

# Group Benefit Plan



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



**Lambton Kent**  
**District School Board**  
*Student Achievement ✓ Community Success*

**Secondary Occasional Teachers**  
**Division 2**

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](http://www.greatwestlife.com).

#### **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 1-800-263-5742.

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This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy No. 153336** (Employee Life Insurance and Global Medical Assistance) and **Plan Document No. 51804** (Employee Life Insurance and Global Medical Assistance) 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**



and arranged by

Modern Benefit Planning  
150 Ouellette Place  
Windsor, ON N8X 1L9

## Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. When you apply for coverage or benefits, we establish a confidential file of personal information. 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.

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

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- 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, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us when necessary to administer the plan.

All claims under this plan are submitted through you as plan member. We may exchange personal information about claims with you and a person acting on your behalf when necessary to confirm eligibility and to mutually manage the claims.

For more information about our privacy guidelines, please ask for Great-West Life's **Privacy Guidelines** brochure.

## **Liability for Benefits**

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

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# Benefit Summary

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

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<b>Employee Life Insurance</b>	\$20,000, reducing by 50% at age 65
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## Healthcare

### Deductibles

In-Canada Prescription Drug Expenses	
- individual	\$25 each calendar year
- family	\$25 each calendar year
All Other Expenses	Nil

Reimbursement Level	100%
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### Basic Expense Maximums

Hospital	Private or semi-private room
Home Nursing Care	90 eight-hour shifts each calendar year
Chronic Care	\$3 per day to a maximum of 120 days each calendar year
In-Canada Prescription Drugs	Included
Hepatitis B Vaccines	3 injections
Rabies Vaccines	6 doses
Fertility Drugs	\$18,000 lifetime
Hearing Aids	\$500 every 3 years
Custom-fitted Orthopedic Shoes	Included
Custom-made Foot Orthotics	2 pairs each calendar year to a maximum of \$400 per pair

Braces	1 per body part every 2 years
Myoelectric Appliances	An amount equal to the amount that would be paid for standard artificial limbs
External Breast Prosthesis	Included
Surgical Brassieres Following Mastectomy	6 every 12 months
Mechanical or Hydraulic Patient Lifters	\$2,000 per lifter once every 5 years
Outdoor Wheelchair Ramps	\$2,000 lifetime
Blood-glucose Monitoring Machines, External Insulin Infusion Pumps and Needleless Insulin Jet Injectors	\$1,000 each calendar year
Extremity Pumps for Lymphedema	\$1,500 lifetime
Custom-made Compression Hose	6 pairs each calendar year
Wigs for Cancer Patients	1 lifetime

#### Paramedical Expense Maximums

Chiropractors	\$7 per visit 20 visits each calendar year \$25 for x-rays each calendar year
Chiropodists	\$7 per visit 20 visits each calendar year
Dieticians	\$200 each calendar year
Physiotherapists	\$12.20 per visit
Podiatrists	\$7 per visit 20 visits each calendar year
Naturopaths	\$7 per visit 20 visits each calendar year
Osteopaths	\$7 per visit 20 visits each calendar year
Psychologists/Social Workers	\$420 each calendar year
Speech Therapists	\$260 each calendar year
Massage Therapists	\$225 each calendar year

### Visioncare Expense Maximums

Eye Examinations	\$75 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery	\$325 every 24 months

Lifetime Healthcare Maximum                      Unlimited

### Dentalcare

Payment Basis    The dental fee guide in effect in your province of residence one year prior to the date treatment is rendered

Deductible     Nil

### Reimbursement Levels

Basic Coverage	100%
Major Coverage	50%
Orthodontic Coverage	50%
Accidental Dental Injury Coverage	100%

### Plan Maximums

Basic Treatment	Unlimited
Major Treatment	
- tooth-coloured retainers and pontics on molars	\$50 per occurrence
- all other major treatment	\$2,500 each calendar year
Orthodontic Treatment	\$2,500 lifetime
Accidental Dental Injury Treatment	Unlimited

## **COMMENCEMENT AND TERMINATION OF COVERAGE**

You are eligible to participate in the plan on the date your employment begins.

- You must apply for coverage no later than 31 days after you become eligible. After 31 days, you must provide evidence of good health 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.

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.
- 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 90 days or until they no longer qualify, whichever happens first, provided the applicable premium payments are continued.

## DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

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

- Your unmarried children under age 21, or under age 25 if they are full-time students.

Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

## **EMPLOYEE LIFE INSURANCE**

You may name a beneficiary for your life insurance and change that beneficiary at any time by completing a form available from your employer. On your death, your employer will explain the claim requirements to your beneficiary. Great-West Life will pay your life insurance benefits to your beneficiary.

- If you become disabled while insured, you may be entitled to have your life insurance continued without premium payment throughout the benefit period. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Great-West Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your employer for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.
- If any or all of your insurance terminates before age 71, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your employer for details.

## HEALTHCARE

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

The plan covers 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.

### Covered Expenses

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

For ambulance transportation, pay the hospital the amount OHIP does not cover, then submit your paid receipt for reimbursement.

- Private or semi-private room and board in a hospital in Canada for acute, convalescent or palliative care which are defined as:
  - 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.

For out-of-province accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in your home province is 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.

Services intended primarily as custodial care are not covered.

- Home nursing services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse

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

- Chronic care, provided in a hospital, nursing home or for home nursing care, for a condition where improvement or deterioration is unlikely within the next 12 months
- Drugs and drug supplies described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care provision.
  - Drugs which require a written prescription, including oral contraceptives
  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered
  - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips
  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug
  - Certain other drugs that do not require a prescription by law may be covered when they are prescribed. If you have any questions, contact your plan administrator before incurring the expense.

The plan will also pay for preventative immunization vaccines and toxoids.

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, including modifications to orthopedic footwear, when prescribed by a physician. A letter from the physician must be submitted stating the diagnosis, price and material used.
- Custom-made foot orthotics, including arch supports, when prescribed by a physician. The physician's prescription must be renewed every 9 months.
- 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. Scales, cookbooks and carrying cases for insulin are not covered.
- External insulin infusion pumps recommended by an endocrinologist, or prescribed by a physician for a pregnant diabetic
- Needleless insulin jet injectors prescribed by a physician
- Blood-glucose monitoring machines prescribed by a physician
- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan. PSA Tests (Prostate Cancer Screening Tests) are not covered.

- Physician services provided outside your province of residence, limited to 3 times the amount stated in the Ontario Medical Association Suggested Fee Guide in effect on the date the service is rendered
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor. Assessments are not covered.
- Out-of-hospital treatment of nutritional disorders by a registered dietician
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist, including treatment at the Canadian Back Institute
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist. Assessments are not covered.
- Out-of-hospital services of a qualified chiropodist. Assessments are not covered.
- Out-of-hospital treatment by a registered psychologist or qualified social worker. Tests for Attention Deficit Hyperactivity Disorders (ADHD) are covered only when performed by a registered clinical psychologist. Tests of Variables of Attention (TOVA) are not covered.
- Out-of-hospital treatment of speech impairments by a qualified speech therapist
- Out-of-hospital services of a qualified massage therapist including:
  - reflexology
  - trager massage when referred by a physician

- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays. Assessments are not covered.
- Out-of-hospital services of a qualified naturopath. Assessments are not covered.

### **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.

### **Global Medical Assistance Program**

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

- On-site hospital payment when required for admission, to a maximum of \$1,000

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

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

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

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

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

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

No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada unless you are a full-time student. If you or your dependent is hospital confined at the end of the 60-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 you are entitled to without charge by law or 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
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility
  - contraception, other than oral contraceptives
  - magnetic field treatment
- 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
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
- Obus Formes or pillows
- Eneuretic devices for bed wetting
- Blood pressure monitoring kits
- Transcutaneous nerve stimulators for the control of chronic pain
- Treatment by a homeopath
- Treatment by an acupuncturist
- Hydrotherapy
- 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
- Smoking cessation products
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Proprietary or patent medicines registered under the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy
- Drugs dispensed during treatment as an in-patient or an out-patient in a hospital
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens
- Synvisc
- Drugs used to treat erectile dysfunction

## How to Make a Claim

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

Obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. Residents of all provinces except Manitoba and the Territories must also obtain the Government Assignment form and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

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

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

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

Out-of-country claims must be submitted within a certain time period that varies by province. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-800-957-9777.

- For all other Healthcare claims, 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, a Health Assure check will be done. Health Assure 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 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. 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 to purchase eyewear for yourself and your dependents at a reduced cost.

Shopping for eyewear through 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 or eye examination, 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 of purchase
- Select your eyewear and pay the reduced PVS price. If you have vision care coverage, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

## DENTALCARE

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

The plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**.

### Treatment Plan

- Before incurring any dental expenses over \$500, or beginning any orthodontic treatment, ask your dentist 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 every 36 months
  - limited oral examinations once every 6 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 once every 6 months
  - complete series of x-rays every 36 months
  - intra-oral x-rays, except bitewing x-rays, to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered
  - intra-oral bitewing x-rays once every 6 months

- Consultations required by the attending dentist, limited to a maximum of 2 time units every 12 months
- Preventive services including:
  - polishing and topical application of fluoride each once every 6 months
  - scaling, limited to a maximum combined with periodontal root planing of 8 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 hygiene instruction once every 6 months
- pit and fissure sealants on bicuspid and permanent molars for dependent children under age 19 only
- space maintainers, including appliances for the control of harmful habits, for dependent children under age 19 only
- finishing restorations
- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns, including stainless steel crowns, for primary teeth for dependent children under age 19

- Endodontic services, including isolation of teeth

Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months.

- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 8 time units every 12 months
  - occlusal adjustment and equilibration, limited to a combined maximum of 8 time units every 12 months

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

- desensitization

- Denture maintenance, after the 3-month post-insertion care period, including:
  - denture relines once each calendar year
  - denture rebases once each calendar year
  - resilient liner in relined or rebased dentures, once every 36 months
- Oral surgery
- Adjunctive services

### **Major Coverage**

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

Replacement crowns, onlays and inlays are covered when the existing restoration is at least 4 years old and cannot be made serviceable

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
  - the existing appliance is a covered temporary appliance
  - the existing appliance is at least 4 years old and cannot be made serviceable. If the existing appliance is less than 4 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth
- Denture-related surgical services for remodelling and recontouring oral tissues
- Denture and bridgework maintenance following the 3-month post-insertion period including:
  - denture remakes, once every 48 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 persons age 6 or over when treatment starts

## **Accidental Dental Injury Coverage**

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

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

## **Limitations**

If you do not apply for dentalcare coverage within one month after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic Coverage expenses are limited to \$100 during the first 12 months of your coverage
- No benefits will be paid for Major Coverage expenses during the first 12 months of your coverage
- No benefits will be paid for Orthodontic Coverage expenses during the first 24 months of your coverage

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, enlargement of pulp chambers and endosseous intra coronal implants

- The following periodontal services - topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

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

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

If additional bridgework is performed in the same arch within 48 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

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

- Expenses covered under another group plan's extension of benefits provision
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private 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, except orthodontics
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

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

Obtain form M445D from your employer. Have your dentist 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.

## 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.