Quebec).

(3) Acrylic Dentures :

52111 to 52113 inclusive, 52201 to 52203 inclusive, 52211 to 52213 inclusive, 52301 to 52303 inclusive, 52311 to 52313 inclusive, 52401 to 52403 inclusive, 52411 to 52413 inclusive, 52501 to 52503 inclusive, 52511 to 52513 inclusive (other than in the Province of Quebec).

52120 to 52124 inclusive, 52230 to 52232 inclusive (in the Province of Quebec).

(4) Cast Partial Dentures:

53101 to 53103 inclusive, 53111 to 53113 inclusive, 53201 to 53203 inclusive, 53205, 53211 to 53213 inclusive, 53215, 53301, 53302, 53701 to 53703 inclusive, 53711 to 53713 inclusive (other than in the Province of Quebec).

52400, 52410, 52420, 52500, 52510, 52520, 52530 (in the Province of Quebec).

C. Fixed Prosthodontics

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

(1) Pontics:

62101, 62501, 62701, 62702 (other in the Province of Quebec).

62000, 62100, 62510, 62700, 62702 (in the Province of Quebec).

(2) Retainers and Abutments:

67101, 67102, 67111, 67121, 67129, 67131, 67161, 67171, 67181, 67201, 67202, 67211, 67221, 67231, 67241, 67251, 67301, 67311, 67321, 67322, 67331, 67341 (other than in the Province of Quebec).

65500, 65510, 67101, 67200, 67210, 67410, 67721 to 67723 inclusive (in the Province of Quebec).

(3) Repairs:

66211 to 66213 inclusive, 66221 to 66223 inclusive 66301, 66302, 66711, 66719 (other than in the Province of Quebec).

66600, 66610, 66620, 66710, 66720 (in the Province of Quebec).

(4) Retentive Pins in Retainers and Abutments:

69301 to 69305 inclusive (other than in the Province of Quebec).

69701 to 69704 inclusive (in the Province of Quebec).

Dental 3 Extension of Insurance

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

1. Termination of an Member's employment.
2. The Member ceases to qualify under the definition of Member.
3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 3 Extension of Insurance on Replacement of this Policy

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

Dental 3 Limitations

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

1. The existing crown, inlay, onlay, denture or bridgework cannot be made serviceable.
2. The denture or bridgework replacement is for an equivalent denture or bridgework.
3. The existing denture or bridgework is an immediate temporary denture or bridgework, for which impressions were taken while the Insured is covered under this provision. The permanent replacement denture or bridgework must be placed within 12 months from the date of installation of the immediate temporary denture or bridgework.
4. The existing denture or bridgework is replaced because additional teeth have been extracted after the denture or bridgework insertion, and while the Insured is covered under this provision.

Exclusions

No amount of Benefit will be payable under this provision for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- Intentionally self-inflicted injury.
- War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.
- Participating in any riot or civil commotion.
- Committing or attempting to commit a criminal offence or provoking an assault.
- Any cause for which you may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- Any Group or Policyholder-Sponsored dental care or treatment.
- Any dental care or treatment for which you are not legally obliged to pay.
- Any dental care or treatment which is principally for cosmetic purposes.
- Any appointments not kept or for the completion of claim forms.
- Any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction.
- Any endodontic treatment commencing before you or your dependent became insured under this benefit.
- Replacement of mislaid, lost or stolen appliances.

- Any crowns placed on teeth that are not functionally impaired by incisal or cuspal damage.
- Any crowns, bridges or dentures for which tooth preparations were made before you or your dependent became covered under this benefit, except as required to be consistent with the terms of the applicable Extension of Insurance on Replacement of the Policy section.
- Any charges incurred for other than metal only crowns or pontics, posterior to the second bicuspid tooth.
- Any procedures, appliances, or restorations used to increase vertical dimension, or to repair or restore teeth damaged or worn due to attrition or vertical wear, or to restore occlusion.
- Any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants.

How To Submit a Claim

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

Claims must be submitted to Great-West Life within 180 days after the end of the calendar year in which the claim was incurred.

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

For claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form from your employer. For prompt payment, it is necessary that the claim form be completed in full.

Account bills or receipts for incurred covered charges in any calendar year under the Dental Benefit should be mailed directly to the Group Health Claims Department at Great-West Life on a monthly basis whenever possible.

A claim form must be completed in full and submitted with original bills within 180 days after the end of the calendar year in which the claim was incurred for all covered charges. Your dental service provider will be required to complete a section of the form so it would be advisable to take the form with you on your appointment.

COORDINATION OF BENEFITS

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

Order of Benefit Determination

Payment of benefits will be decided in the following manner.

1. If another plan does not contain a Coordination of Benefits provision, the benefits of that plan will be deemed payable prior to the application of benefits under this plan.
2. If another plan does contain a Coordination of Benefits provision, the benefits of that plan will be coordinated with our benefits as follows:
 1. If your spouse has coverage under another plan, his/her charges must first be submitted under that plan.
 2. Charges for dependent children should first be submitted to the plan of the parent whose month and date of birth comes earlier in the calendar year (excluding the year of birth).

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

THIRD PARTY LIABILITY

If you or your dependent have the right to recover damages from any person or organization with respect to which benefits are payable by the plan, you will be required to reimburse the plan in the amount of any benefits paid out of the damages recovered.

The term damages will include any lump sum or periodic payments received with respect to:

- (1) past, present or future loss of income, and
- (2) any other benefits, otherwise payable by the plan.

If you or your dependent receive a lump sum payment under judgement or settlement for benefits which would otherwise be payable by the plan, no further benefits will be paid by the plan until the benefits that would otherwise be payable equal the amount of the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse the plan the amount that reasonably reflects the loss of benefits that would otherwise be payable by the plan.

You or your dependent must notify us of any action commenced against a third party and of any judgement or settlement in the circumstances described above.

PHYSICAL EXAMINATION AND AUTOPSY

A physician of the plan's choice may be required to examine anyone in respect to a claim. If required, payment will only be considered after the examination. The plan will pay all expenses of such examination. In the case of death, an autopsy may be performed.

LEGAL ACTION

No action or proceeding against Great-West Life concerning a claim may be started within sixty days of the date on which initial proof of the claim is given to Great-West Life, or more than one year (or longer by law) after the end of the period when initial proof of claim is required.

PURPOSE OF THIS BOOKLET

These booklet pages are provided solely for the purpose of explaining the principal features of the Group Plan. All rights with respect to your benefits as a member of the plan will be governed by the Group Plan issued by The Great-West Life Assurance Company.

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